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ADDRESSING BEHAVIOR NEEDS BY DISABILITY CATEGORY

by

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ADDRESSING BEHAVIOR NEEDS BY DISABILITY CATEGORY

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The purpose of this study was to determine whether students with identified behavioral needs were provided a different level of behavioral intervention based on their special education disability category verification. A second purpose of this study was to determine what caused potential differences as interpreted by individuals working in the field.

The participants in this study were school-aged students (K-12) verified in the special education categories of Behaviorally Disordered (BD), Autism, and Other Health Impaired (OHI) from four Nebraska school districts. Multidisciplinary Team (MDT), Individualized Education Plan (IEP), functional behavioral assessment (FBA), and behavior intervention plan (BIP) documents were analyzed from a sample of 310 students (107 Autism, 91 EBD, and 112 OHI). In addition to the student participants in each district, a qualitative component to the study was completed with interviews of a sample of six educators in each district in order to determine their perceptions about why there were differences in the way behavior is treated across the three verification categories.

Results indicated a significant difference in the behavior interventions for students with identified behavioral needs depending on their disability category. Significant differences were calculated from those student records, which indicated behavioral needs (Autism 65, EBD 89, and OHI 59). Students in the EBD disability category had a significantly higher percent of behavioral goals, FBAs, and BIPs when compared to

students in the categories of OHI and Autism. Students classified as OHI were least likely to have behavioral goals, FBAs and BIPS. Themes derived from the qualitative portion of the study were "process" (assessment, time, paperwork, and support), "effectiveness" (thought on training issues and implementation), and "differences" (participants' views about service differences for students depending on the disability category).

These results implied that some students with behavioral needs are not receiving what research has shown to be effective intervention; that is the use of FBAs and BIPs. It is recommended that procedures and policies surrounding FBAs and BIPS be reviewed keeping in mind the current demands on educators' time and mandatory requirements for both creation and implementation of FBAs and BIPs. Institutions of higher learning as well as school districts should also take note to ensure that programming for professionals include training that would encourage behavior intervention for all students. These results further imply that districts, states, and national administrators should undertake similar research to discover the status of behavior intervention and possible adjustments needed in their policies, procedures and staff training.

Dedication

What an incredible journey! Although I am glad it has come to an end, I thoroughly enjoyed it from start to finish. I have been fortunate to have some incredible individuals help me along the way.

First and foremost, I would like to thank Dr. Reece Peterson, my advisor. I knew when we first met that he was perfect to guide me along this path. He is truly caring, considerate, and helpful, and one of the best educators I have been privileged to encounter. I would tease that the longer I was in his office the longer my list would become, but he kept me moving forward. I know he never asked me to work any harder than he was working. In the end, WE got it accomplished.

Additionally, I would be remiss if I didn't thank the rest of my committee: Dr. John Maag, Dr. Don Uerhling, and Dr. Del Harnisch. I also had the opportunity to experience them as instructors. In both instances they were exceedingly gracious with their time.

There are lots of other individuals at UNL who helped me through. The staff at the NEAR center who met with me repeatedly, secretaries who helped me through the paperwork while I tried to get everything done from Omaha, instructors who never tired of my questions and other individuals too numerous to name.   It is with pride that I say I attended UNL because I was entirely pleased with the support at all junctures.

Lastly, I would like to thank my family. They have been terrific through the whole trip, and I do mean "trip." For five years, I have packed books and computer everywhere we have gone. My husband let me read while we drove even if it was for half an

hour. My family let me sit in the back of the van on numerous road trips, so I could plug

in my computer and spread out my materials. I often felt that I wasn't entirely "present"

for them. They allowed me to set aside time even while we were on trips to continue to

work.   In this way, I tried to precariously balance these two parts of my life.

Well guys, I'm yours now – FULL TIME.

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CHAPTER I

INTRODUCTION

Functional Behavioral Assessments (FBAs) and Behavior Intervention Plans (BIPs) have been shown to be effective in helping students maintain appropriate behaviors in schools. Since public schooling began, inappropriate student behavior has been an issue. Attempts to control undesirable student behaviors have taken many forms, including traditional corporal punishment (Hyman & Wise, 1979), and exclusionary practices that are still used today (Levin & Rabrenovic, 2004). The exclusion of children with disabilities from public schools was addressed with a series of legislative acts beginning in 1965 and resulting in the passage of the original special education law, PL 94-142 (Education of All Handicapped Children Act) that instituted the beginning of modern universal special education. Special education legislation has been amended several times resulting in changes in the special education category some students receive services. In addition the understanding of children's mental health issues has changed as research in the area has increased. This introduction will include a discussion of disabilities and mental health diagnosis to assist with the understanding of the research problem and specific questions to be addressed.

One component of special education law was to address the needs of students whose behaviors were severe enough to negatively impact learning. In 1997 the Individuals with Disabilities Education Act (IDEA) was reauthorized and amended to require that the Individualized Education Plan (IEP) team shall consider strategies, including positive behavioral interventions and supports, to address the needs of students with disabilities who display behavior problems, regardless of their disability category.

In these situations, a BIP, based on a FBA, must be created (Yell & Shriner, 1997). The 2004 reauthorization again changed the requirement slightly to indicate that the IEP teams "must consider the use of positive behavioral supports and other strategies to address that behavior" (20 U.S.C. § 1414(d)(3)(B)(i), 34 C.F.R. § 300.324(a)(2)(i)).

Although the federal law only addressed students with disabilities who were being disciplined, there appears to be consensus in the professional community that FBAs and BIPs would be appropriate and valuable for all students whose behavior was interfering with their learning (Maag, 2004).   Researchers have generally supported the efficacy of FBAs and BIPs for addressing students' behavioral needs (Sugai et al, 1999; Ellis & Magee, 1999; Symons, McDonald et al, 1998).   Research on FBAs and BIPs has also addressed students with varying disabilities (Mueller & Nkosi, 2007; Blair et al, 2007; Martin, Drasgow et al, 2005).   As a result, most researchers and practitioners would probably expect these procedures to be employed routinely with all students with disabilities whose behavior was a significant concern regardless of disability category.

Although a reasonable expectation, as a result of the research on FBAs and BIPs, would be that these procedures would universally be employed with students with disabilities whose behavior was a concern, no published research has investigated the assumption. However, a pilot study conducted by the author indicated that there was reason to doubt that all special education students were receiving these interventions when apparently appropriate. The pilot study showed a marked difference in the way behaviors were addressed, depending on the special education verification of the student. It examined the differences in the percents of behavior interventions between students verified as Other Health Impaired (OHI) and Emotionally Behaviorally Disordered

(EBD) in one high school. The purpose of the current study was to determine if IEP goals, FBAs, and BIPs were being used for three categories of special education students, those served under the categories of Autism, EBD, and OHI.

<div align="center">Disability and Mental Health Diagnoses</div>

Brief History. In order to more clearly understand the current status of special education for students, it is helpful to have a historical perspective, not only to understand the changes in special education legislation, but also some changes in psychological classifications. The three disability categories examined in this study and mental health diagnosis, although not legally tied, overlap in the diagnoses and education of students.

Since the passage of PL 94-142, there have been amendments to specify eligibility criteria for special education services, and there is constant lobbying for further changes by interest groups. These changes have created differences in the types of students served under the disability categories of EBD and OHI and have created a new category of Autism. The original disability categories were mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed (SED), orthopedically impaired, other health impaired, deaf-blind, multi-handicapped, or specific learning disabilities. The law has been through several reauthorizations. In 1990 the name of the law was changed to Individuals with Disabilities Education Act (IDEA) to emphasize person-first language (Friend & Bursuck, 2006). New categories of disability were added in the 1990 reauthorization of IDEA. Autism and Traumatic Brain Injury (TBI) were added as separate disability categories. In 1997 Attention Deficit Hyperactivity Disorder (ADHD) was proposed as an additional disability category, but ultimately was not included in the reauthorization. However, perhaps as a gesture of

recognition of this effort, in 2004 the Office of Education added both Attention Deficit Hyperactivity Disorder (ADHD) and Tourette's Syndrome to the list of possible qualifying conditions under the OHI disability description. This addition of ADHD changed the type of students who were receiving services in the OHI category. Forness, Kavale, and Davanzo (2002) have estimated that children with ADHD accounted for 68% of the new students identified in the OHI category in the 4 years before their study. This is a change since OHI traditionally served students with physical illnesses such as cancer and diabetes.

In addition, some disability names were changed. For example the word "seriously" was dropped from "Seriously Emotionally Disturbed" and "Hard of hearing" is now "Hearing Impaired." The term ED has been the subject of debate. There is a strong coalition of professionals that would like to have the term changed to Emotional/Behavioral Disordered (EBD). Nebraska uses behaviorally disordered (BD). In an attempt to be more inclusive, EBD, the proposed new title of the coalition, will be the disability term used in this paper.

Diagnostic and Statistical Manual of Mental Disorders (DSM).   Another tool sometimes used as supporting information to help determine the existence of a disability is the *Diagnostic and Statistical Manual for Mental Disorders* (American Psychiatric Association, 2000). It is the standard classification of mental disorders used by a majority of mental health professionals in the United States. The DSM may be used by clinicians and researchers in a wide variety of contexts (American Psychiatric Association, 2000). "Mental Health Professionals use this manual when working with patients in order to better understand their illness and potential treatment" (AllPsych

Online, 2004, p. 2) and to provide access to health insurance coverage. Although a DSM diagnosis is not required for special education services in most states, it is sometimes used as supporting information and these diagnoses may sometimes be found in the verifying information in students' special education files.

Identification of disabilities for special education. Changes in society and the associated changes in the identification of students with behavioral needs, such as DSM diagnoses, have led to changes in numbers of students identified as having a disability. Information from the current study will be beneficial in providing services to student regardless of their disability that may have changed with the reauthorization of special education legislation. For example, the number of students in the verification category of OHI has tripled since 1997 according to past Annual Reports to Congress. This increase may be in part a result of more students who have DSM diagnoses, like ADHD and Tourette's syndrome, having received special education services under the category of OHI. (Forness et al., 2002) Previously those students may have been identified as EBD since often these students have difficulty managing their behaviors. At their 3-year reevaluation the IEP team may have changed these students' disability categories because the OHI label is less stigmatizing than an EBD label. Because of the use of medications to treat DSM diagnoses, professionals may see OHI as a more fitting disability category since medication would indicate a medical condition. Research on conditions, such as Autism, may also have changed the perception of psychiatric conditions; behaviors may be seen as less voluntary than previously thought (Frosch, 2005; Filipek PA, et al., 2000, Connors et al., 1999). The broadening of the definition of Autism has tripled those incident numbers. These increases have made it difficult to fill the increasing number of

special education teaching positions, which are needed for these students (Deshler & Schumaker, 2006).

The explosion of the use of the internet in recent years has connected those who advocate for individuals with specific disabilities in a way that was not possible in the past. Many individuals have come together to advocate for new verification categories. There are advocacy groups for each disability category and DSM diagnosis. A quick Google search identified over 40 different nationwide advocacy groups, each with their own web site. These advocacy groups and access to the internet have made it possible for parents to easily get information about disabilities. These new resources have made today's parents much more knowledgeable about learning and psychological difficulties of all types. The public may also be more aware of the DSM and its terminology, as knowledge about the diagnoses has become accessible via the internet. It would not be unreasonable to suppose that this knowledge would give parents information to seek resources for their struggling child. Craig (2007) found that the number of students receiving treatment for bi-polar disorder has increased approximately 40%. This is just one out of many possible DSM diagnoses that would possibly allow students access to special education under the OHI category. This could partially explain the substantial increase in OHI numbers.

<center>Statement of the Problem</center>

Categories of disability have changed greatly since the passage of PL 94-142 and continue to change under IDEA. Consequently students who were served under one disability category previously may now be served under another now. Some reasons for this move in categories may be due to changed federal and state definitions and resulting

interpretations in local multidisciplinary teams, schools considering DMS diagnoses, and pressure from parents. There is concern that students who would have been originally verified under the EBD category are now verified as OHI (Boreson, 2009). The changing of disability categories would not be concerning, but as a result of the focus on EBD students as users of FBA and BIP, there has been concern that FBAs were not being conducted and BIPs were not being developed for students with troubling behaviors in other special education categories such as OHI or Autism. Researchers have shown that FBAs and BIPs are best practices for many types of students, and all students with significant behavior problems would benefit from those services. The purpose of this study was to discover if the percentage of students receiving behavior interventions for identified behavior issues in the special education categories of EBD, OHI, and Autism were equivalent, and if not, why educators believe that is the case.

Pilot Studies

The current study is an extension of two pilot studies.

Pilot Study #1. The first pilot study examined the rates of FBAs and BIPs for two disability categories, OHI and EBD. The purpose of this study was to determine if there was a difference in the rate of documented behaviors, behavior goals, FBAs and BIPs for students in the disability categories of OHI and EBD in one high school. An additional purpose was to compare the documented behaviors for severity. A convenience sample of special education students' records from these two disability categories in a suburban high school was examined. The sample included 40 students in the OHI category and 22 students in the EBD category. The primary investigator gathered data during the fall of 2006. The variables in the study were the students' special education verifications, their

behavioral problems documented in the Individualized Education Plan, the existence of goals, FBA and BIP. The data was analyzed by the primary investigator using descriptive analyses. The rate of behavior-related IEP goals and existence of FBAs and BIPs were determined for each disability category and were converted to percentages. The comments, documented in the IEP, were noted for each disability area. They were ranked from most to least severe. The behaviors were then compared across the disability categories.

This study found that a large number of OHI students (77%, 31 students) had behavioral needs, but that of those that had behavioral needs, only 71% (22 students) had behavioral goals in their IEPs. This compared to students with emotional or behavioral disorders that had identified behavioral needs (91%, 20 students), but among those, 95% (19 students) had behavioral goals. Only 19% (6 students) of OHI students had an FBA compared to 80% (16 students) of EBD students, and only 23% (7 students) of OHI students had a BIP compared to 105% (21) of EBD students. (The 105% is a result of one student not having needs mentioned but having a behavior plan in place.) This study; therefore, found an apparently large difference in the rates of FBAs and BIPs by disability category (see Table 1). However, this research did not find a difference in the severity of behavior for the two categories. The behavioral comments for each disability category were similar. The conclusion was that for this district there was a large difference in the way students' behaviors were addressed depending on the disability category. This study did not identify or address the reasons for the discrepancy, and additional research was needed to understand the reasons for this difference in treatment, and to determine whether the data from this one school were an anomaly.

Pilot Study #2. The second pilot study used a qualitative method and attempted to determine educators' perceptions about differences in the way behavior problems were treated based on disability category. This study addressed the following question: "Do special education teachers who work in the schools discern that there is a difference between the services for students with behavior concerns depending on their special education disability category?" The convenience sample of subjects included three Nebraska special education teachers who attended the National Education Association's Annual Representative Assembly in July of 2008.

Steps for data analysis were adapted from those put forth by Hatch (2002). Each teacher was interviewed employing a protocol developed by the investigator (see Appendix A). Each interview was recorded and transcribed; then each interview was read and codes were developed for the ideas expressed by participants. The three themes that resulted from data analysis were (a) data, (b) staff, and (c) conceptualization of FBAs and BlPs. Once those themes were identified, the data were examined again. The themes were used to organize the codes and place them under the appropriate headings.

Each participant in this study discussed data collection at length. It is viewed, therefore, as a very important component of FBAs and BIPs. They each indicated that data were needed to build effective plans for students. There was, however, a great deal of diversity in what data were collected and how often the data were collected. There was general agreement that there was concern about educators knowing what the data meant in terms of creating plans for students. For example, if the assessment tested and confirmed a hypothesis of "power and control" as a function of student behavior,

participants weren't sure if the staff would know what would be appropriate interventions for this function of behavior.

Staff was the second major theme to come from the data analysis. Since the schools were very diverse, it was not surprising that the personnel responsible for completing FBAs and BIPs were different. It is concerning, however, that two of the three schools had individuals responsible for conducing functional analyses rather than a team. The Center for Effective Collaboration and Practice (2007) states on its on-line help documents, "we want to stress the role that teamwork plays in addressing student behavior problems." This is especially important because the second sub theme about staff was the importance of training and the lack of staff that are trained in these procedures.

Tied to the concern about training of the individuals or teams responsible for FBAs and BIPs was the differing conceptualization of FBA and BIP. The data collection was of particular concern. There did not seem to be a clear understanding that data should be collected from several sources and that data needed to be continually collected. Being sensitive to the data and making changes when necessary is imperative to a successful plan for continued growth.

The result of pilot study #2 was a better understanding of how professionals perceived these processes relating to FBAs and BIPS. It was understood that although FBA and BIP processes are very involved, labor intensive, and time consuming, they were essential to the success of students who suffer from behavior difficulties. The additional question, "Do those who work in the schools discern that there is a difference between the services for students with behavior concerns depending on their special

education verification?" was not clearly answered by this study. Participants never approached the topic on their own when discussing FBAs and BIPs, and when asked directly appeared puzzled by the question. One participant immediately offered that she does use these assessments for students with Autism, however, then referred to only behavior rating scales as the method of assessment. The other two participants paused when asked the questions. They both indicated that they could be used for students not identified as EBD. One suggested that they are not as often used because of the amount of work involved in referring students for behaviors compared to other disability areas. In conclusion this study did highlight the differences and concerns from practitioners, but it did little to really examine the issue of differences in the rate of FBAs or BIPs depending on disability category. The current study proposed to change the questioning strategy in order to discover not only perceptions of FBAs and BIPs from current practitioners, but also if there was any awareness of differences in services for students with behavior problems depending on disability category and why there may have been a difference.

