National Concerns about RtI and PBIS:

A Review of Policy and Practice Recommendations Not Based on Research or Effective Practice

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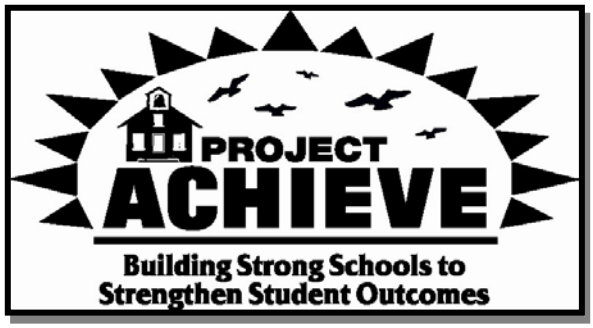

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A Division of PROJECT ACHIEVE INCORPORATED
49 Woodberry Road
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Designed by Howard M. Knoff, Ph.D.
Printed in the United States of America

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Introduction

Over the past decade especially, there have been a number of policies, practices, or recommendations advocated by OSEP-funded national Technical Assistance Centers (notably, the PBIS, RtI, and Scaling-up centers) that:

- Have not been empirically demonstrated prior to being recommended on a national or state scale;
- Have been limited in nature relative to the diversity of reasons that explain why students have academic or behavioral difficulties at school;
- Have applied research or data—presenting or implementing them as conclusive facts or established procedures—from non-educational domains, areas, or contexts before empirically demonstrating their transferability and/or applicability on a large scale (e.g., practices meant to facilitate "scaling up" at the organization or systemic levels, using incident or epidemiological data from the public mental health arena to predict academic or behavioral problem rates in schools); and/or
- Presented a singular perspective without providing comparable attention, description, and systematic acknowledgement of other (sometimes more effective) approaches.

For those who assume that these TA Centers are providing objective, unbiased recommendations, for those who depend on these TA Centers to provide them the best, evidence-based guidance relative to practice, for those who do not have the time, capacity, or ability to independently evaluate the recommendations made by these TA Centers, and/or for those who would not question the "authority" or "wisdom" of the experts at these TA Centers or, vicariously, the U.S. Department of Education, many of these questionable (at best) and faulty (at worst) recommendations have been accepted, or blindly accepted, and put into practice with children and adolescents across the country.

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Moreover, in accepting these unproven, untested, questionable, or faulty recommendations, untold amounts of time, effort, and money have been invested (wasted)—at the state, district, and school levels—either in professional development or implementation.

Finally, and most critically, some of these recommendations have negatively impacted students' academic or behavioral learning, progress, mastery, or proficiency; and in some cases, caused harm.

This document will review and critique a number of these recommendations—providing specific reasons as to why they are questionable or ill-advised, discussing how they are impacting students or staff in our schools, and suggesting alternative perspectives or procedures. Most of the discussion will focus in the areas of positive behavioral supports (PBS) and/or Response-to-Intervention (RtI). As such, it would be important to reference the most-recent practice documents from the PBIS and the RtI national Technical Assistance Centers (Essential Components of RTI – A Closer Look at Response to Intervention, National Center on RtI, April, 2010; Implementation Blueprint and Self-Assessment—Positive Behavioral Interventions and Supports, PBIS TA Center, September, 2010; Practical Functional Behavioral Assessment Training Manual for School-Based Personnel, PBIS website, Loman & Borgmeier).

The specific recommendations, principles, and/or practices of include the following concerns:

1. Using a single universal approach to screen students in a comprehensive area of functioning (e.g., literacy or behavior).

2. Screening approaches that are not immediately followed up with functional assessments.

3. Recommending functional assessment approaches that assume the "student has the problem," and thus, that focus the entire assessment process on students who are demonstrating an academic or behavioral problem.

4. Recommending functional assessment approaches that do not require (or strongly recommend) a comprehensive review of a student's records and history as soon as there are concerns about the student (and/or at the beginning of the assessment process).

5. That the functional assessment approaches recommended still predominantly focus on either a student's motivational or emotional status.

6. That a small number of "universal" Tier 2 interventions have been recommended nationally, and these are not linked to the results of a comprehensive functional assessment.

7. That, when Tier 2 interventions are unsuccessful, it is assumed that the student has a more serious or "resistant" problem than first thought, and Tier 3 interventions are (largely immediately) implemented for/with the student.

8. That treatment integrity has been emphasized to the exclusion of treatment intensity.

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9. That a number of principles guiding the multi-tiered PBIS and RtI systems have been recommended, but have not been empirically validated. Some of these recommendations have resulted in ineffective or inappropriate services for students.

10. That a number of principles and practices guiding the PBIS implementation system have been recommended nationally that have not been empirically validated or field-tested. Some of these practices have resulted in ineffective or inappropriate services for students.