Research Questions

Research Question 1.1.

What percentage of students identified as EBD, OHI, or Autistic have Diagnostic and Statistical Manual of Mental Disorders 4th Edition - Revised (DSM-IV-R) diagnoses identified in the MDT and IEP documents?

Research Question 1.2.

What percentage of students identified as EBD, OHI, or Autistic have an indication of behavioral needs in special education documents?

Research Question 1.3.

What percentage of students identified as EBD, OHI, or Autistic who have documented behavioral needs have at least one IEP goal related to behavior? Do those goals relate to one or more of the behavior concerns identified in the documents?

Research Question 1.4.

What percentage of students identified as EBD, OHI, or Autistic and having documented behavioral needs have an FBA?

Research Question 1.5.

What percentage of students identified as EBD, OHI, or Autistic and having documented behavioral needs have a BIP?

Research Question 2.1.

If differences exist between verification categories on these questions, what are some possible explanations for these differences?

Limitations

Because this study took place entirely in Nebraska, it is impossible to generalize the results beyond the state. There is also some question if it can be generalized to the smaller districts within the state because they were not part of the samples. This study is also limited in its scope. There are students with behaviors of concern in other disability categories besides EBD, OHI, and Autism. This study did not address those students; instead those disability areas where most students with significant behaviors would be placed were chosen as the focus. In addition to the existence of FBAs and BIPs for students, the issues of quality and fidelity of implementation were not addressed.

Significance

The results of this study will, however, be of use as a model for others to use if it is suspected that a similar problem may exist in smaller districts, other states or nationwide. As a community of educators, it is important to continue to look at current practices as our population of learners changes. This study may have implications for not only individual districts but also for states and the nation. Results may have implications for federal, state, and district policies concerning services provided to students struggling with behavior. Hiring staff, both teachers and psychologists, who are trained on FBA and BIP processes, has been a challenge to districts for many years, so the results may also inform our institutions of higher learning. They may be better able to meet the staffing needs of our public schools as they continue to provide needed services to students.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Three main areas were reviewed to facilitate an understanding of current and historical research regarding the disability areas of EBD, OHI, and Autism and the use of FBA and BIP strategies to aid students and staff in dealing with inappropriate behaviors. These areas were: (a) definition, history, and prevalence of disability areas; (b) historical research on FBA and BIP; and (c) research of the use of FBA and BIP and effectiveness with each disability area (EBD, OHI, and Autism).

Definitions, History, and Prevalence of Disability Areas

A review of the definitions, history, and prevalence will aid the reader in understanding how these areas have served the same types of students during past reauthorizations of special education legislation.

Definitions

The Individuals with Disabilities Education Act is the law that provides the "rules" for placing students in special education. Each disability category is defined with criteria for student eligibility. There is a process that must be followed for determining eligibility. This process is designated by both federal and state guidelines. Students who meet specific criteria for each disability area may access special education supports.

Prevalence

Prevalence information for each of these disability categories is reported by the U.S. Department of Education. Each year an "Annual Report to Congress on the Implementation of the Individuals with Disabilities Act: To Ensure the Free Appropriate

Public Education of All Children with Disabilities" is published. Publishing is usually at least 2 years in arrears. These documents have a great deal of information about the prevalence of each disability area as well as a myriad of other facts. Using past issues as well as most current, a picture of trends could be painted. The reauthorizations of the law have revised some of the data collection procedures. For example, in 1997 the U.S. Department of Education instituted the requirement that race/ethnicity information be reported. States also report current data in much the same way, but the information is usually more current.

Emotional/Behaviorally Disordered

Definition. The terminology and definition of EBD is arguably the most controversial of the special education disabilities. There have been calls by a coalition of professionals to change not only the terminology used, but also the definition itself. The federal definition for emotional disturbance is as follows:

(i) Emotional disturbance means a condition exhibiting one or more of the

following characteristics over a long period of time and to a marked

degree that adversely affects a child's educational performance:

(A) An inability to learn that cannot be explained by intellectual, sensory,

or health factors.

(B) An inability to build or maintain satisfactory interpersonal

relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal

circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (c)(4)(i) of this section. (IDEA, 2004, CFR §300.7 (a) 9.)

This definition addresses chronicity, which indicates that the behavior problem has existed "over a long period of time"; severity, showing that the child's behavior differs from that of other children "to a marked degree" and affects the child's ability to learn or "adversely affects educational performance."

Many times students who meet the requirements for EBD are also diagnosed with a mental disorder. The DSM–IV offers the following broad categories of behavioral disorders:

Conduct disorder: Students may seek attention, are disruptive and act out.

Socialized aggression: Students join a subculture group of peers who are openly disrespectful to their peers, teachers, and parents. Common are delinquency, truancy, and dropping out of school.

Attention problems -- Immaturity: These students may have attention deficit disorders, are easily distractible and have poor concentration. They may have the tendency to be impulsive and may not think about the consequences of their actions.

Anxiety/Withdrawal: These students are self-conscious, reticent, and unsure of themselves. They typically have low self-esteem and withdraw from immediate activities. They are also anxious and frequently depressed.

Psychotic behavior: This student displays more bizarre behaviors than others do. They may hallucinate, may deal in a fantasy world, and may even talk in gibberish.

Motor Excess: Students with motor excess are hyperactive. They cannot sit still nor listen to others nor keep their attention focused.

(Watson Institute, 2005)

Although DSM diagnoses are not required for inclusion in special education, nor does a diagnosis necessarily ensure inclusion, these diagnoses are sometimes used as supportive documentation in the identification process.

History. In the original law (PL 94-142), the title of the EBD disability category was Seriously Emotionally Disturbed (SED). This definition and title have come under scrutiny over the years. In 1992, Forness and Knitzer wrote an article outlining the difficulties with the current definition. In this article they stated some of the problems.

The five SED criteria are not supported by previous or current research on subtypes of children with emotional or behavioral disorders (Quay, Morse, & Cutler, 1966; Rutter, et al., 1990). Adverse educational performance has been too narrowly interpreted to mean just "academic," as opposed to "social or behavioral," performance. Exclusion of "social maladjustment" is problematic since the original five SED criteria in IDEA were taken

from a study in which children were actually considered on the basis of

their social and emotional problems in school (Bower, 1982). In addition,

the second SED criterion virtually defines social maladjustment (i.e.,

inability to build or maintain satisfactory relationships with peers and

teachers)... the federal SED terminology and definition are currently

neither clear nor comprehensive enough to determine appropriate

eligibility in this category. (Forness & Knitzer, 1992, p. 12)

A coalition named the Workgroup on Definition of the National Mental Health and

Special Education Coalition, comprising some 30 professional mental health and

education associations, believed that students were being underserved in the EBD

disability category. Currently about .9% of all school-aged children are identified as

EBD. Conservative estimates of actual numbers from current research suggest that at

least 7% of all children and adolescents may have emotional disorders severe enough to

warrant treatment (Brandenburg, Friedman, & Silver, 1990). The U.S. Department of

Health and Human Services Annual Report (2001) indicated that 11% of students have a

mental illness that impairs their functioning. These numbers indicate that special

education is, indeed, not serving a great many students who could benefit from services.

Despite the efforts of the collaboration, and after two reauthorizations of the law, the only

change has been the elimination of the word "serious" from the title as a technical change

by the U.S Department of Education. This change was made in 1997.

Possibly because of the controversy over the definition and label, the EBD

disability category has a variety of labels in state statutes. Although their definitions are

not inconsistent with the federal definition, they often have different interpretations of the

law (McInerney, Kane, & Pelavin, 1992). In fact, many states have adopted their own specific terminology and criteria (Center for Effective Collaboration and Practice [CECP], 2001; Gonzalez, 1991; Swartz, Mosley, & Koenig-Jerz, 1987; Tallmadge, Gund, Munson, & Hanley, 1985). In addition, other governmental agencies have their own definitions. For example, the Center for Mental Health Services (CMHS) uses the *DSM-IV-TR* definition, yet the Social Security Administration's definition requires medical proof of a mental condition (CECP, 2001).

Nebraska's title for this disability category is Behavior Disordered, yet the Nebraska definition in Nebraska's Rule 51 mirrors the federal definition. The only difference is that Nebraska's definition adds a comment indicating that for children under five there is a need to show developmental impact rather than educational impact. This addition opens the door for preschool children to be served under the special education disability category of BD.

Prevalence. Nationally, the prevalence of emotional disturbance has remained stable at approximately 0.9% of the total school population since OSEP began collecting these data in 1976 (CECP, 2001). Although there has been support for instituting a new disability category for students with Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD), currently these students may be placed in several categories of disability, one of them being EBD. Information attained from a parent survey reported that 14% of ADHD students were categorized as EBD (OSEP, 2005). Another statistic reported is that:

the percentage of black students with disabilities who received special

education services for emotional disturbance is considerably higher than

the percentage for any other racial/ethnic group . . . and 2.3 times more

likely to receive special education and related services for emotional

disturbance than all other racial/ethnic groups combined (OSEP, 2005).

However, "emotional disturbance was also among the five largest disabilities for all

racial/ethnic groups except Asian/Pacific Islander" (OSEP, 2005).

Currently in Nebraska the prevalence is approximately 2,500 students in this

category, about 0.8% of all public school students. The number and percent of students

in this category have seen a slight downward trend during the last 4 years.

Other Health Impaired

Definition. Other Health Impaired was also an original disability category,

although the types of students served in this category have changed significantly over the

years. Originally this category was meant to serve students with medical conditions, such

as diabetes or epilepsy (Texas Council of Developmental Disabilities, 2008). The federal

definition is as follows:

(9) Other health impairment means having limited strength, vitality, or

alertness, including a heightened alertness to environmental stimuli, that

results in limited alertness with respect to the educational environment,

that--

(i) Is due to chronic or acute health problems such as asthma, attention

deficit disorder or attention deficit hyperactivity disorder, diabetes,

epilepsy, a heart condition, hemophilia, lead poisoning, leukemia,

nephritis, rheumatic fever, sickle cell anemia, and Tourette's syndrome;

and

(ii) Adversely affects a child's educational performance. (IDEA, 2004)

The Nebraska definition mirrors the federal definition with the addition of a statement for those below age 5, requiring proof of developmental impact (NE Rule 51, 006.04J).

The list of medical conditions in the law is not intended to be inclusive, nor do the listed conditions automatically qualify a student for special education services. Each case must be considered independently. It has also been found that average performance in a regular educational environment will not necessarily disqualify a child from receiving special education services (Grice, 2002). The Office of Special Education Programs has encouraged practitioners to look at both academic and nonacademic skills to assess the impairment caused by the medical condition. Since the addition of AD/HD in the examples of the definition, more students are being served in this disability category that have *DMS IV-R* diagnoses. "AD/HD students are the highest incidence condition in this category" (Texas Council of Developmental Disabilities, 2008).

> The other health impaired category often serves as a catchall to identify as
> eligible for special education services students who do not meet the
> qualifications for other, more clearly defined classifications or who have
> certain medical diagnoses, such as attention deficit disorder or attention
> deficit hyperactivity disorder (Grice, 2002, p. 7).

A doctor usually confirms a child's medical condition, and then the child's educational performance is examined for inclusion in the category of OHI.

History. Although OHI was an original disability category, it has seen changes. In 1997 Attention Deficit Hyperactivity Disorder was added to this list of possible impairments; in 2004 Tourette's Syndrome was added. These additions were a

compromise with those who were advocating for them to be their own disability category. These additions may have resulted in an increase in the number and type of students in this disability category.

ADHD is a condition that is considered a psychiatric diagnosis defined in the *DSM- IV-R*. Forness, Kavale, and Davanzo (2002) have estimated that children with ADHD accounted for 68% of the new students identified in the OHI category in the 4 years before their study. During the 2000-2001 school year, parents of ADD/ADHD students were surveyed to determine which disability category their child was placed in for special education services; 12% were placed in OHI (OSEP, 2005).

The addition of ADHD, a *DSM* diagnosis, in the examples for OHI in the federal definition, has also opened the door for other *DMS* diagnosis to be placed in this disability category. During the same time frame as the addition of ADHD to the OHI examples, other *DSM* diagnoses became more prevalent in the school-aged population. For example, the rate of children receiving treatment for bipolar disorder increased by 40% between 1994-2003 (Craig, 2007). Dr. Olfson of Columbia University Medical Center theorized that the increase was caused by the change in the diagnostic criteria and lack of independent subjective criteria (Craig, 2007).

Many districts have seen an increase in the number of students verified as OHI. It would seem logical to assume when students were reevaluated in the 3-year cycle some professionals chose to verify students as OHI rather than EBD because of the more negative connotation of EBD. The extent of the overlap is difficult to clearly identify. The number of students diagnosed with AD/HD has also grown, so the increase may be

due to the impact of larger numbers using OHI as a vehicle to access special education services for the first time (Low, 2009).

Prevalence. Other Health Impaired is among the five largest disability categories; the other four are Specific Learning Disability (SLD), Speech or Language Impairment (SLI), Mental Handicapped (MH) and Emotional Disturbance (ED). Nationally in 2005, nearly 450,000 students were served by special education under this disability category, which is about 0.75% of school-aged children nationally. This number is up from under 200,000 during the 1997-1998 school year (0.35%) (OSEP, 2005). This figure is up even further from under 0.2% in 1993. The number of OHI students has more than tripled in those years. The percentage of white students with disabilities who received special education services for other health impairments is nearly twice the percentage for the nearest racial/ethnic group, and they are 1.6 times more likely to received special education and related services in OHI than all other racial/ethnic groups combined (OSEP, 2005).

In Nebraska, the most recent numbers for 2004-2005 also show a dramatic increase in percent of students in the OHI special education disability category. The 1998 December child count showed 0.51% of public school students were receiving services under the OHI category. By 2004, that percent had increase to 12.3 %, an increase of over 2,500 students (Nebraska Department of Education, 2008).

Autism

Definition. Autism was not an original disability category; it was added, as its own category in the 1990 reauthorization of IDEA. The federal definition is as follows:

(i) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

(ii) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (c)(4) of this section.

(iii) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in paragraph (c)(1)(i) of this section are satisfied. (IDEA, 2004)

The Nebraska definition mirrors the federal; the only difference being the words "behavior disordered" rather than "emotional disturbance" are used since that is the disability terminology used in Nebraska.

Autism, like some of the conditions listed in the OHI definition, is also a *DSM – IV-R* diagnosis. The current *DSM – IV-R* definition of autism is as follows:

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

   1. qualitative impairment in social interaction, as manifested by at least two of the following:

a. marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

b. failure to develop peer relationships appropriate to developmental level

c. a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

d. lack of social or emotional reciprocity

2. qualitative impairments in communication as manifested by at least one of the following:

a. delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

b. in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

c. stereotyped and repetitive use of language or idiosyncratic language

d. lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

3. restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

      a. encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

      b. apparently inflexible adherence to specific, nonfunctional routines or rituals

      c. stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)

      d. persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder. (Center for Disease Control and Prevention, 2008)

The DSM definition is more descriptive than that of IDEA; however, they generally address the same areas of impairments. The term most often used in research today is Autism Spectrum Disorder (ASD):

As the term 'spectrum' indicates, there can be a wide range of effects. Those at the lower-functioning end of the spectrum may be profoundly unable to break out of their own world and may be described as having *Kanner's autism*. Those at the higher-functioning end, sometimes diagnosed with *Asperger Syndrome (AS)*, may be able to lead independent lives but still be awkward in their social interactions (Mauro, 2009).

The U.S. Department of Education's Institute of Education Sciences also recognizes this term. Their current grant descriptions use this term when describing research grants available.

History. Autism has been a recognized disability since the early 1900's, and has been a topic of research since that time as well. Early on, Autism had several names and had been studied in several countries. By 1967 there was a general consensus that Autism was a form of schizophrenia. As such, it was placed in the International Statistical Classification of Diseases and Related Health Problems (Johnson, 2008)

In 1980, the DSM-III was released and we finally see the inclusion of autism as a separate diagnostic category. At this point, there was only one autism designation and it was entitled infantile autism. Due to some controversy surrounding the descriptor *infantile*, this category was changed to autistic disorder in 1987. (Hincha-Ownby, 2008)

"From the 1980s through the early 1990s, the cause, prognosis, and treatment of Autism were vigorously under study" (Williams, 2000). In 1989, the Autism Diagnostic Interview was published (Warber, 2009). This was the first generally recognized tool for diagnosing Autism. Currently, Autism is recognized as a spectrum disorder. There are several Autism Spectrum Disorders (ASD) which include Pervasive Developmental Disorder (PDD), Asperger's Syndrome, Rett's Syndrome, and High-Functioning Autism (Autism Spectrum Disorder, 2005).

Prevalence. Autism was not included PL 94-142 legislation. However:

between 1977 and 1995 alone, the number of (autistic) students involved

in federal programs for children with disabilities increased 47%, while the

total public school enrollment decreased by 2%. These counts are based

on reports from the 50 states and submitted to Congress to aid in the

enactment of the Individuals with Disabilities Education Act by the

National Center for Education Statistics, U.S. Department of Education,

'Digest of Education Statistics,' 1997 (Williams, 2000).