To begin, it is important to recognize how the stated outcomes of a school-wide PBS and RtI system influence certain policies, procedures, and recommendations. From our perspective, effective PBS processes should focus on (a) facilitating all students' social, emotional, and behavioral self-management; (b) using behavioral science to guide the teaching and development of needed skills in these self-management areas; (c) student behavior both in the classroom and common areas of the school; and (d) helping students to prevent and appropriately, safely, and successfully respond to teasing, taunting, bullying, harassment, hazing, and physical aggression. Effective RtI processes should focus on (a) instruction and interventions, not diagnostic labels; (b) individualized, functional assessment, not universal or standard assessment batteries; and (c) student-centered decisions. Finally, both PBS and RtI systems should be integrated, guided by data-based decision-making, and organized along a multi-tiered continuum of services, supports, strategies, and programs needed by students to facilitate their academic and social, emotional, and behavioral success.

Below are examples of some of the unproven, untested, questionable, or faulty recommendations advocated by one or more of OSEP's national Technical Assistance centers.

1. There is a concern about recommending: the use of a single universal approach to screen students in a comprehensive area of functioning (e.g., literacy or behavior).

Historically, the Reading First approach, advocated through the U.S. Department of Education during the 2000s, recommended that students receive reading interventions based solely on the use of a universal screening instrument (e.g., DIBELS, among others).

More recently, PBIS proponents have advocated the use of a single social, emotional, or behavioral screening instrument to identify (and even suggest interventions for) students with difficulties in those areas. This latter position was recently questioned by Lucille Ebert, a national PBIS trainer from Illinois, on a conference call (January 4, 2012) where she described the data and results from an OSEP-funded Dissemination grant awarded to her. And yet, over the previous five years or more, Ebert had strongly advocated for a single assessment approach to social, emotional, and behavioral screening at numerous national PBIS and other conferences.

Response. The use of a single screening instrument to make any diagnostic, instructional, or intervention decision violates both research and the established professional principles and practices of a number of national associations (e.g., the National Association of School Psychologists). Indeed, if this practice were used to qualify a student for special education services, it would violate federal (i.e., IDEA) law.

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Appropriate professional practice dictates that, when students are demonstrating significant or persistent academic or behavioral problems, all diagnostic, instructional, or intervention decisions are based on multi-source, multi-instrument (or format), multi-setting assessments. This is because single screening instruments typically provide, at best, only an indication that a student is or is not having a problem—relative to some psychometric standard, norm group, or other criterion. And yet, this result may not be valid (that is, it may be a "false-positive" or "false-negative" result), and—even if valid—the result may represent a "symptom," rather than the predominant problem. Finally, screening results rarely explain why a problem is present.

Thus, the results of any screening tool must be validated through additional assessments, and these (or other) assessments must additionally determine why the problem (if valid) exists. To assume that any screening result is valid without additional, corroborating data is completely inappropriate. Moreover, to use any screening outcome to (immediately) initiate an academic or behavioral instructional or intervention program, or to put any student into remediation group or class is indefensible.

Beyond this, it is essential to note that most social, emotional, or behavioral screening instruments involve rating scales, and that most rating scales—unless they have built-in validity (or "lie") scales—measure the perceptions of the person completing the scale. For example, unless they have systematically collected the data beforehand, when teachers are asked to rate their students on the frequency, duration, or intensity of twenty to thirty different behaviors over a specific period of time, their ratings reflect their perceptions (or recollections) of these behavioral events. Significantly, as teachers are asked to rate more students, over more behaviors, and across longer and less recent timeframes, their ratings become susceptible to a number of different response biases that potentially invalidate their results.

This, once again, is why—especially in the social, emotional, and behavioral areas—the results of any single screening tool must be validated through additional, more objective assessment data. As noted above, any diagnostic and/or intervention decision, based on an uncorroborated social, emotional, or behavioral screening result, is inappropriate at best, and unethical at worst. Screening results must be viewed only as "red flags" that indicate there may be a problem. Follow-up assessment is required to validate that there is a problem. And, additional diagnostic assessment is needed to determine what the actual problem is, and why it is occurring.

2. There is a concern about recommending: screening approaches that are not immediately followed up with functional assessments.

As noted above, screening results must be immediately followed-up with more extensive diagnostic or functional assessments to determine why a problem is occurring. The results of this assessment process then should be directly linked to instructional or intervention services, supports, strategies, and/or programs. Moreover, functional assessment should not occur only at the Tier 3 level—that is, after a series of instructional or intervention approaches have not worked with a student.

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Response. If, for example, a reading screener identifies four students as having the same type of comprehension difficulties, it may be that:

- Student A has a comprehension problem in all areas or types of comprehension questions;
- Student B has a comprehension problem with abstract, inferential, and higher ordered thinking comprehension questions, but not concrete, main idea, factual recall questions;
- Student C has phonetic decoding problems that are interfering with reading fluency that are then interfering with comprehension; and
- Student D "blew the test off" because he didn't care about it.

Based on the results of the screener, it "looks" like all four students have the same kind and severity of difficulty in reading comprehension. However, based on the diagnostic, functional assessments that must follow, there are different reasons for each student's problem and, hence, there will be different instructional or intervention goals, instructional or intervention approaches, and expected outcomes.

Even beyond the explanations above, what if Student A is having reading comprehension difficulties because previous classroom instruction was ineffective? What if Student B never received instruction in the abstract, inferential, and higher ordered reading comprehension areas due to a prolonged medical absence? What if the (whole language) curricula used in Student C's district did not focus on decoding and reading fluency skills? And what if an error analysis of Student D's test did not occur?