These "December 1st child counts" are required for federal funding. "Although Autism

makes up a small percentage of children served under IDEA, the number of students

receiving services for Autism in the 6-through-11 and 12-through-17 age groups grew

markedly over the past 10 years" (OSEP, 2009). When reporting started in 1992 less

than 20,000 students nationwide were served by special education under the Autism

disability category. By 2001 over 90,000 students were being served in this category.

Currently autistic students account for 0.3% of all public school students. Over 80% of

those students are male. According to Centers for Disease Control's Autism and

Developmental Disabilities Monitoring (ADDM) Network, released data in 2007 that

found about one in 150 8-year-old children in multiple areas of the United States had an

ASD (CDC, 2008). Dr. Zimmerman (2000), director of medical research at the Kennedy

Krieger Institute Center of Autism, explained, "It is the fastest-growing developmental

disability in the U.S." Autism appeared in the top five disability categories only for the

Asian/Pacific Islander racial/ethnic group (OSEP, 2005).

During the 2004-2005 school year, Nebraska special educators served 838

students in the disability category of Autism. That number represented 0.3% of school-

aged students. This number was up from 240 students during the 1999-2000 school year,

which was 0.12% of the school age population. The prevalence in Nebraska has more than tripled in less than 10 years.

<div align="center">Historical Research on FBAs and BIPs</div>

During the early 20th century behaviorism came to be accepted in the field of psychology. It began with the work of Ivan Pavlov who discovered the classical conditioning process. "Through classical conditioning, a child may learn to anticipate a significant event on the basis of a preceding environmental cue reliably associated with the event" (Remington, 1996, p. 101).

"An American psychologist named John B. Watson soon became one of the strongest advocates of behaviorism. Initially outlining the basics principles of this new school of thought in his 1913 paper *Psychology as the Behaviorist Views It" (*Van Wagner*, 2009, p. 1). Watson was a critic of psychology because of its emphasis on introspection. Watson felt that instead scientific methods should be used to study only things that could be observed and measured (Dewey, 2007).

Watson's ideas inspired the work of B. F. Skinner, who also became a leading proponent of behaviorism. Skinner conducted research on operant conditioning and negative reinforcement. "He found that behavior did not depend on the preceding stimulus as Watson and Pavlov maintained. Instead, Skinner found that behaviors were dependent upon what happens *after* the response" (Van Wagner, 2009, p. 2). Skinner also extended the ideas of operant conditioning to include schedules of reinforcement.

Skinner's influence encouraged a great deal of research in the field of Applied Behavior Analysis (ABA).

The *Journal of Applied Behavior Analysis* was founded in 1968 to provide

an outlet for studies describing clinical applications of behavior analytic

concepts and procedures. A study published by Sailor, Guess, Rutherford,

and Baer (1968) in that journal in its first year provides a good illustration

of an attempt to assess the variables that control a troublesome behavior in

an educational setting. (Ervin, Ehrhardt, & Poling, 2001, p. 173)

During the early years of research, "Applied behavior analysts had great success (e.g.,

Michael, 1993). During this period, interventions based on operant (and sometimes

respondent) conditioning proved to be effective across a wide variety of behaviors, client

populations, and settings" (Ervin et al., 2001, p. 175).

These concepts were extended further with the introduction of functional

behavioral assessment. "FBA derives from operant learning theory that is grounded in a

philosophy of science known as functionalism" (Gresham, Watson, & Skinner, 2001, p.

156). Functionalism is concerned with "why" a student behaves is such a way, and is less

concerned with the topography of behaviors. "FBA can be defined as a collection of

methods for gathering information about antecedents, behaviors, and consequences in

order to determine the reason (function) of behavior" (Gresham et al., p. 157). Once the

function of a behavior is known a plan can be built to help the student acquire

replacement behaviors. Research from the early 1960's through the present has given

practitioners a wealth of information, which demonstrated the value of "defining the

variables maintaining a problem behavior prior to constructing an intervention" (Sugai,

Horner, & Sprague, 1999, p. 254). In 1997, IDEA was amended to include the

requirement that FBAs and positive behavior supports (PBS) be used to address students'

behavior needs in the school setting. It requires the IEP team to consider using PBS to address behavior that impedes the child's learning and/or the learning of others [614 (d)(3)(B)]. In addition, IDEA requires that a functional behavioral assessment be conducted for a student either before or not later than 10 days after a disciplinary action [615 (k)(1)(B)(I)] (Warger, 1999). In the 2004 reauthorization, IDEA changed from the "requirement" and opted for "recommending" the use of these strategies.

Current Research

There is substantial positive research on the effectiveness of functional behavioral assessment as a tool to decipher the function of inappropriate behavior, which leads to effective behavior intervention plans. "Basic principles of behaviors and their accompanying change procedures have been demonstrated in thousands of experiments across various species, behaviors, and conditions" (Maag, 2004, p. 66). The antecedents and consequences, which continue to reinforce the behaviors, can also be determined using an FBA. There continue, however, to be conflicting opinions on the ability of these practices to be effectually used in regular school settings. Some of the following research addresses this concern.

Strategies

Many professionals described the FBA process using similar stages, although the terminology they have used is not always identical. For example, Maag (2006) preferred the term functional assessment to functional behavioral assessment, stating that the later term is repetitive. McIntosh and Av-Gay (2007) referred to functional behavior plan (FBP) rather than BIP, which was used in this study. OSEP Center on Positive Behavioral Intervention and Support in their *Technical Assistance Guide* stated that,

A number of procedures exist for conducting a FBA, but we maintain that

any professionally appropriate assessment, at minimum, should conclude

with three main results. The first is hypothesis statements that include

three key features: (a) operational definitions of the problem behaviors(s),

(b) descriptions of the antecedent events that reliably predict occurrence

and nonoccurrence of the problem behavior, and (c) description of the

consequence event that maintain the problem behaviors(s). The second is

direct observation data supports these hypotheses. The third FBA result is

a behavior support plan. (Sugai at al, 1999, p. 13)

Ellis and Magee (1999) researched how professionals in educational settings

should address issues of students with behavioral challenges. The purpose of their study

was to combine descriptive and functional analysis of behavior into a single assessment

that could be administered in a public school setting. The results of the study indicated

that is was possible to implement this strategy in public school settings given the

appropriate support and training of staff.

Symons, McDonald, and Wehby (1998) also addressed the problem of assessing

and supporting students with difficult behavior in a regular classroom setting with school

staff implementing the behavior assessment and intervention. There are proven

strategies, which have been shown to be effective, but they are "labor and time intensive"

(p. 3). There were two purposes for their study. The first was to assess whether school

staff are able to assess and intervene in situations where students present challenging

behaviors. The second was to affect a difference in the behaviors of two students with

frequent disruptive behaviors while maintaining them in the classroom setting. Results

concluded that these interventions were successful and acceptable by the staff and did result in a reduction of disruptive behavior by students.

McIntosh and Av-Gay (2007) presented a literature review of guidelines for effective FBAs and Functional Behavior Plans. The body of literature describing assessment and intervention plans used in schools shows mixed results. There appears to be a need for more information about what makes an effective assessment and plan. The purpose of their review was to "provide six guidelines based on recent research that may lead to more effective use of FBA and FBP in schools" (p. 40). The six guidelines include: situate within an continuum of support, consider academic factors, use validated FBA measures, design and implement plans using a team approach, plan for high fidelity of implementation, and build and maintain local expertise.

Stichter, Lewis, Richter, Johnson, and Bradley (2006) took a close look at student "opportunities to respond" (OTR) strategies used by teachers to improve student academic and behavioral performance. The problem stated was that there is little empirical evidence about the professional models used to train teachers and those strategies' affect on both teacher and student outcomes. The purpose was to explore the impact of peer coaching as compared to "one-shot" in-service on both teacher and student outcomes. This data showed that OTR was successful in changing student behavioral and educational outcomes. The type of teacher support, however, did not show significant differences in the teachers' ability to implement the teaching strategy with fidelity.

Use of FBA and BIP with Disability Categories

Other Health Impaired. This researcher was unable to identify any research that specifically mentioned the OHI category of students. However, there is research, which

was conducted with students with DMS diagnoses that may have qualified them for special education services under the OHI verification category (Ellis & Magee, 1999; Stichter et al., 2006; Symons et al., 1998).

Emotional/Behaviorally Disordered. Mueller and Nkosi (2007) addressed behavioral support for EBD students. They stated that even though the benefits of FBAs and BIPs for students with severe behaviors are well documented, there was no empirical case examples published. In their article, they described the Behavior Analytic Consultation to Schools (BACS) model. The purpose of the study was to publish two case study examples of students with severe behaviors who were supported using the BACS model. There are eight components in the model. After presenting implementation of the model used to support the two students, the authors also examined the acceptability of the model to the staff. It was felt that this was an effective approach because the students' inappropriate behaviors decreased and teachers' perceptions of social validity were high.

Lane, Barton-Arwood, Spencer, and Kalberg (2007) also addressed the problem of the utility of functional assessments in school settings not being supported by literature. The purpose of their study was to train teams of teachers and as a result to determine if the training resulted in the ability to "design, implement, and evaluate the function-based intervention" (p. 35). The results were generally positive; each student made progress in decreasing undesirable behaviors. Therefore it was concluded that functional assessment could be implemented in regular schools if sufficient training was provided to the staff.

Finding effective interventions to support students with troubling behavior was the topic of an article by Stichter, Lewis, Johnson, and Trussel (2004). The problem of having limited information of intervention success at the antecedent stage was the concern addressed. These authors tested the effectiveness of a pilot program (SFAT) as compared to traditional school-based functional assessment in reducing student's problem behaviors. The SFAT was used to provide environmental and instructional recommendations to the teacher for support of all students. One student in the disability category of EBD with significant behaviors was the target participant in the study. In a single subject design, it was determined that the SFAT was effective in support of the most disruptive student in the classroom as well as other students.

McDougal, Nastasi, and Chafouleas (2005) used a qualitative study design to find an effective way to support students with disabilities in the public school settings. The purpose of their study was to use the consultation process to "increase the teachers' ability to effectively manage, accommodate, and remediate behavioral difficulties in the classroom setting so that behavior improved and the student was not referred to special education or a more restrictive setting" (p. 540). Several measures were used to collect data. A collection of meeting minute forms was analyzed as well as a variety of checklists, student daily behavior report cards, and interviews. A BCT Satisfaction Rating Scale for Teachers was also given to teachers. Results were generally positive. There was some resolution of the referral problem in 75% of the cases. The difference between successful and unsuccessful cases appeared to be a result of the integrity and acceptability of the intervention.

Autism. Butler and Luiselli (2007) stated, "many children with developmental disabilities demonstrate problem behavior that is maintained by escape from instruction" (p. 195). The best way address this type of behavior was unclear. The purpose of this single subject research with a reversal design was to use a multiphase functional analysis and intervention evaluation to change the behavior of a 13-year-old autistic girl. The data showed that it was possible to attenuate the aversiveness of instruction with a change in methods and non-contingent escape.

Even though positive behavior support has been shown to be an effective method of improving the rate of appropriate behaviors, there was little evidence of continued improvement post-intervention in a Lucyshyn et al. (2007) study. The purpose of this study was to improve the internal and external validity of PBS. Quality of life issues were also measured as well as post-intervention data. The participants in this study were a 5-year-old girl with Autism and her family. This 10-year study worked with the family to design an intervention to improve four family routines. These goals were measured using a single- subject design. Quality of life issues were measured using a more qualitative approach. The results of this study were very promising. The child's behaviors decreased to near zero levels, while her participation in family routines increased to 75%. The quality of life was also much improved for not only the student but also for her family.

Blair, Umbreit, Dunlap, and Jung (2007) stated "challenging behaviors present the single biggest obstacle to including young children with disabilities in typical early education programs" (p. 134). The purpose of their study was to ascertain the usefulness of function-based interventions for problem behaviors in order to maintain students in an

inclusive setting. Results indicated that a functional assessment created within the regular classroom environment was effective in creating a plan, which was able to change the troubling behavior of this student.

Volkert, Lerman, and Vorndran (2005) found that a functional analysis was an effective method of composing support for students with troubling behaviors; however, the reinforcement magnitude "often appears to have been selected arbitrarily" (p. 147). Therefore the purpose of this study was to determine "the impact of reinforcement magnitude on the results of functional analysis" (p. 150). Participants included six children who had been diagnosed with Autism or moderate to severe developmental disabilities. Most of the students were visually impaired and all exhibited aggression or self-injurious behaviors (SIB) or a combination of those behaviors. The study was a single subject design with dependent variables being the target behavior of the students. The results suggested that reinforcement magnitude was not a critical element in the outcome of functional analysis.

Martin, Drasgow, Halle, and Brucker (2005) studied Functional Communication Training (FCT), which uses the same behavior assessment typically used to define the function of behaviors with communicating students. The purpose of this study was to examine the direct and indirect effects of FCT for a non-verbal student. A single subject ABC research design was used. The participant was a 10-year-old autistic boy. He was taught in his self-contained classroom. He was taught to use an icon to reject an item rather than pushing or yelling. This training did decrease problem behaviors in the A-phase. Those behaviors rebounded in the B-phase. It was hypothesized that the additional effort of the new behavior was aversive enough to make the subject revert to

known patterns of rejection. "The C-phase consisted of increasing the number of trials and decreasing session duration to facilitate acquisition and to reduce the amount of downtime between trials" (p. 290). The problem behavior also returned to almost baseline frequency during the C-phase. It was thought that the communication training had little effect on the behavior.

Further Study

The research presented in the review clearly indicates that FBAs and BIPs are effective at ameliorating behaviors of many types and specifically from each of the three special education categories targeted by this review. It also became clear that these strategies were probably not used equally with all three categories. There appeared to be an absence of research on the effectiveness of FBA for students who are categorized as OHI. Although studies were found which included students who could be verified under this category, each of the studies main purpose was to validate a method of implementing FBAs and BIPs. The focus was clearly not on the students themselves. There appeared to be no published research which addressed this topic, even though OHI numbers continue to increase greatly.

<div align="center">Summary</div>

The current definitions of special education disability categories have changed the types and numbers of students who are able to access special education supports. These changes in definition have increased the number of students in the categories of OHI and Autism. Together with EBD, these students comprise the majority of students in special education with behavioral issues. Research on how to best address these issues began in the early 20th century with the work of Watson and Skinner, and it continues to the

present. "Initially, FBA was investigated as a tool for use in clinical settings. . . . However, with the legal initiatives of IDEA, researchers have expanded the investigation to … special and general education classrooms" (Katsiyannis, Conroy, & Zhang, 2008, p15). Numerous research articles have documented the effectiveness of these strategies in classroom settings with a variety of students and behavior issues. It is not known, however, if these strategies are being used with different types of students.

The present study examined the rates of FBAs and BIPs as quantitative variables for students in three categories (OHI, EBD, and Autism) to encompass those that include students most likely to have concerning behaviors. In addition, a qualitative component was used to follow-up and answered the question of why a difference was found. Special education teachers were interviewed to decipher the views of professionals. The purpose of the study was to evaluate current practices surrounding behavior intervention to ascertain if there was a difference in how the behaviors of students from different special education categories were addressed as well as the reasons behind those practices, in order to make professionals aware of a potential shortcoming. Consequently, the problems can be rectified.

CHAPTER III

METHODOLOGY

Introduction

The purpose of the present study was to discover if there was a significant

difference in the way student's behavior problems were treated depending on their special

education disability category. Students who are identified in special education as having

a disability of Emotional/Behavioral Disorders, Other Health Impaired, or Autism are

among those students most likely to have challenging behaviors. For a sample of

students in these three categories in Nebraska, the present study examined whether

behavioral issues were identified in Multidisciplinary Team (MDT) evaluation and

Individualized Education Planning documents in each of these three disability categories.

For those within each category that had behavioral issues identified, the study examined

whether these were reflected in IEP goals, and whether Functional Behavioral

Assessments with related Behavior Intervention Plans were created. Some comparisons

of other features of behavior programming for these students were also identified. In a

second part of this study a small sample of educators involved in creating these

documents were interviewed to determine possible explanations for differences in the use

of FBAs and BIPs between the disability categories.

Design

Based on the results of both pilot studies, a mixed method approach was used for

this study to address both the nature of the quantitative differences between the disability

categories and the reasons behind of the results obtained in the quantitative component.

Creswell (2008) explained, "You engage in a mixed methods study when you want to

follow up a quantitative study with a qualitative one to obtain more detailed, specific information than can be gained from the results of statistical tests" (p. 553). More specifically, this study used the Explanatory Mixed Methods Design. To keep these components clear, the first, quantitative portion was identified as Study 1. The qualitative, follow-up of Study 1 was identified as Study 2.

Study 1

Study 1 – Participants

Participants of this study were a sample of students in grades K-12 who were identified in one of three disability categories across four moderate-sized school districts in eastern and central Nebraska. Archival data were colleted from 310 students in the special education categories of Autism, EBD, and OHI. Three hundred and sixty records were requested, but not all records were usable. Student files were selected using a systematic procedure. The four school districts ranged in student population from about 6,100 to 34,000 students (Nebraska Education Directory, 2008), although all four ranked within the 10 largest districts in Nebraska.

The four school districts were selected because a sufficiently large population of students would be available in each of these three disability areas to ensure an adequate sample size in each of the four school districts. Autism, with the smallest incidence, was the category that limited district selection. It was unlikely that smaller school districts would have a sufficient population of students with Autism to be able to match samples in the other categories. In addition, it was desirable that the four school districts would be somewhat geographically separated, but still reasonably accessible for the study. Two of these districts served suburban areas, one served an urban areas and one was from a

rural setting. As a result, four districts, with a likely adequate number of identified students with Autism, were chosen; they were approached for participation, and all four were willing to participate in the study.

The minimum sample size for each disability category within each district was determined using the G*Power 3 computer program. The parameters required were anticipated effect size, alpha, power, and the degrees of freedom (df). The effect size entered into the equation was .5; this was a large effect size for a Chi square test. The pilot study indicated a large effect was likely, so it was chosen for this parameter. The alpha entered was .025. This was a conservative alpha level. It was used because of the number of separate Chi square tests to be calculated. The desired power was .975. This Chi square study had three groups, so the df was 2. Therefore, the minimum sample for each group was 83 participants. In order to plan for attrition, the actual number of subjects initially sought was 120, about 40 more than required. This figure was used to account for possibilities such as a district declining the research request, difficulty in completing requested district data gathering, or sample documents not being complete or unreadable. Each of the four school districts approached were willing to participate, and all had an adequate number of students in each category with the exception of District #1 in the category of EBD. The final number of records in each disability category across all four districts ranged from 112 to 91 for a total of 310 (see Table 2).

The samples of student files were systematically selected from each of the three categories in the four cooperating Nebraska school districts. Staff in each district created lists of students in kindergarten through twelfth grade in each disability category, OHI, EBD, and Autism. The number of students in each list was divided by 30, the number of

records to be selected (e.g. 120 OHI students/30 = 4). Because each district had slightly

different ways of managing the archived data needed for this study, a detailed list of

procedures was created for each of the four school districts. These procedure sheets are

included in Appendix 2.

Study 1 - Instrumentation/Measures

Data collection was completed using existing archived documents. The data

collection form (see Appendix C) was created by the investigator and was designed to

facilitate the gathering of information from the students' existing records, specifically

their MDTs and IEPs and to compare the rates of FBAs and BIPs in selected disability

categories. The pilot study helped to refine the form to its present state. Using the data

form the researcher documented information, not only about the rate of FBAs and BIPs

but also some of the quality indicators. Behaviors of concern were also documented.

Three of the four school districts chosen for this study used the same internet

based student record system for maintaining special education records. The fourth

district had its own computer based record system for its special education students.

Although records were obtained from two different systems, both systems contained

similar student information. These include some sections of the subject student's MDT

report and IEP, which were available for all students. The MDT pages used were the

cover page and the current level of functioning pages. The cover page included

identifying information about the student. The IEP sections that were used included the

cover page, current level of functioning page, special considerations page and goal pages

from the IEP. Included in both the MDT and IEP, these pages also included information

about the disability category. The current level of functioning pages and special

consideration pages included information about the strengths and weaknesses of the student in such areas as academic performance, language skills, behavior skills, and cognitive skills. The goal pages specifically stated the goals for student in these areas. In addition whenever FBAs and BIPs existed for any of the subject students they were analyzed.

In order to evaluate each of these students' documents, the investigator created a data gathering form. (see Appendix C)   Using the initial section of the data form the researcher recorded basic information such as age, grade, gender, and an identification number to be used in case there were questions about the record. Information about the disability verification was also found on the cover page of the MDT and/or the IEP documents. Within the body of the IEP in sections entitled "Current Levels of Performance" or "Special Considerations" narrative information was found regarding any *Diagnostic and Statistical Manual* diagnosis and or other specific behavioral issues. Although *DSM* information does not guarantee a special education verification of a disability, it is sometimes included in the document. This information may also have been located in the MDT document. Information on the FBA and BIP was found in a variety of locations depending on the district. In one district, it was part of the IEP. In others, it was a separate document which was collected from specific buildings and attached to the MDT and IEP documents (see Figure 1).

Study 1 – Procedures

The procedures among each of the four districts varied slightly as each district housed their information in a slightly different way (see Appendix 2). Generally, after the selection of participants, districts compiled the needed documents and removed any

identifying information and replaced the name with a number. This name/number list

was kept by a research contact in each district in case of questions.

Reliability. Once the documents were collected and identifying information

removed, the principal investigator completed the data collection. To ensure reliability in

data collection, 10% of the documents were checked for inter-rater reliability of at least

70% on the documented information included on the data form. A doctoral student not

connected to this study was used to check reliability. This person is currently employed

with a large metropolitan district as a behavior consultant.

Data Formatting. Once all of the data forms were completed and reliability

calculated, the data from the forms was entered on an Excel spreadsheet for further

manipulation and analysis. Descriptive statistics were calculated. Additionally, a series

of Chi square statistics were calculated on the data collected from the questions on DSM

diagnoses (#2) and behavior issues, goals, FBA, and BIP (#3-6) and a Contingency

Coefficient was calculated.

Study 1 - Research Questions and Procedures

Five research questions were addressed in this study. For each, the hypothesis

and the proposed analysis are also described.

Research Question 1.1.

What percentage of students identified as EBD, OHI, or Autistic have *DSM IV-R*

diagnoses identified in the MDT and IEP documents?

Hypothesis. It was hypothesized that there would be a significant difference in

the rate of documented *DSM IV-R* diagnosis between the three groups. Because Autism

is both a disability category and a *DSM* diagnosis, it was expected to be at a rate of nearly

100%. The other two groups (EBD and OHI) would have a percentage of students with these diagnoses, but were not expected to be near 100%.

Procedure. To answer this question, inquiries about disability category from the documents were used from the data collection form. Percentages of students in each disability category who also had a "yes" response to documented *DSM IV-R* diagnosis were calculated. Chi square statistics were used to examine whether the rates of DSM diagnosis were significantly different between the three disability categories.

Research Question 1.2.

What percentage of students identified as EBD, OHI, or Autistic has an indication of behavioral needs in documents?

Hypothesis. Pilot research found that 77% of students in the disability category of OHI had behavioral needs. The hypothesis was that 75% of students in each of the categories of OHI and Autism would have behavioral needs, and that 100% of students with Emotional or Behavioral Disorders would have behavioral needs.

Procedure. To answer this question, inquiries about disability category and behavioral needs from the documents were used from the data collection form. Percentages of students in each disability category who also had a "yes" response to documented behavior were calculated. Chi square statistics were used to examine whether the rates of documented behavior issues were significantly different between the three disability categories.

Research Question 1.3.

What percentage of students in each of the three verification categories who have behaviors of concern have at least one IEP goal related to behavior? Do those goals relate to one or more of the behavior concerns identified in the documents?

Hypothesis. The pilot study indicated that there was a sizeable difference between the percentages of behavioral goals for students in the two disability categories. It was hypothesized that there would be a significant difference between the three disability categories' rates of behavior goals. The second question was answered using the data from the goals. It was hypothesized that the rate of goals, which addressed behaviors documented in the IEPs, would not be significantly different.

Procedure. To answer this question, inquiries about disability category and behavioral needs from the documents were used from the data collection form. Percentages of students in each disability category who also had a "yes" response to behavior goals were calculated. The "yes" response to the inquiry about goal related to the documented behavior was also calculated. Chi square statistics were used to examine whether the rates of, behavior goals were significantly different between the three disability categories.

Research Question 1.4.

What percentage of students identified as EBD, OHI, or Autistic and having identified behavioral needs has a functional behavioral assessment?

Hypothesis. The pilot study indicated that there was a large percent difference between the two disability categories. The hypothesis was that there would be a significant difference between the disability categories of EBD, OHI, and Autism.

Procedure. To answer this question, inquiries about disability category and behavioral needs from the documents were used from the data collection form. Percentages of students in each disability category who also had a "yes" response to FBA were calculated. Chi square statistics were used to examine whether the rates of FBAs were significantly different between the three disability categories.

Research Question 1.5.

What percentage of students identified as EBD, OHI, or Autistic and having identified behavioral needs has a BIP?

Hypothesis. A larger difference was found in the percentages of BIPs for each of the disability categories in the pilot study. The hypothesis was that there would be a difference between the rates of BIPs for the three disability categories.

Procedure. To answer this question, inquiries about the existence of BIPs was used from the data collection form. Percentages of students in each disability category who also had a "yes" response were calculated. Chi square statistics were used to examine whether the rates of BIPs were significantly different between the three disability categories.

Since a number of Chi Square analyses were conducted, a conservative alpha level was established at .025.

<div align="center">Study 2</div>

Study 2 - Subjects

Qualitative sample. Two special education professionals from each grade level in each district were selected from a list of special education staff members from each district. Although it would have been ideal to be able to select more than six staff

members from each district, the investigator decided that time and cost constraints prevented more than two from each level in each district. Twenty-four professionals from all districts were viewed as a sufficient number to assess the views of professionals in these four districts. The intent was to sample from the various professionals directly involved in the process of undertaking FBAs and creating BIPs.

The principal investigator was provided a list of special education personnel delineated by building so that she had the names and contact information for special education staff separated by school and level – elementary, middle, and high school. In addition she was provided a list of psychologists, behavior consultants and other professionals who might be involved in developing FBAs and BIPs for students. Using a systematic process like the one used to select students, one teacher from each group was randomly selected and then the others were chosen by taking the number of possible teachers and dividing by the number needed, using that number to count down the list from the first teacher. A sample of one teacher from each level and one of the psychologists or consultants was selected. The principal investigator contacted those professionals and using criteria based on experience with FBAs and BIPs and willingness to participate, accepted or rejected them until a sample number of six teachers, and/or psychologists, coordinators or other professionals willing to participate was identified from each district.

Study 2- Instrumentation/Measures

Interview information was collected using the interview protocol (see Appendix 4). This protocol was modified from the original used in the pilot study. This form is open-ended as is appropriate with qualitative studies. It asks a few questions about the

participant's view on FBAs and BIPs. It also specifically asks about their view on any perceived differences in services provided depending on disability categories. This change was made because participants in the pilot study never approached the specific subject. Additional follow-up questions permitted the researcher to obtain better information than was possible on the pilot. This protocol was given to the participants in advance of the interview to facilitate the subjects having time to ponder the question about the difference in services depending on disability categories. The pilot study showed that participants had difficulty with this question.

Study 2 - Procedures

Interviews were conducted at the convenience of the subjects. Less than one hour was needed to complete each of them. Each interview was recorded and during the interview the investigator took notes about the details of the interview. After interviews were conducted the recording was transcribed. Member checking was done to ensure validity and accuracy of the information. During the interview the researcher would often restate the information shared to check for accuracy. After the interview was completed, a transcript of the interview was provided to each participant asking him or her to read through it and provide the researcher with any information that was incorrect or did not seem to be clearly communicated. (Kuzel & Like, 1991)

Using a grounded theory approach, which Creswell (2007) describes as forming a theory which might explain practices, the data were analyzed.

Study 2 - Research Question

Research Question 2.1. If differences exist between verification categories on these above questions, what are some possible explanations for these differences?

Hypothesis: During the qualitative pilot study some central themes emerged; one of these was the use of data. There was concern about the amount of time data collection requires. There was also concern about the frequency of data collection. Another theme involved the lack of training of staff. The hypothesis was that these themes would emerge again and would more completely describe the differences in procedures for students in different disability categories.

Study 2 Data Analysis

Teachers at each level (elementary, middle, and high school) from each district were interviewed using the interview protocol and interviews were transcribed. Most interviews took about ½ hour. These interviews were analyzed using a grounded theory approach. Open coding was the first step, which was followed by axial coding to define the themes. Hypotheses were developed that partly explained the results of the quantitative piece of the research.

Institutional Review Board

In compliance with University policy on human research, the research protocols for both studies were submitted to the University of Nebraska-Lincoln's Institutional Review Board (IRB). The IRB's purpose is to "foster responsible conduct of university research and scholarship, in compliance with federal, state and university regulations and guidelines" (UNL, 2009). Approval was received on March 26, 2009. The IRB approval number is 2009039020EP (see Appendix 5).

CHAPTER IV

RESULTS

Introduction

This study was completed using a mixed method design, so for the ease of the reader, the two parts will be noted as Study 1 and Study 2. In Study 1 data were collected from existing documents on special education students in order to answer the questions pertaining to the differences in behavior services for students depending on their special education disability category. In Study 2, interview data was analyzed to determine possible explanations for difference in the way services were provided to students based on disability category.

Study One

Reliability

A doctoral student in the UNL Special Education Department who was not connected to the study checked reliability. This professional is currently employed as a behavior specialist for special education services in a large metropolitan district which did not participate in the study.

Procedures indicated that 10% of the records would be checked; however 11.6% were actually examined. A random sample was selected from two districts for the reliability check. Although much of the data was marked according to "yes" or "no" if the item was in the student's files, the item involving the identification of behavioral issues in the documents and the item on whether a goal was found that addressed the behavior, required expert judgment. The goal was to reach reliability of at least 70% on

each of the four primary questions. Reliability for "behavior issues identified" was 86%, goals 81%, FBA 94%, and BIP 100% agreement.

Participants

Student records came from all levels – kindergarten through twelfth grade. Some records only indicated school placement as elementary, middle, or high school, so exact numbers from each grade could not be calculated. One hundred and forty seven students were elementary (grades K-5; 47.4%), 91 students were middle level (grades 6-8; 29.4%), and 72 were high school level (grades 9-12; 23.2%). It appeared that there was a similar representation from all grade levels. The sample was 80.6% male. Each district had a similar percentage spread in gender, ranging from 74% to 86.3% male.

Research Question 1.1.

The first question was "What percentage of students identified as EBD, OHI, or Autistic has DSM IVR diagnoses identified in the MDT and IEP documents?" During data collection, the question, "DSM diagnoses identified anywhere?" was answered yes if there was any indication that the condition had been diagnosed by a medical doctor or outside psychologist. This distinction was important, especially for Autism, because it is also a *DMS* diagnosis. Many Autistic student records indicated that school personnel had determined the disability, and there was no indication of diagnosis made by someone outside the school district.

There were a variety of *DSM* diagnoses documented in student records. Most of these were found in the Present Level of Functioning section of the IEP or on the MDT document. Nineteen different diagnosis were found; eight of them occurred three or more times (see Table 5). Attention Deficit Disorder with and without hyperactivity

accounted for 100 of the 174 records with *DMS* diagnosis. Of those in the OHI category, 78 of 87 were diagnosed with ADD/ADHD, and 22 of 43 students identified in the category of EBD were diagnosed with ADD/ADHD. Autism Spectrum Disorders (Autism/Asperger's/PDD- NOS) combined for a count of 44 student records. The rest of the diagnoses were found in comparatively small numbers.

Using SPSS, Version 17, a Crosstabulation and Pearson Chi Square Test of Independence analysis were computed. Analysis indicated a significant difference in the percentages of students with a DSM diagnosis (see Table 4), in the three disability categories $\chi2(2) = 33.82$, $p < .025$ ($p = .000$). It was hypothesized that the Autism percentage would be near 100%, however it was calculated to be 41.1% (44 of 107) of the sample. OHI was the biggest percentage at 77.7% (87 of 112) and EBD was 47.3% (42 of 91).

Research Question 1.2.

The second question was "What percentage of students identified as EBD, OHI, or Autistic has an indication of behavioral needs in special education documents?" During data collection, the question, "Are behavioral issues identified in the IEP's present 'current levels of functioning'?" was answered, "yes" if there was any indication that the student displayed behaviors that were outside the norm. The results showed 97.8% (89 of 91) of those students identified as EBD did have behavioral issues documented. It was also expected that those student records from the Autism category would have a larger proportion of "yes" answers. This category did show a majority of students had behavioral issues at 60.7% (65 of 107). Traditionally, the OHI category would show a smaller percentage of behavioral needs, as it was originally intended for

students with purely medical needs. In reality, slightly more than half of the records from this category indicated behavioral issues with 52.7% (59 of 112) (see Table 6).

Using SPSS, Version 17, a Crosstabulation and a Pearson Chi Square Test of Independence analysis was computed. Although there was a difference in the percentages of students with behavioral needs, this difference was expected. It was hypothesized that the percentage for students in the categories of Autism and OHI would be near 75%; both percentages were below that level. The difference between the groups was statically significant $\chi2(2) = 52.367$, p < .025 (p = .000).

Research Question 1.3.

The third question was "What percentage of students identified as EBD, OHI, or Autistic who have documented behavioral needs have at least one IEP goal related to behavior? Do those goals relate to one or more of the behavior concerns identified in the documents?" Using records of students who had documented behavioral issues, it was expected that 100% (n=213) in all categories would have goals related to those needs. This was found to be true for the EBD category. The OHI and Autism categories did not show that needs were addressed at that level. OHI had 78% (46 of 59) and Autism had 87.7% (57 or 65) which were significantly below 100% (see Table 7).

Using SPSS, Version 17, a Crosstabulation and a Pearson Chi Square analysis were computed on only those records of students with behaviors of concern noted on special education documents. The number of students noted as "yes" was 192. There was a statistically significant difference in the percentages of students with behavioral goals $\chi2(2) = 20.013$, p < .025 (p = .000). This indicated that students in the disability

categories of OHI and Autism have a lower rate of behavioral goals for behavior significant enough to be noted in their IEP documents.

Research Question 1.4.

The fourth question was "What percentage of students identified as EBD, OHI, or Autistic and having documented behavioral needs has a FBA. It would be expected that students in the disability category of EBD should have an FBA; however, only 47.2% (42 of 89) of those records indicated that the student had an FBA. Although research has shown FBA to be a useful tool when addressing behavior needs, the pilot research indicated that it would be much less likely to be used with students in the categories of OHI or Autism. This current research clearly indicated that trend to be accurate, with only 10.2% (6 of 59) of OHI records and 12.3% (8 of 65) of Autism records indicating that an FBA has been completed (see Table 8).

Using SPSS, Version 17, a Crosstabulation and a Pearson Chi Square analysis were computed on only those records of student with behaviors of concern noted in special education documents. Analysis confirmed a significant difference it the percentages of students in different disability categories with FBAs; this difference was expected. It was hypothesized that the percentage for students in the categories of Autism and OHI would be significantly lower than the percentage for EBD students. The difference between the groups was statically significant $\chi2(2) = 34.532$, $p < .025$ ($p = .000$). This indicates that students in the disability categories of OHI and Autism have a lower rate of FBAs for behavior significant enough to be noted in their IEP documents.

Research Question 1.5.

The fifth question was "What percentage of students identified as EBD, OHI, or Autistic and having documented behavioral needs has a BIP?" Since best practices indicate that an FBA is conducted prior to the BIP and is used to create it, it would be expected that the frequency percentages would be much the same. It was found, however, that there were higher percentages for BIPs. The EBD category frequency of records was 61.8 % (55 or 89), OHI was 32.2% (19 of 59), and Autism was 38.5% (25 of 65), indicating that a BIP was present (see Table 9).

Using SPSS, Version 17, a Crosstabulation and a Pearson Chi Square analysis were computed on only those records of students with behaviors of concern noted in special education documents. Analysis indicated a significant difference it the percentages of students with BIPs; this difference was expected. It was hypothesized that the percentage for students in the categories of Autism and OHI would be significantly lower than the percentage for EBD students. The difference between the groups was statically significant $\chi2(2) = 14.909$, $p < .025$ ($p = .001$). This indicates that students in the disability categories of OHI and Autism have a significantly lower rate of BIPs for behavior significant enough to be noted in their IEP documents.

<div align="center">Study 2</div>

Participants

Twenty-four teachers, six from each district, were interviewed. Two interviews were conducted over the phone; the remainder of the interviews was conducted in person. Several different locations were used for interview sites including homes, coffee shops, schools, and restaurants. Questions and the consent form were sent in advance of each

interview. Each district had participants selected from each academic level; two from elementary, two from middle school and two from high school. At least one participant at each level was the person primarily responsible for conducting FBAs and creating BIPs. Because school psychologists and behavior interventionists hold this role in many settings, there was some overlap in levels as these professionals will often serve students at several levels. The participants included four males and 20 females. The amount of experience of the participants varied greatly, spanning over 25 years. Some participants were relatively new with 2 years experience; others were in their last year before retirement. The amount of time spent in their current position also varied greatly. Many had new assignments; others had been working in the same site for their entire careers. It was felt the sample was a good representation of special education staff population.

Each participant signed the consent form and was willing to have their interview recorded and transcribed. Using the interview protocol, the interviews were semi-structured. There were four open-ended questions and an invitation to share more at the end of each interview. The researcher would often ask probing questions to have the participants elaborate on their answers. Each interview lasted approximately 25 minutes. After the interview, the primary investigator transcribed the conversation and sent it back to the participant for review. Participants were asked to check for accuracy and to see if the answers truly reflected their opinions, then respond with any corrections or additions needed. In this way, the data were checked for accuracy and participants had an opportunity to clarify answers prior to analysis.

Data Analysis

As the primary investigator transcribed the interviews, notes were made about the general tone of the interview, general impressions, and main ideas expressed. Although difficult to quantify, there was the general impression that those who were responsible for conducting the FBA and creating the BIP had a better understanding of the process. In District #4, case managers, rather than school psychologists or behavior interventionists, were responsible for the FBA and BIP. In some cases these staff members had a better understanding of the process than their peers in districts where they were not primarily responsible for these processes.

After all interviews were complete, the data were coded. "Coding is the strategy that moves data from diffuse and messy texts to organized ideas about what is going on." (Richards & Morse, 2007, p. 150) This process allowed the researcher to be totally immersed in the data. At this step data were also inspected line by line to discover topics of meaning. Quotes of significance were added to the categories. After the initial coding, the data were again compressed into categories of text. The text was analyzed several times with different arrangements of central ideas. Lastly the categories were introduced back into the original questions as a way to evaluate how the questions were answered by the coded categories. The question was asked by the researcher, "How do these categories of information answer the research questions?" The research question for the qualitative piece was, "If differences exist between verification categories on these quantitative questions, what are some possible explanations for these differences?"

Themes

After reflecting on the data from the perspective of the research question, three major themes emerged. These themes were process, effectiveness, and differences. (Figure 2) The theme process included ideas about how the FBA was conducted, including paperwork required, and by whom, how often the FBA was completed, and evaluation concerns. The theme effectiveness consisted of positive reflections and concerns about training issues, how well the resulting behavior plans were implemented, and how behaviors were affected. Differences expressed the participants' views about service differences for students depending on the disability category.

Process. A large part of the discussions with teachers included this theme about the surrounding processes involved in FBAs and BIPS. This theme had many sub-topics: assessment, time, paperwork, and support. Views on these topics also varied as far as approval or concerns about those special education processes.

The first sub-theme was quality assessment. There were concerns that when looking at behavior issues, the first step should be to address academic needs. Three different participants mentioned that this was often an issue that was not addressed. This comment was particularly insightful when discussing the academic needs not being met for EBD students, ". . . you would never let that happen with an autistic child. But I don't see that same kind of relentless focus with the BD kids, that is troubling I think."

The second sub-theme of process was time. Admittedly, these processes do take time. One participant quoted one of her university instructors when she said, "Make sure that it is a behavior that you really want to change because it is going to take some work." Another teacher commented, "The paperwork, teacher meetings, lesson planning, and

parent meetings, (and) IEPs are extremely time consuming. You barely have time to

actually spend individual time with the students on your caseload."

The third sub-theme under process was paperwork. One concern, which relates to

time, that was heard repeatedly was dismay at the amount of the paperwork involved.

One teacher with a Masters Degree in behavior disorders made this observation,

I am concerned about the process of behavior assessments. I think you

should be able to observe the behavior and discover the function fairly

easily. It has become a document with pages and pages, which ask the

same questions about function several different ways. Function is the key,

but the process has become too cumbersome.

Another teacher quipped, "I think for some it might be more of a paper process rather

than a working process." Often teachers would say apologetically that they have plans

that work for students, but they are not written down anywhere. These comments would

explain some of the lack of FBAs and BIPs found in student records.

The fourth sub-theme, which was connected to time and paperwork, was

evaluation. The concerns reflected the worry about how often and how well plans are

evaluated once they are put into place. A comment like this one was common, "I have

concerns about the program evaluation. I think we go along and get so busy that we

forget to evaluate. Our behavior specialists have other things to do, so if things seem to

be going well, they don't get to the assessment." Another common thread was this

comment, "The problem with behavior planning in general is a lot of times they're

developed and they look really nice on paper, but they're not used. Or they're abandoned

if the student doesn't do well – without revisiting the plan." Some special education staff

seemed to know that this is not best practice since many mentioned that "Once a year is not frequently enough to revisit a behavior plan." Others made comments about not having to do FBAs since the student had already been identified as EBD. Remarks, like this one, which indicate that FBAs are only used for evaluation at the time of verification, were common at all levels, "The behavior assessment is usually a group effort by the school psychologist and myself on some new kiddos that we get at the high school." These comments seem to indicate FBAs are only used at the time of verification, which is not helpful in developing and monitoring a quality BIP.

The final subtopic under process was support for staff when completing the FBAs and BIPs. Again this subtopic had a wide spectrum of views. Many teachers expressed pride in the fact that there was support of teachers in a variety of ways. They talked about working in teams to complete FBAs and write plans. There seemed to be comfort in the fact that someone was in charge of the process. Comments such as this were commonly recorded, "We have behavior specialists who lead the process. It is always a team process though." The leadership of these plans varied also. Cadre, behavior consultants, behavior specialists, school psychologists, therapists, team leaders, and behavior interventionists were all staff positions that were reported to have led the assessment and plan development. In three of the districts, few special education staff outside of these previously stated positions felt they were responsible for these documents

In the fourth district, special education teachers were very much the leadership in these assessments and plans. In this district there was concern about the time needed to complete this process. One teacher showed her frustration in this comment, "So in our

inclusive based setting in the high school, I don't look at the behavior plans as much as I should because there is other things that they need too – that we need to work on just to get them to graduate." These teachers also mentioned at the high school level that it was not a team process unless it was an initial evaluation.

Effectiveness. A large portion of the effectiveness conversations dealt with the implementation of the behavior plans and training issues. Again these discussions covered the spectrum of views, although the participants rarely disagreed. They felt that well-implemented plans were effective and poorly implemented plans were not. They also generally felt that if people understood the process and value in BIPs, they would be implemented well. If there was a lack of knowledge, it was more difficult to get teachers to "get on board."

Training was a sub-theme of effectiveness that was addressed at many levels. Nine participants made comments about their concern with the lack of training. One middle school psychologist commented, "Last year behavior was a focus in our district and one of the things that was brought to light was the fact that not all of our special education teachers knew what an FBA was." Another teacher from an elementary school in a different district made the following comment when discussing the lack of training, "It seems like sometimes people go to great lengths to avoid them [FBAs and BIPs]." She went on to explain that the special education teachers in her school had only 1 hour of staff development on FBAs.

Training was also mentioned in a positive light. Several teachers mentioned the ability to use the structure of FBAs to teach other staff members about the functions of behaviors and how to monitor behavior. They mentioned that staff members were

empowered when they were able to see improvement. One school psychologist who had

moved to a new building commented on the difference from building to building. She

said, ""The FBA or behavior intervention plan may have been just integrated into the

fabric of my last school. And to come here and it seems so foreign. [Teachers say],

"Why do I have to have a behavior plan for this student?'" Overall, staff seemed to feel

that there were some training issues. It was felt that the training that happened when staff

were guided through the process was the most valuable.

Motivation seemed to be a problem for implementation on several planes. One

teacher said, when discussing motivation, "Having the teachers understand that this isn't

just about extrinsic motivation, which a lot of people see as bribing, it's about making

students feel successful by allowing them to be comfortable in their own skin and

comfortable in the school setting." They also worried about putting an extra load on

classroom teachers. One participant explained, "The size of the classroom, the amount of

support, types of student disabilities, teacher knowledge of interventions all have a big

impact on how effective the plans are." Most staff members taught in settings that were

inclusive, which meant that special education teachers were supporting students in

multiple classrooms. Therefore, special education teachers weren't always available to

implement the plan. This was especially true in middle and high school settings. One

teacher worried, "I'm at the mercy of other teachers because the behavior is happening in

their classrooms, so I have to look at their data and figure it out. And sometimes their

data can be – we'll call it skewed." Another explained her concern when she said,

> The only concern I have about behavior plans in a high school setting and
>
> probably in a junior high setting, . . . you're working with seven different

teachers and then an advisor and so you have all of these different

dynamics within each classroom, so they can be tricky for a student who

has behavioral or emotional issues.

As well as concerns, there were several positive comments relating to

effectiveness. One elementary school counselor explained, "Teachers like them because

we get kids to be turned around and changed." Another explained that the use of FBAs

and BIPS "helps reduce the number of students who are really out of control." Many of

the participants worked in schools that had a Response to Intervention (RtI) structure.

Many mentioned that FBAs were initiated when students reached Level Three

interventions. One teacher expressed her views by saying, "I think any time a behavior

has been elevated to the point where it needs to be on a plan, it's a positive because

people have noticed it, they have identified it and they're working with it." This

comment shows that staff in this particular setting have bought in to the process and see

value in it.

Differences. The third theme was differences in services. This question was

asked directly to the participants, "Do you believe that the services provided to students

with behavior needs are different depending on their verification category?" As with the

other themes, teachers differed in their perceptions. Some felt that absolutely there were

differences in the treatment of students depending on disability category and others felt

that there was no difference. As they talked about procedures and expectations of their

diverse settings, most of them probably were accurate. Overall, however, the quantitative

part of the current study clearly shows a significant difference in procedures. Seventeen

of the participants were able to give a clear yes or no answer to the question. Eight said

that there were no clear differences and nine said that there were differences. The other

seven participants were not sure or qualified their answer in such a way that it was

unclear. When asked the question, one of those teachers who was unsure asked if she

could look at her files. She checked the files of students who were not EBD but who had

significant behaviors and added, "So I guess what you're asking, Do they do that

consistently? No I guess not . . . Not seeing it."

Most teachers who felt there was not a difference added that they served all

students according to their needs. One high school teacher summed up her feelings with

this statement, "I think that the underlying philosophy is that no matter what the

verification, we have to serve them appropriately." This high school teacher was the

exception rather than the rule. Most of the respondents who did not feel that there was a

difference worked in elementary settings; six of the eight were elementary staff members.

When teachers expressed the view that there was a difference, they also most

often expressed the view that there should not be one. One high school psychologist

made this statement, "There should not be a difference, but I think we approach students

differently based on their verification. I think we should look at the students' needs

without bias first." She was referring to the idea that Autistic students may be allowed

some of their inappropriate behaviors because people view their disability differently. In

fact, one teacher described a likely scenario were two students were refusing to give a

speech at the middle school level. She stated that she would be very firm with the EBD

student because he could do the speech, but that she would allow the Autistic student to

have extra practice and perhaps another setting to give his speech. She didn't seem to

have two particular students in mind, but as a general rule that was how students in these two categories would be treated in her classroom.

Other teachers mentioned policy, which created differences in services. Several teachers in one district made similar comments to this one,

> The requirement is that if a student is verified as having a behavioral
> disorder, they have to have a behavior plan. Although I think that there
> are times, when a student may not necessarily need a behavior plan as
> much as a student within another category. And I think that with all the
> paper work we do, we sometimes get a little bit lazy and don't do behavior
> plans for kids who are, maybe OHI, and need one. Or even kids who have
> autism and need a behavior plan. We work on their behaviors, but we
> don't write it up. We don't functionally analyze it.

Programs in one district also required an EBD label to acquire those services. One teacher, when discussing a student who had changed labels from EBD to autistic, made the following comment, "There's another program in our district for BD kids but because his label was not BD any longer, he could not go there, so it kind of shut a door for him." She was expressing her desire to have the assistance of a behavior specialist, which because of the student's disability category she could not access.

CHAPTER V

DISCUSSION

Overview

The purpose of this study was to determine whether students who have identified behavioral needs are provided a different level of behavioral intervention based on their special education disability category verification. The question of why such differences existed was explored through interviews with special education staff. The results indicated that there was a significant difference in the percentage of students with DSM diagnosis and behavioral concerns. Additionally, there was a significant difference in the percent of goals, FBAs, and BIPs for students in the disability categories of EBD, OHI, and Autism. Special education professionals' discussions about these issues centered on the themes of: process, effectiveness, and differences. The first theme included several sub-themes: assessment, time, paperwork, and support. This discussion of results will continue to be reported as Study 1 and Study 2 for the ease of the reader.

Study 1

The quantitative study addressed five research questions. They were:

Question 1.1 What percentage of students identified as EBD, OHI, or Autistic has DSM IVR diagnoses identified in the MDT and IEP documents?

Question 1.2 What percentage of students identified as EBD, OHI, or Autistic has an indication of behavioral needs in special education documents?

Question 1.3 What percentage of students identified as EBD, OHI, or Autistic who have documented behavioral needs have at least one IEP goal related

to behavior? Do those goals relate to one or more of the behavior concerns

identified in the documents?

Question 1.4 What percentage of students identified as EBD, OHI, or

Autistic and having documented behavioral needs has a FBA?

Question 1.5 What percentage of students identified as EBD, OHI, or

Autistic and having documented behavioral needs has a BIP?

Review of Statistics. Each of the previous questions was answered by a

calculation of a Crosstabulation and a Pearson Chi Square Test of Independence. Each

question showed a significant difference in the percentages for the three groups, Autism,

EBD and OHI, although the difference was not always what was hypothesized.

Research Question 1.1 was, "What percentage of students identified as Autistic,

EBD or OHI has DSM IVR diagnoses identified in the MDT and IEP documents?" This

question was addressed because it relates to the type and severity of the disability. It was

used to compare the three categories in relation to the type and severity of their disability.

The answer to this question was also seen as an indicator of how the members of the OHI

category had changed in the last few years. For example, the number of students in the

verification category of OHI has tripled since 1997 according to *Annual Reports to*

Congress. This increase may be partially a result of more students who have *DSM*

diagnosis, such as ADHD and Tourette's syndrome, having received special education

services under the category of OHI. The current study's sample appears to corroborate

that theory as 80 of the 87 students in the OHI category had a DSM diagnosis of ADD or

ADHD.

Presumably a student's disability would need to be perceived as a significant problem for the parents and/or the school personnel to consider an outside authority as a resource for the child. It was also presumed that a *DSM* diagnosis would indicate a mental disorder rather than a purely physical disorder, as in the case of traditional OHI special education verification.

It was hypothesized that the Autism category would find nearly 100% of the students with a *DMS* diagnosis, since Autism is not only a special education disability category but also a *DSM* diagnosis. This assumption proved to be incorrect for this sample. Only 41.1% of the records indicated that a doctor or outside psychologist had diagnosed the condition. This would indicate that school personnel have placed the majority of students in this disability category.

The largest percentage of *DSM* diagnosis was in the OHI category; 77.7% of students. This statistic clearly shows the shift in types of students identified in this category. The researcher's assumption when beginning this research was that a significant number of students in the OHI category did have *DSM* diagnosis. The shift in types of students is shown since traditionally students with purely medical needs were placed in the OHI category. If this sample is an indication, approximately ¾ of students in this category have a mental health rather than purely medical diagnosis. Eighty of the 87 records in the OHI category in this sample with *DSM* diagnoses were diagnosed with either ADD or ADHD.

Nearly half of the students verified in the special education category of EBD had a *DSM* diagnosis (47.3%). Of those 43 students, 18 had a diagnosis of ADD or ADHD.

Other diagnoses with multiple occurrences were Bi-Polar, Oppositional Defiant Disorder, and Anxiety Disorder (see Table 5).

Although these results were not expected, they did show that the rate of *DSM* diagnoses for the categories of OHI (77.7%) and Autism (41.1%) were close to, if not over, the rate of EBD students (47.3%). (See Table 4) This could be viewed as an indication that the severity of the disability categories was much the same. The assumption is that if the severity was similar then the resulting intervention should be on the same level.

Research Question 1.2 was "What percentage of students identified as EBD, OHI, or Autistic has an indication of behavioral needs in special education documents?" Assuming that the severity of the disability was similar, the documentation of behavior issues should have also been similar. In the case of autism and EBD, the higher percentage of behavior indications over the *DSM* percentage is understandable. Neither of these two disability categories requires *DSM* diagnoses to be placed in the verification category. The verification of students in either of these categories, by definition, indicates some behavioral issues, although of different types. The OHI category would require a student to have a *DSM* diagnosis or other medical diagnosis to acquire special education services. The EBD percentage was 97.8%; however, the Autism percentage was much lower at 60.7%. As explained in one interview, Autistic students are perceived as less in control of their behaviors, which may explain the lower percentage. Whether these perceptions are accurate or not is debatable. The OHI percentage of 52.7% was confusing. The researcher expected the percentage to be near the percentage of *DSM* diagnoses or at least close to the percentage of students identified as ADD or ADHD

(71.4%). The percentage was, however, the lowest of the three at 52.7%. This may also be a result of a difference in perception by special education staff since an OHI verification was traditionally for students with health issues. They may perceive the students as less in control of their behaviors, too.

Even though the resulting percentages were not as high as expected, it should be noted that over half of the students in each category did have behaviors severe enough to be noted in their special education documentation. If behavior issues were noted in the Current Levels of Performance section of the IEP, they should have been addressed by goals and, if severe enough, by FBAs and BIPs. Not all behaviors are of the severity that would warrant the time needed to complete a FBA and BIP. An example of this type of behavior mentioned in the documentation was, "Not using time wisely." Although certainly something that would impact education success, it would probably be addressed with a goal. In contrast, a behavior such as "Has pinched adults with whom he is working," would clearly need to be addressed with and FBA and BIP in order to understand the function of the behavior. In summary, behaviors that manifest themselves internally may be more likely to be addressed with goals only; whereas behaviors that are expressed externally would more likely be addressed with a goal, FBA, and BIP.

Research Question 1.3 was "What percentage of students identified as EBD, OHI, or Autistic who have documented behavioral needs have at least one IEP goal related to behavior? Do those goals relate to one or more of the behavior concerns identified in the documents?" As was expected, the EBD category had a percentage of 100% for goals related to behaviors documented. In fact, although not included in the analysis, one student who did not have documented behaviors did have a behavior goal. The other two

categories had significantly lower percentage of goals that addressed behaviors noted in IEP documents (OHI, 78% and autism, 87.7%). As a result we might presume that, as predicted, students in these two categories do not have their behavioral needs met in the same way as EBD students. Fewer of these students had behavioral goals identified. This difference should be troubling to those in the profession. As one teacher commented, "Behavior is everything. You can't get out of control or you can't learn." It would be important to have a behavioral goal, so that change in behavior is being sought and measured, indicting if growth is occurring.

It should also be noted that goals varied a great deal. District #2 had obviously trained staff in how to make their goals measurable and include baseline data. An example of such a goal was, "Will demonstrate compliance by following directions increasing from 1.8 average to 3 of 5 times refraining from arguing or talking back during a class period." In contrast, goals such as this were also seen repeatedly, "Demonstrate appropriate social skills." It is beyond the scope of this research to quantify these responses except to point out that there was a large discrepancy in the quality of goals stated.

Research Question 1.4 was, "What percentage of students identified as EBD, OHI, or Autistic and having documented behavioral needs has a FBA?" The differences in services were the greatest in this category. There was a very clear delineation between the percentages (EBD, 47.2%; OHI, 10.2%; Autism, 12.3%). Admittedly, FBAs are time intensive, so staff would need to believe that student behavior warranted the process. These results would lead one to believe that there was a clear difference in the types of behaviors that these students displayed. The data collected from the documents included

the text describing documented behaviors. This information was examined. To quantify

the data, each statement was grouped according to level of disruption to a classroom.

The first level included those behaviors that put the disabled student or those around

him/her in danger. Aggression was a common term in this level. The second level

included those behaviors that would disrupt a classroom environment. Common

indicators would be difficulty with social skills, and/or non-compliance. The third level

included students who seem to self-disrupt. Phrases often seen in the documents were

"inattentive" or "difficulty completing work." The percentage of students who had

documented behaviors of concern at each level was calculated. The EBD category had a

greater percentage of students in level one (aggressive) with 33.7%, compared to OHI at

13% and Autism at 26%. The differences are considerable, but they did not account for

the even greater difference in FBAs found in the documents. The percent of students in

the level two grouping was virtually the same at 46.1%, 44.1%, and 46.2% respectively.

Katsiyannis et al. (2008) examined which types of behaviors were likely to result in an

FBA being conducted. The authors reported that 96% of students with chronic problems

that were defined as behaviors, "seriously disruptive to a classroom" (p. 23) were likely

to have FBAs completed for them. Taking this into account, the current study showed

that difference in the types of behaviors did not account for the significant difference in

the percentage of FBAs completed for students in the three disability categories.

Research Question 1.5 was, "What percentage of students identified as EBD,

OHI, or Autistic and having documented behavioral needs has a BIP?" The data showed

a large difference in the percentages for the three disability categories (EBD, 61.8%; OHI

32.2%; autism, 38.5%) The percentages for each category are higher than that of the

FBA, which is concerning. The FBA should be the foundation of a quality BIP. When looking at the quality of BIPs, using the quality indicators listed on the data collection form (Appendix C), most of the BIPs were found to be merely adequate. They had most of the parts but often the function of the behavior was not addressed. Twenty-four of them, approximately one quarter, were found to be Very Poor/Poor. These were lacking several parts of a quality plan.

The results of this study show that there are clear differences in the way students who have identified behavioral needs are provided behavioral intervention based on their special education disability category. (See Tables 10 and 11) These differences do not appear to be accounted for by the students' type of behavioral needs, such as aggression, disruption, or distraction. Each category had a significant number of students with *DSM* diagnoses, which may be an indicator of the severity of their behavioral needs. Of those students with *DSM* diagnosis, a large percentage consisted of students diagnosed with ADD/ADHD who were found in two categories (OHI and EBD). Each category had at least half of the students whose records documented behavioral needs. Although the EBD disability category had a higher percentage of aggressive students, each group was nearly equal in the percentage of students with behaviors that would appear to be disruptive to a classroom setting. Yet, even that difference doesn't appear to account for the disparity in the number of goals, FBAs, and BIPs for the different disability categories.

Study 2

Since the quantitative part of this study (Study 1) did not give clear answers as to why there was a difference in behavioral interventions, it was important to complete the

qualitative component (Study 2). Research Question 2.1 was, "If differences exist between verification categories on these above questions, what are some possible explanations for these differences?" There were clear differences in behavior services and this study provides some insight into possible explanations.

A broad spectrum of interviewees participated in this study. Twenty-four teachers from four districts and 21 different sites were interviewed. Eight staff members from each level of public education, elementary, middle and high school were interviewed. New staff members (within the first 3 years) to very seasoned (ready to retire) staff members were included. Additionally, different types of professionals were included: special education teachers from all levels, school psychologists, behavior consultants, transition facilitators, and team leaders. From this very diverse group, some common themes emerged that helped to answer this question.

After data analysis, three themes emerged: process, effectiveness, and differences. (See Figure 2) The first theme included several sub-themes: assessment, time, paperwork, and support. These subtopics helped to answer the research question about the reasons for the significant differences found in Study 1. Because of the variety of sites in which staff included in the study worked, there were differences. However, it is obvious that FBAs and BIPs are being completed for some students in each district as evidenced by the examples found in the sample of documents from each district.

Concerns about process could certainly account for some of the differences seen in the quantitative data. Some of those concerns were arranged around the issue of time. Most educators would agree that time is always at a premium. The changes in special education, especially inclusion, have increased the expectations for special educators.

One teacher with years of experience said, "The job description has really changed as they have put more and more of the more severely handicapped students into the classroom, so I am spending all of my day, now, basically rewriting curriculum for three or four students in each of the classrooms." Budget cuts have also impacted teachers in the area of time. One secondary teacher explained, "The school district also cut our para time. So we have less paras than we have ever had in my history in the district and more severe students." As explained in Chapter IV, some teachers feel overwhelmed with the special education required paperwork including the forms for many of the districts' FBAs and BIPs.

The lack of time may also account for the number of FBA records that were over a year old. Admittedly, FBAs do take a fair amount of time when done well. However, behavior assessment needs to be an on-going process if it is to be helpful. One young teacher explained how his team met at the end of each week and shared the results of their behavior plans, which they charted daily. This would be an example of behavior planning which follows best practices. There is concern, however, about the number of participants who clearly believed that an FBA was only something done when a child was being evaluated for special education services. In one district it was perceived that they only completed FBAs when the district was considering a Level 3 placement. District #4 had the clear expectation, that students who were identified as EBD would have an FBA and BIP. For this district, almost all students in the category of EBD did have an FBA and BIP, but almost no students in other categories who had behaviors of concern had FBAs. Recognizing this trend, District #3 developed two FBAs, the one used by school psychologists for evaluation and a mini assessment. This mini was to be used by

classroom and special education teachers when students had troubling behaviors. Several staff members in that district mentioned how helpful it had been in getting staff to use them to truly think about the functions of behaviors.

The lack of frequent evaluations of students' BIPs could be another reflection of the lack of time. The concern of one elementary school psychologist was expressed this way, "The piece that was probably missing was the assessment of whether those plans were working as well as they thought they were." Occasionally teachers expressed concern about whether they were used at all. One teacher explained that she and the school psychologist would spend time working on a plan and it would not be used. She stated, "So it is kind of a time consuming thing if it's not used." This kind of frustration would not inspire a staff member to continue to complete plans which were not used.

Support provided to teachers varied greatly. School District #2 adopted the Behavior Intervention Support Team (BIST) strategy in several of their schools. This plan had a training component for all staff. It was believed that this kind of training was very helpful in creating a cohesive team to deal with students with challenging behaviors. The BIST example provided those staff members with a team to facilitate the process. Other districts have individuals responsible for the FBA and BIP. Best practices provided by the U.S. Department of Education on its web site encourage the use of teams.

Another concern arose about the support provided to classroom teachers. This was expressed by one special education teachers as,

I really worry about the, you know, what kinds of things we're putting on

teachers and we do work hard to make it as simple as possible, but its still

distracting them from teaching and especially if they have more than one

kid in their class that they are trying to chart on. That's very difficult.

If teachers are expected to be responsible for these kinds of tasks without sufficient

training and support, it seems they often would resist the idea.

Teaming was seen as an integral part of an effective process. One teacher

commented, "We can all work together to increase their positive behaviors." There

appeared to be more problems in schools where the process was left to one individual,

regardless of their position in the school. There was less buy-in from those who were

needed to implement the plan. Complaints such as this were made, "I don't think that we

have the follow through after the assessment has been done and the plan has been written.

I think that it kind of ends there." There was also concern that the time was not always

taken to communicate effectively when one individual developed the plan. This concern

was communicated, "I do think you would need some time to work with your support

personnel, the other teachers and educational assistants, so that everybody is following

the plan."

The second theme was effectiveness. The two sub-themes were implementation

and training. Most participants felt that FBAs and BIPs, when used correctly and with

enough support, were very effective. On more than one occasion the term "necessary"

was used to describe them. One middle school teacher commented, "The behavioral

assessments work if you have the staff to back them up." Staff mentioned that ability to

be pro-active and "load supports up-front" was very helpful for students.

However, when training needs were not met, there was frustration. Training

appears to be needed not only for special education staff, but also for classroom teachers.

There were many comments about lack of teacher "buy in" to the process. One concern was expressed in this way, "Classroom teachers don't follow the intervention plan very well." Another teacher mentioned, "There will be teachers who aren't really on board, but are thinking they're going to have a lot of extra work to do. That's not necessarily the case. So that can cause some bumps in the road." If classroom teachers do not have the background understanding of the process, they will not be as helpful in implementation of the plan.

There also appeared to be other training needs. Multiple teachers mentioned their concern that academic needs were not being address in the beginning of the process for EBD students or when addressing the function of behavior. These professionals realized that academic struggles could serve as triggers for behavior. Most of the teachers that mentioned this issue felt that EBD students in general have less academic support than students in other disability categories.

Positively for FBA/BIP training, staff mentioned the ability to use the process as communication and training tools. One positive mentioned was, "The ability to teach those you are working with about the student." This school psychologist went on to say that this training, which occurs while working on improving behavior of students, gave those closest to the child a new perspective on the behavior. Often those individuals became cheerleaders for that child. Over time, those in the position to train others saw a new culture in the school. Professionals became more skilled at intervening when behavior was an issue, so that behaviors did not become so severe.

The last theme included those comments about the differences in services that were seen at each site. Some felt there were differences and others did not. When

looking at the data, it appeared that elementary sites were more likely to serve children according to their needs rather than according to their verification category. Secondary sites were more likely to see differences. This was not always the case, but most often occurred in this way. One high school psychologist reported, "I think that the underlying philosophy is that no matter what the verification is we have to serve them appropriately." This participant also mentioned that they were 'tricky' at this level. An elementary teacher stated, "Quite honestly I don't believe it makes a difference. Not just SPED kids, but some gen. ed. kids have charts too." One middle school teacher made this comment; "Truly this child was not going to get any different services from us if she was BD or AU." Even though these participants felt that there was no difference, the data clearly showed a significant difference. It would be interesting to match participants to records to check the accuracy of their perceptions. Unfortunately, that kind of analysis is beyond the scope of this study.

Many participants expressed the belief that there was a difference in services, however. Comments like this were often heard, "We aren't necessarily doing FBAs and behavior interventions on all children, but we should be. I mean in essence, especially if the behavior is a problem." Another reflection about services for an autistic student was, "If we had had a functional behavioral assessment and behavior intervention plan – I would think that things could have gone a little more smoothly." One middle school teacher was unsure when this question was posed to her. She asked if she could check her files and responded in this way, "So I guess what you're asking, 'Do they do that consistently?' No I guess not. Not seeing it. I had another last year that was Asperger's Syndrome just like this young man, and he did not have a functional behavioral

assessment done either on him." District # 4 required FBAs and BIPs for students who are in the EBD category. A teacher in that district responded in this way,

> The requirement is that if a student is verified as having a behavioral
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> disorder, they have to have a behavior plan. Although I think that there
>
> are times, when a student may not necessarily need a behavior plan as
>
> much as a student within another category. And I think that with all the
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> paper work we do, we sometimes get a little bit lazy and don't do behavior
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> plans for kids who are may be OHI, and need one. Or even kids who have
>
> autism and need a behavior plan. We work on their behaviors, but we
>
> don't write it up. We don't functionally analyze it.

Another comment from that same district was similar, "I believe that it is only our BD kids that have plans. The protocol in our school is that if you are BD then you must have a plan. And I don't think that . . . other students have them." There was no stipulation about not having plans for students not in the EBD category; it just was not done as frequently. FBAs and BIPs appear not to be done for all the reasons stated above.

Additionally, District #2 appeared to have specific programs for certain disability categories. One middle school teacher mentioned, "There's another program in our district for BD kids but because his label was not BD any longer, he could not go there – so it kind of shut a door for him." She was referring to a student who had moved to another category as a result of parental urging.

There may be multiple reasons for the discrepancy in services between different disability categories. The processes and policies involved may have a great deal to do with the differences found in the quantitative part of the research. The process in terms

of paperwork required in most districts appears to be perceived as excessive. It was mentioned that the forms were a "book." Another participant discussed the repetitiveness of the questions on the form. One participant who seemed very familiar with the process was concerned about the number of pages in her district's document; she found it "cumbersome." Because of the length of some of these documents, an extended time is required to complete them. In an effort to alleviate some of the excess, one district implemented the "mini" FBA.

Staff members report not having enough time to work with students because of other requirements of their jobs. The lack of time also impacts the quality of FBAs. Often participants reported that FBAs were only done when students were first identified for special education. FBA documents examined confirmed that this was often the case.

This lack of current FBAs may also be the result of training needs. In addition to the frequency of FBAs as a training issue, there seems to be some training needed on the best practices of FBAs and BIPs. It was reported in one district that last year's focus on behavior had highlighted the fact that many staff didn't know what an FBA was. Several special education teachers reported that there were specialists who were responsible for the process. They indicated that they had enough to do without learning the process for themselves. As a result of this lack of teaming and knowledge, it was believed that implementation and consistent evaluation of the plans suffered. Support, however, was seen as a positive in every instance from the teachers' perspectives. Those responsible for the plans did not always refer to the support by those implementing the plans as positive. At times teaming didn't seem to be part of the process. Not one participant reported that FBAs and BIPs were not valuable in helping students with troubling

behaviors; however, there was concern about the frequency of assessment and the implementation of the plans. Generally participants felt that more students should have the benefit of FBAs and BIPs when behavior was an issue.

Overall, teachers were anxious to share their thoughts on this topic. Most interviews were conducted in the summer when the participants were not working. They saw a need for improvement in the area and were hopeful that this research was an avenue to making some positive changes.

Implications from the Current Study

This research indicates that there are significant differences in the level of intervention students receive depending on their special education verification category. This difference was seen in all types of intervention, whether or not a behavioral need is reflected in one or more behavioral goal, an FBA is conducted for the student and a BIP is created for the student.

Although there was a difference in the types of behaviors (e.g., aggressive, disruptive, inattentive) documented in their IEPs, this difference in behaviors reported did not account for all of the disparity in services. EBD students were more likely to display aggressive behaviors, but the percentage difference did not account for the difference in percentage of interventions.

Results also showed that a large percentage of the sample had *DMS* diagnoses, which indicates a high level of concern for a student's disability. Given these indicators, changes should be made to facilitate all students with behavioral needs receiving quality services for those needs. Katsiyannis et al. (2008) reported in their study on FBAs that

when FBAs are not being conducted proactively, this leads to an increase in the behaviors.

Professionals at 21 different sites indicated that there were many possible reasons for the disparity in services, depending on special education disability category. One educator believes that there is a, "need to develop a policy that if a student's behavior is impacting their learning that they should have a behavior plan." Policy does seem to make a difference. In District #4 where EBD students were required to have an FBA and BIP, essentially all of those students did. So having a policy like the one stated above, is likely to be effective in having the paperwork completed.

However, implementation was also a concern mentioned by many participants. Although having a strong policy would be a place for districts to begin improvement, training and teaming would also need to be addressed. Schools that were using the Response to Intervention model and the BIST strategy reported that they were serving a wider variety of student with behavior needs using a type of FBAs and BIPs. Both of these strategies have a training component and a teaming model for dealing with challenging behaviors. Having a team process not only enhances the process because insights from several individuals can be used to benefit students, but additionally it leaves all participants with a feeling that they are supported. As new individuals join these staffs, teams lend themselves to mentoring new members. These two programs are not the only ones available; there are many highly successful programs and strategies available to help schools provide some structure to their process. McIntosh and Av-Gay (2007) stated that they found six basic components of successful programs in their literature review. Three of them relate to this discussion, "situate within an continuum of

support," "implement plans using a team approach," and "build and maintain local expertise."

Training should not only be considered by specific school districts, but also by institutions of higher learning. Students should be entering the field with a strong understanding of how to assess behavior and create an appropriate intervention plan. All educators should have a basic understanding, but those with a special education endorsement should be proficient in their use.

When considering policy and process issues, districts should keep in mind the paperwork involved in their process. When looking at forms, they should be as efficient as possible. Many individuals interviewed mentioned the length and repetitious nature of their current forms. School District #2 had instituted a mini FBA to encourage the use of these strategies. In at least two sites, training was provided to help staff members strengthen their skills in using a mini FBA. This is an interesting idea. They have one FBA to use as a tool for identification, and one mini FBA/BIP that they use for day-to-day instructional needs. Long, cumbersome paperwork issues were likely to reduce consistent use. Having clear expectations concerning how plans would be monitored would also increase the effectiveness of the process. As one participant stated, "Once a year is not frequently enough to revisit a behavior plan."

The results also imply that there are needed changes in definition and policy guidelines at both the state and national levels. The impact of student verification changes and additional categories being added to IDEA appears to be affecting the behavioral services for students. Policy makers at these levels need to assess the current condition and make needed amendments.

Time is an issue for all educators, if not for most professionals in today's fast moving society. It is beyond the scope of this study to find "time" for educators. It should be noted that time is a concern that does reduce the effective use of strategies known to be effective in helping student with behavioral needs. Administrators would be wise to look at structures that would allow teachers time to work together to help students.

When all of these ideas converge, one is left asking how these recommendations make a difference for students. Does a policy cause individuals to implement these plans? Does more time ensure that quality FBAs and BIPs are created? In both of these instances, and other questions that might be asked, the answer is "no". In all cases, strong leadership that provides the needed policies, time, training and so forth and then creates and environment that facilitates the practice of those skills is needed to make a difference for students. A strong team process that encourages individuals to gain skills and knowledge has been shown to be effective (McIntosh & Av-Gay, 2007; Lane et al., 2007). It; however, takes leadership to create and maintain those teams. Therefore, the nexus between the understanding of the use of FBAs and BIPs and quality services for behavior intervention for all students appears to be strong leadership.

Limitations

As with all research, these results should be interpreted with certain cautions in mind. This research was collected within a system that is constantly changing. As the research data were being collected and interviews initiated, the systems from which these data sources were being gathered were changing. For example, in one district changes were being made in the training of their professionals. In another, new documents used

for FBAs and BIPs were being phased in. Therefore, this research should be considered a "snapshot in time" of current practices. The mere participation in research also changes the system in subtle ways.

Secondly, this current research takes place only in medium to large sized districts in Nebraska. It will be difficult to generalize the results beyond the state. There will also be some questions about whether it can be generalized to the smaller districts within the state since they were not part of the samples. Additionally, when looking at the population of the state, a relatively small number of files were sampled within each category. The results cannot be generalized to other districts in Nebraska or to other states, although these finding should lead others to examine the status of behavior intervention in their districts and/or states as well.

Furthermore, this study is also limited in its scope. There are students with behaviors of concern in other disability categories besides EBD, OHI, and Autism. This study did not address those students. In addition to the existence of FBAs and BIPs for students, the issue of quality and fidelity of implementation were not addressed.

Additionally, there may be characteristics unique to those professionals willing to take time to be interviewed. Although a random process was used to invite individuals to participate, the decision was theirs. A large, diverse sample was achieved, but the willingness to participate may have in some way biased the answers given.

<div align="center">Implications for Future Research</div>

A larger budget and much more time would have created more ability to generalize the results by having samples obtained from more varied sites. Therefore, one

implication for future research is for other districts and/or states to embark on similar research.

Another questions that arose pertained to the matching of students from different disability categories by some parameters such as scores on behavior rating scales. In this way, the severity of the behavior is more closely matched than in the current study. It would certainly give researchers a more definitive answer to this question.

Finally, the percent of students diagnosed with ADD and ADHD, although expected to be large, was unexpectedly large. Additional research on where ADHD students are placed in special education would be valuable as continued research. There is discussion about creating a special education category for ADD/ADHD. This type of research could help advise that decision.

Summary

The research clearly showed that for this sample there were differences in the way behavior was addressed depending on disability category. These differences were shown in the percent of goals, FBAs, and BIPs found in existing documents for students with documented behavior needs in the disability categories of autism, EBD and OHI. Additionally this research presented several possible reasons stated by teachers in these schools for these discrepancies. Among the reasons stated were the processes, including assessment, time, paperwork, and support. Those in the position to make decisions in these areas should take into account the guidelines presented by McIntosh and Av-Gay (2007) in Chapter II. There are six guidelines: situate within an continuum of support, consider academic factors, use validated FBA measures, design and implement plans using a team approach, plan for high fidelity of implementation, and build and maintain

local expertise. These guidelines not only address the concerns stated in the theme processes, but also for the theme effectiveness. There is a body of research that indicates that it is possible to implement effective programs in public schools. (Lane et. al., 2007; McDougal et al., 2005).

Although there are limitations to consider when interpreting this research, the results of this study will be of use as a model for others if it is suspected that a similar problem may exist in smaller districts, other states, or nationwide. As a community of educators, it is important to continue to look at current practices as our population of learners change.

Results may have implications for federal, state, and district policies, procedures, and training concerning services provided to students struggling with behavior. Hiring staff, both teachers and psychologists, who are trained on FBA and BIP processes has been a challenge to districts for many years, so the results may also inform our institutions of higher learning in order to enable them to meet the staffing needs of our public schools as they continue to provide needed services to students.

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Figure 1 - Variables of interest from MDT, IEP, FBA, and BIP documents

Variable name	Explanation	Why important for this study
Individual Student Information	Grade, Ethnicity, Birth date, Gender	This information will help further disaggregate the results to check for differences
Verification Information	Primary and secondary disability verification, dates, DSM diagnoses where available	Verification information needed to answer questions about services for each disability. DSM will further disaggregate the information
Current Level of Functioning Information.	This will include any mention of behavior difficulties in the "current levels" pages	This information will be used to determine whether the information provides documentation of behavior difficulties. It will also be used to compare the magnitude of the behavior difficulties.
Goals	Included is information about # of goals and whether they are for academics or behavior. It will also document quality indicators (this would be a subjective comment by the investigator)	The numerical data will be used to compare the percentages of student who have behavior goals. The quality information will be used as supporting evidence of quality of services)
FBA	Included is information about the existence of an assessment. This variable will also document quality indicators (this would be subjective comments by the investigator)	The data will be used to compare the percentages of student who have FBAs. The quality information will be used as supporting evidence of quality of services)
BIP	Included is information about the existence of a plan. This variable will also document quality indicators (this would be subjective comments by the investigator)	The data will be used to compare the percentages of student who have BIPs. The quality information will be used as supporting evidence of quality of services)
Other	As investigator is completing documentation, other information was noted as it was deemed important.	This will be used as supporting documentation. (An example might be placement of a student outside the district)

Figure 2 - Themes Derived from Study #2

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                              │  Themes  │
                              └────┬─────┘
          ┌────────────────────────┼──────────────────┐
    ┌──────────┐            ┌─────────────┐      ┌─────────────┐
    │ Process  │            │Effectiveness│      │ Differences │
    └────┬─────┘            └──────┬──────┘      └─────────────┘
  ┌───────┼───────┐          ┌──────┴──────┐
┌──────┐     ┌──────────┐ ┌──────────────┐ ┌──────────┐
│ Time │     │Assessment│ │Implementation│ │ Training │
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┌─────────┐    ┌──────────┐
│ Support │    │Paperwork │
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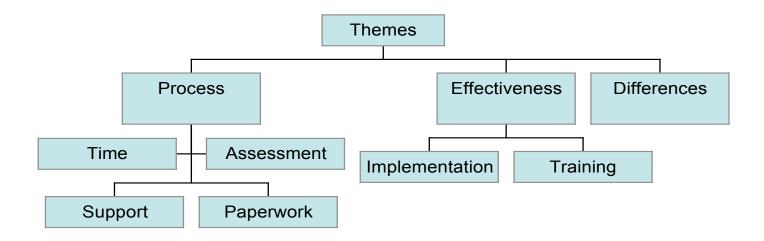
Table 1

Results of Pilot Study Comparing Rates of Behavior Interventions for Students in

Disability Categories of EBD and OHI

Data Results	# of students	# of students w/behavioral needs	# of students w/behavioral goals*	# of students w/FBA*	# of students w/FBP*
Students identified as OHI	40	31 (77%)	22 (71%)	6 (19%)	7 (23%)
Students identified as EBD	22	20 (91%)	19 (95%)	16 (80%)	21 (105%)

*Percentage is figured using the number of students w/behavioral needs as the base number

Table 2

District Numbers From Each Disability Category

District	Autism	EDB	OHI	Total
#1	30 (41.1%)	9 (12.3 %)	34 (46.6%)	73 (23.5%)
#2	23 (31.1%)	26 (35.1%)	25 (33.8%)	74 (23.9%)
#3	25 (34.2%)	26 (35.6%)	22 (30.1%)	73 (23.5%)
#4	29 (32.2%)	30 (33.3%)	31 (34.4%)	90 (29%)
Total	107 (34.5%)	91 (29.4%)	112 (36.1%)	310 (100%)

Table 3

Demographic Data From Each District

Statistic	District #1	District #2	District #3	District #4	Total
Gender					
Male	63	59	54	74	250
Female	10	15	19	16	60
Disability					
EBD	9	26	22	30	91
OHI	34	25	26	31	112
Autism	30	23	25	29	107
School Level					
Elementary	34	34	37	42	147
Middle	26	26	16	23	91
High	13	14	20	25	72
Total	73	74	73	90	310

Table 4

What percentage of students identified as EBD, OHI, or Autistic has DSM IVR diagnoses

identified in the MDT and IEP documents? (Research Question 1.1)

Any DSM Diagnosis present	Disability Autism (N=107)	EBD (N=91)	OHI (N=112)	Total (N=310)
Yes	44 (41.1%)	43 (47.3%)	87 (77.7%)	174 (56.1%)
No	63 (58.9%)	48 (52.7%)	25 (22.3%)	136 (43.9%)

Chi Square = 33.82
Degrees of freedom =2
Significance = .000

Table 5

DSM Frequencies

DSM Diagnosis	Autism	EBD	OHI	Total Number
ADHD	-	20	72	92
Autism	21	-	-	21
Misc < 2	-	10	6	16
Asperger's	14	0	1	15
PDD - NOS	9	1	-	10
ADD	-	2	6	8
Bi-Polar	-	5	1	6
ODD	-	3	-	3
Anxiety Disorder	-	2	1	3
Total	44	43	87	174

Table 6

What percentage of students identified as EBD, OHI, or Autistic has an indication of

behavioral needs in special education documents? (Research Question 1.2)

Students with identified behavioral needs	Autism (N=107)	EDB (N=91)	OHI (N=112)	Total (N=310)
Yes	65 (60.7%)	89(97.8%)	59 (52.7%)	213 (68.7%)
No	42 (39.3%)	2 (2.2%)	53 (47.3%)	97 (31.3%)

Chi Square = 52.367
Degrees of freedom =2
Significance = .000

Table 7

What percentage of students identified as EBD, OHI, or Autistic who have documented

behavioral needs have at least one IEP goal related to behavior? (Research Questions 1.3)

	Disability			Total
One or more behavioral goals identified	Autism (N=65)	EBD (N=89)	OHI (N=59)	213
Yes	57 (87.7%)	89 (100%)	46 (78%)	192
No	8 (12.3%)	0 (0%)	13 (22%)	21

Chi Square = 20.013
Degrees of freedom = 2
Significance = .000

Table 8

What percentage of students identified as EBD, OHI, or Autistic and having documented

behavioral needs has a FBA? (Research Question 1.4)

FBA documented	Disability Autism (N=65)	EBD (N=89)	OHI (N=59)	Total 213
Yes	8 (12.3%)	42 (47.2%)	6 (10.2%)	56
No	57 (87.7%)	47 (52.8%)	53 (89.8%)	157

Chi Square = 34.532
Degrees of freedom = 2
Significance = .000

Table 9

What percentage of students identified as EBD, OHI, or Autistic and having documented

behavioral needs has a BIP? (Research Question 1.5)

BIP documented	Disability Autism (N=65)	EBD (N=89)	OHI (N=59)	Total 213
Yes	25 (38.5%)	55 (61.8%)	19 (32.3%)	56
No	40 (61.5%)	34 (38.8%)	40 (67.8%)	157

Chi Square = 14.909
Degrees of freedom = 2
Significance = .001

Table 10

Summary Table for Research Questions 1.1 and 1.2

	Autism	EBD	OHI	Total
Total usable subjects	107	91	112	310
# with DSM diagnosis	44 (41.4%)	43 (47.3%)	87 (77.7%)	174 (56.1%)
# with behavior needs	65 (60.7%)	89 (97.8%)	59 (52.75)	213 (68.7%)

Table 11

Summary Table for Research Questions 1.3, 1.4, and 1.5

	Autism	EBD	OHI	Total
# with behavior needs	65	89	59	213
# with behavior goals*	57 (87.7%)	89 (100%)	46 (78%)	192 (90.1%)
# with FBAs*	8 (10.2%)	42 (47.2%)	6 (10.2%)	56 (26.3%)
# with BIPs*	25 (38.5%)	55 (61.8%)	19 (32.3%)	99 (46.5%)

*Calculated from number with behavioral needs

Appendix A – Pilot Study #2 Interview Protocol

Project: **Special Education Professionals Perceptions of FBA/BIP**

Time of Interview: 2:21
Date: 7/4/08
Interviewer: Cindy Serfass
Interviewee: Elementary
Position of the Interviewee:

[Describe her the project, telling the interviewee about the (a) purpose of the study, (b) individuals and sources of data being collected, (c) what will be done with the data to protect the confidentiality of the interviewee, and (d) how long the interview will take]
[Have the interviewee read and sign the consent form.]
[Turn on the tape recorder and test it.]

Questions:

1) What is your position as a special education professional? What are the main elements of your job?

2) What is your interaction with Functional Behavior Assessments and Behavior Intervention Plans?

3) What are your overall feelings about FBA/BIP?

       3a) What, if any, concerns do you have about FBA/BIP?

       3b) What positives would you like to mention?

[Thank the interviewee and confirm for them that their information is confidential. Discuss possible follow-up interviews]

Appendix B – Research Procedures
B1 **Research Procedure Specifics – District #1**

1 - Randomly Identify the Sample of Student Records– Preparation of Data
    All to be completed before April 15, 2009 by designated staff member
- Obtain lists of students (K-12) in each of the verification categories, Behaviorally Disordered (BD), Other Health Impaired (OHI) and Autism in all cooperative schools
- The number of students in each list would be divided by 30 (number of records to be selected) For example: 120 OHI students/30 = 4.
- Begin anywhere in the list, and using the above number chose the first student and every n^h student until 30 students are identified. In the above example every 4th student would be chosen.
- If the number of students in the Autism group (or other categories) is less than 60, randomly eliminate students so that just 30 remain. If there are less than 30 students include all of the students in that category.
- Using Student Record System (SRS), locate the Individualized Education Plan (IEP) and Multi Disciplinary Team (MDT) records for those identified students and print pages 3 and 5 of the MDT record (verification page and narrative of testing results) and pages 3, 5, 7, 8 of the IEP records (Special Considerations, Present Level, Goal page (s) and Services pages) NOTE – If the MDT is a re-evaluation, please check to see if there is sufficient information or print the pages for the last two evaluations.
- From the SRS note the school and create a combined list for each of the schools of the subjects who are chosen
- We understand that copies of all Functional Behavioral Assessment (FBA) and Behavior Intervention Plans (BIP) documents should be in the district files. Copy any such documents in the files for the 30 students in each category (total of 90). If there is any reason to believe that not all such documents are in the files, contact the case managers for the selected students and ask them to send a copy of FBA and BIP documents to the Central Office.
- Compile the documents for each student subject by clipping the FBA and BIP documents to the other documents printed from the SRS system.
- Remove identifying information (names of student, parents or addresses) from all of the documents.
- On the first page identify the records with a number. This could be the student number or some other number for specific to this study. Someone will keep a code list with students' names and the unique number for each student, so that if necessary she could backtrack to get additional information or answer questions about specific student files later.
- The coded and redacted materials will be set-aside in a secure location for the principal investigator to review at a later time- probably during the summer.

2. Identifying Teachers to be Interviewed
Provide principal investigator with a copy of a list of special education personnel by building so that she has the names and contact information for Special Education Staff

separated by school & level – Elementary, Middle and High School. In addition please provide a list of psychologists, or behavior consultants who might be involved in developing FBAs and BIPs for students. She will use a random process to select a sample of two teachers from each level, and one of the psychologists or consultants. She will contact them and using criteria based on experience with FBAs and BIPs and willingness to participate, accept or reject them until sample number of six teachers or coordinators is complete. She will then schedule a time to conduct an interview with them at their convenience

2 – Data Collection
- o Data collection of processed student records will be completed by principal investigator during the month of June, 2009
- o Interviews will be completed before the end of July, 2009

3 – Data Analysis and writing or reports
- o Data analysis will take place in the late summer and fall of 2009 by the Principal Investigator.

4 – Final Report
- o It is hoped that a final report will be available to districts by Oct '09. Principal Investigator will be available to present results and answer questions.
- o Dissertation to be completed by December 2009
- o Additional materials for potential publication after December 2009.

B2 Research Details for District #2

1 - Randomly Identify the Sample - Completed before May 1, 2009
- o Obtain lists of students in each of the verification categories, Behaviorally Disordered (BD), Other Health Impaired (OHI) and Autism.
- o The number of students in each list would be divided by 30 (number of records to be selected) For example: 120 OHI students/30 = 4
- o Begin anywhere in the list, and using the above number chose the first student and every n^h student until 30 students are identified. In the above example every 4th student would be chosen.
- o Using SRS system, locate the Individualized Education Plan (IEP) and Multi Disciplinary Team (MDT) records for those identified students and print pages 3 and 5 of the MDT record (verification page and narrative of testing results) and pages 3, 5, 7, 8 of the IEP records (Special Considerations, Present Level, Goal page (s) and Services pages) NOTE – If the MDT is a re-evaluation, please check to see if there is sufficient information or print the pages for the last two evaluations.
- o Contact the case managers for the selected students and ask them to send a copy of Functional Behavioral Assessment (FBA) and Behavior Intervention Plan (BIP) documents to the Central Office.
- o Compile the documents for each student and remove identifying information. On the first page identify the records with a number and keep track of that information in case there are questions.

o Provide principal investigator with names and contact information for Special Education Staff separated by level – Elementary, Middle and High School. She will use the process above to select a sample of two teachers from each level. She will contact them and using criteria based on experience with FBAs and BIPs and willingness to participate, accept or reject them until sample number is complete. She will then schedule a time to conduct an interview with them at their convenience.

2. Identifying Teachers to be Interviewed

Provide principal investigator with a copy of a list of special education personnel by building so that she has the names and contact information for Special Education Staff separated by school & level – Elementary, Middle and High School. In addition please provide a list of psychologists, or behavior consultants who might be involved in developing FBAs and BIPs for students. She will use a random process to select a sample of two teachers from each level, and one of the psychologists or consultants. She will contact them and using criteria based on experience with FBAs and BIPs and willingness to participate, accept or reject them until sample number of six teachers or coordinators is complete. She will then schedule a time to conduct an interview with them at their convenience

2 – Data Collection
- o Data collection of processed student records will be completed by principal investigator at the Central Office during the month of June, 2009
- o Interviews will be completed before the end of July, 2009

3 – Data Analysis and writing or reports
- o Data analysis will take place in the late summer and fall of 2009 by the Principal Investigator.

4 – Final Report
- o It is hoped that a final report will be available to districts by Oct '09. Principal Investigator will be available to present results and answer questions.
- o Dissertation to be completed by December 2009
- o Additional materials for potential publication after December 2009.

B3 Research Details for District #3

1 - Randomly Identify the Sample - Completed before May 1, 2009
- o Obtain lists of students in each of the verification categories, Behaviorally Disordered (BD), Other Health Impaired (OHI) and Autism.
- o The number of students in each list would be divided by 30 (number of records to be selected) For example: 120 OHI students/30 = 4
- o Begin anywhere in the list, and using the above number chose the first student and every n^h student until 30 students are identified. In the above example every 4th student would be chosen.
- o Using SRS system, locate the Individualized Education Plan (IEP) and Multi Disciplinary Team (MDT) records for those identified students and

print pages 3 and 5 of the MDT record (verification page and narrative of testing results) and pages 3, 5, 7, 8 of the IEP records (Special Considerations, Present Level, Goal page (s) and Services pages) NOTE – If the MDT is a re-evaluation, please check to see if there is sufficient information or print the pages for the last two evaluations.

- o Contact the case managers for the selected students and ask them to send a copy of Functional Behavioral Assessment (FBA) and Behavior Intervention Plan (BIP) documents to the Central Office.
- o Compile the documents for each student and remove identifying information. On the first page identify the records with a number and keep track of that information in case there are questions.
- o Provide principal investigator with names and contact information for Special Education Staff separated by level – Elementary, Middle and High School. She will use the process above to select a sample of two teachers from each level. She will contact them and using criteria based on experience with FBAs and BIPs and willingness to participate, accept or reject them until sample number is complete. She will then schedule a time to conduct an interview with them at their convenience.

2. Identifying Teachers to be Interviewed

Provide principal investigator with a copy of a list of special education personnel by building so that she has the names and contact information for Special Education Staff separated by school & level – Elementary, Middle and High School. In addition please provide a list of psychologists, or behavior consultants who might be involved in developing FBAs and BIPs for students. She will use a random process to select a sample of two teachers from each level, and one of the psychologists or consultants. She will contact them and using criteria based on experience with FBAs and BIPs and willingness to participate, accept or reject them until sample number of six teachers or coordinators is complete. She will then schedule a time to conduct an interview with them at their convenience

2 – Data Collection
- o Data collection of processed student records will be completed by principal investigator at the Central Office during the month of June, 2009
- o Interviews will be completed before the end of July, 2009

3 – Data Analysis and writing or reports
- o Data analysis will take place in the late summer and fall of 2009 by the Principal Investigator.

4 – Final Report
- o It is hoped that a final report will be available to districts by Oct '09. Principal Investigator will be available to present results and answer questions.
- o Dissertation to be completed by December 2009
- o Additional materials for potential publication after December 2009.

B4 Research Details for District #4

1 - Randomly Identify the Sample

To be completed by April 15th by designated staff member:

- o Obtain lists of students in each of the verification categories, Behaviorally Disordered (BD), Other Health Impaired (OHI) and Autism with the assistance of your support staff.
- o The number of students in each list would be divided by 30 (number of records to be selected) For example: 120 OHI students/30 = 4
- o Begin anywhere in the list, and using the above number chose the first student and every n^{h} student until 30 students are identified. In the above example every 4th student would be chosen.
- o If less than 60 students are in any category, students would be randomly eliminated to get down to 30. If any of the groups are less than 30 all students in that category would be included.
- o Provide principal investigator with the list of students to be included in the study.

2. Identifying Teachers to be interviewed

As soon as is convenient, provide principal investigator with a copy of a list of special education personnel for 2009 so that she has the names and contact information for Special Education Staff separated by school & level – Elementary, Middle and High School. (Completed) She will use a random process to select a sample of two teachers or coordinators from each level. She will contact them and using criteria based on experience with Functional Behavioral Assessments and Behavior Intervention Plans and willingness to participate, accept or reject them until sample number of six teachers or school psychologists is complete. She will then schedule a time to conduct an interview with them at their convenience

2 – Data Collection
- o Principal investigator will complete data collection during the months of June and July.
- o Interviews will be completed before the end of July, 2009
3 – Data Analysis
- o Data analysis will take place in the fall of 2009 by the Principal Investigator.
4 – Final Report
- o It is hoped that a final report will be available to districts by Oct '09. Principal Investigator will be available to present results and answer questions.
- o Dissertation to be completed by December 2009
- o Additional materials for potential publication after December 2009.

Appendix C

Data Gathering Worksheet

1. Date data records examined: _____

2. School District: 1. District #1   2. District #2   3. District #3 4. District #4

3. Student ID _____

4. Birth date _____

5. Grade: _____

6. Ethnicity:

 1. White 2. Black 3. Latino 4. Asian 5. Am. Indian   6. Bi/Multiracial 7. Other

8.Unknown

7. Gender: 1. Male   2. Female

8. Current primary disability verification: 1. BD   2. OHI   3. Autism

9. Date of most recent verification: _____

10. Date of initial verification: _____

11. Secondary disability verification (if any): _____(identify the disability

   category)

12. DSM diagnoses identified anywhere? 1. Yes   2. No

      a.   Date: _____ Diagnosis_____

13 Additional DSM diagnosis if any? 1. Yes   2. No

      a.   Date: _____ Diagnosis _____

      b. Date: _____ Diagnosis _____

   Individualized Education Program (IEP)

14. Are behavioral issues identified in the IEP's present "current levels of functioning"   1. Yes

2. No   If yes, describe or explain: _____

      _____

      Sample of exact wording:

_____

15. Are there behavioral issues addressed in the Goals of the IEP? 1. Yes   2. No

      If yes, describe or explain: _____

      _____

Sample of exact wording:

_____

16. Total number of goals on IEP: _____

17. Number of goals pertaining to behavior: _____

18. Number of goals pertaining to academics: _____

19. Number of all other goals (mobility, speech, etc.)? _____

20. What is the first behavioral goal on this IEP? (write out exact wording)

_____

21. Is the behavior in the goal specific enough to be objectively measured?   1. Yes   2. No

22. Overall what is the quality of these IEP goals?

    1. Very Poor   2. Poor   3. Adequate/Average   4. Good   5. Excellent

Functional Behavioral Assessment

23. Is a Functional Behavioral Assessment included or mentioned in the student's file:

    1. Yes   2. No

24. Has the target behavior(s) been defined in observable terms?   1. Yes   2. No

25. Is there an indication that broad behavioral data has been collected?   1. Yes   2. No

26. Is there an indication that a structured behavioral observation has been employed? 1. Yes

2. No

27. Has a hypothesis been identified regarding the function of the behavior?

    1. Yes   2. No

28. What is the function, which is identified: _____

29. Is there evidence that the hypothesis has been tested?   1. Yes   2. No

30. Is there evidence that the tested intervention(s) have been evaluated?   1. Yes   2. No

31. Overall what is the quality of this Functional assessment?

    1. Very Poor   2. Poor   3. Adequate/Average   4. Good   5. Excellent

    Explain:

_____

(Indicators may be manipulations use to test hypothesis, notation of recording technique used, graphing of behavioral observations…)

32. Other comments or notes regarding FBA:

_____

_____

Behavior Intervention Plan

33. Is a Behavior Intervention Plan included or mentioned

     in the student's file: 1. Yes   2. No

34. Does the plan state the hypothesis of the function of the behavior?   1. Yes   2. No

35. Does the plan identify a replacement behavior?   1. Yes   2. No

36. Does the plan include setting event (antecedent) strategies?   1. Yes   2. No

37. Does the plan include instructional strategies?   1. Yes   2. No

38. Does the plan include consequent strategies?   1. Yes   2. No

39. Does the plan indicate certain situations where the behavior is likely to occur?

     1. Yes   2. No

40. Does the plan indicate how progress will be monitored?   1. Yes   2. No

41. Does the plan state how the replacement behavior will be reinforced?   1. Yes   2. No

42. Does the plan state how inappropriate behaviors will be managed?   1. Yes   2. No

43. Overall what is the quality of this Behavior Plan?

     1. Very Poor   2. Poor   3. Adequate/Average   4. Good   5. Excellent

Explain:

_____

(Indicators may include specific information on reinforcement interventions, behavior contracts, and potential problem behaviors…)

44. Other information or notes regarding the BIP:

_____

_____

Other notes or comments:

Appendix D

Interview Protocol

Project: Study 2: **Special Education Professionals Perceptions of FBA/BIP**

Time of Interview:
Date:
Interviewer:
Interviewee:
Position of the Interviewee:

[Describe her the project, telling the interviewee about the (a) purpose of the study, (b) individuals and sources of data being collected, (c) what will be done with the data to protect the confidentiality of the interviewee, and (d) how long the interview will take]
[Have the interviewee read and sign the consent form.]
[Turn on the tape recorder and test it.]

Questions:
1) What is your position as a special education professional? What are the main elements of your job?

2) What is your interaction with Functional Behavior Assessments and Behavior Intervention Plans?

3) What are your overall feelings about FBA/BIP?

      3a) What, if any, concerns do you have about FBA/BIP?

      3b) What positives would you like to mention?

4) Do you believe that the services provided to students with behavior needs are different depending on their special education verification category?

[Thank the interviewee and confirm for them that their information is confidential. Discuss possible follow-up interviews]

Appendix 5 – IRB Official Approval Letter

March 26, 2009

Cynthia Serfass
Department of Special Education and Communication Disorders
4602 Borman St Omaha, NE 68157

Reece Peterson
Department of Special Education and Communication Disorders
202A BKC UNL 68583-0732

IRB Number: 2009039020EP
Project ID: 9020
Project Title: Addressing Behavior Needs by Disability Category

Dear Cynthia:

This letter is to officially notify you of the approval of your project by the Institutional Review Board (IRB) for the Protection of Human Subjects. It is the Boards opinion that you have provided adequate safeguards for the rights and welfare of the participants in this study based on the information provided. Your proposal is in compliance with this institution's Federal Wide Assurance 00002258 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Your stamped and approved informed consent form has been uploaded to NUgrant (Informed_Consent_Form-Approved.pdf file). Please use this form to make copies to distribute to participants. If changes need to be made, please submit the revised informed consent form to the IRB for approval prior to using it.

Date of EP Review: 03/25/2009

You are authorized to implement this study as of the Date of Final Approval: 03/26/2009. This approval is Valid Until: 03/25/2010.

We wish to remind you that the principal investigator is responsible for reporting to this Board any of the following events within 48 hours of the event:
ï Any serious event (including on-site and off-site adverse events, injuries, side effects, deaths, or other problems) which in the opinion of the local investigator was unanticipated, involved risk to subjects or others, and was possibly related to the research procedures;
ï Any serious accidental or unintentional change to the IRB-approved protocol that involves risk or has the potential to recur;
ï Any publication in the literature, safety monitoring report, interim result or other finding that indicates

an unexpected change to the risk/benefit ratio of the research;
ï Any breach in confidentiality or compromise in data privacy related to the subject or others; or
ï Any complaint of a subject that indicates an unanticipated risk or that cannot be resolved by the research staff.

For projects which continue beyond one year from the starting date, the IRB will request continuing review and update of the research project. Your study will be due for continuing review as indicated above. The investigator must also advise the Board when this study is finished or discontinued by completing the enclosed Protocol Final Report form and returning it to the Institutional Review Board.

If you have any questions, please contact the IRB office at 472-6965.

Sincerely,
[Image]
Mario Scalora, Ph.D.
Chair for the IRB

[Image]