Clearly, these additional instructional, curricular, and student explanations for the four students' reading screening results would necessarily influence the instructional or intervention approaches needed to "solve the problem."

Relative to the results of a social, emotional, or behavioral screener, the same thing could happen. For example, if a behavioral screening tool identified five kindergarten students each exhibiting high levels of swearing in their classrooms, it could be that:

- Student A is swearing because he has never learned the more appropriate language or ways to express his anger;
- Student B is swearing because his immediate, conditioned, reactive impulse when angry about something is to swear;
- Student C is still swearing in the classroom—even though the behavioral training he is receiving with the school psychologist has eliminated swearing in the office (but is not transferring to other settings and situations);
- Student D is swearing because his enjoys the (inappropriate) attention that he receives from the teacher and peers after swearing; and
- Student E is swearing because the (inappropriate) teacher attention he has received for swearing is inconsistent and, thus, has strengthened this inappropriate behavior.

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Once again, it is notable that—even if the inappropriate behavior noted on the screener is valid and occurring, the behavior often does not occur "in a vacuum." That is, the behavior typically occurs in an ecological context—for example, in a classroom in the presence of others (teacher, peers) who are responding appropriately or inappropriately to the student or behavior of concern. Thus, the functional assessments that follow-up the results of any screening are crucial to understanding the context for and the reasons why the behavior is occurring. These reasons then must be factored into the instructional or intervention approaches to follow, as well as to any other needed services or supports.

3. There is a concern about recommending: functional assessment approaches that assume the "student has the problem," and thus, that focus the entire assessment process on students who are demonstrating an academic or behavioral problem.

The functional assessment process should involve assessments that investigate possible teacher, instructional, curricular, and student factors that may be contributing to a student's difficulties. That is, it should not be assumed that an academic or behavioral problem is a student-only problem, and thus, functional assessment should not involve assessments done just with the student.

Response. In the reading comprehension example above, there were a number of possible reasons to explain the source of the problem:

- Non-existent or poor instruction
- Untrained or inexperienced teachers
- Undifferentiated or unmodified instruction
- Non-existent or poorly organized or designed curricula
- Student attendance due to medical issues
- Uneven student learning
- Prerequisite student skill deficits
- Student motivation problems

Given this, the functional assessment process—focused on determining the underlying reasons for an academic problem—needs to consider and assess the possibility that teacher, instructional, and/or curricular might be interacting with student factors to cause or contribute to a student problem.

The same is true when students are demonstrating social, emotional, or behavioral problems. If only the student is assessed, the following possible underlying reasons for the problem might be missed:

- A teacher who is inadvertently reinforcing inappropriate student behavior
- A peer group that is harassing a student to the degree that s/he is emotionally unable to function in the classroom

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- A classroom that is so crowded that the student has difficulty behaviorally functioning
- A school that is so focused on test scores that it does not teach students the social skill and classroom expectations that they need to know and demonstrate

And so, once again, the functional assessment process must take an ecological or systems perspective, and consider and evaluate all of the possible domains that may be causing or contributing to a student's problem—even if the data eventually determine that the student is largely or exclusively responsible for the problem.

Beyond the points above, there is another concern when all of the assessments done to "explain" why an academic or behavioral problem is occurring are done on or with the student. This concern involves the increasing potential that a "Type 1" error occurs when multiple assessments are done on the same target. When a Type 1 error occurs, the data appear to indicate that the "problem" lies within the student, when the result is a "false-positive" result that occurs as an artifact of the many assessments completed.

4. There is a concern about recommending: functional assessment approaches that do not require (or strongly recommend) a comprehensive review of a student's records and history as soon as there are concerns about the student (and/or at the beginning of the assessment process).

It is inappropriate to complete a comprehensive review of a student's records, history, and development only after Tier 1 or Tier 2 interventions are unsuccessful.

Response. Reviewing the points above, no medical doctor in America would:

- Conduct a medical screening of a patient using a single screening approach (#1 above). For example, during a medical screening, doctors do more than just take blood—even though multiple assessments are run with that blood sample.
- Make a definitive medical conclusion based on the results of a single screening result (#2 above). The doctor, instead, would do follow up assessments both to validate the screening result and to determine (if valid) why the screening results occurred.
- Assess only the physiological status of the patient (#3 above). That is, the doctor would also look at factors related to the patient's family history, diet, exercise, life stresses, etc. to determine generational, external, or contextual factors that might be causing or exacerbating an identified concern.

And now, it is suggested that no medical doctor in America would ever begin to treat a patient, especially with a clear and existing medical problem, without first getting his or her medical history; previous diagnostic assessments; surgery, hospitalization, and other treatment records; and other charts or reports detailing his or her response to previous intervention.

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Relative to students identified with academic or behavioral problems, the same principle should be followed. Information gathered, for example, from (a) a cumulative folder review, (b) existing intervention and medical records, (c) student attendance and testing data-bases, (d) interviews with parents and previous teachers or consultants is critical to understanding a student's academic and social, emotional, and behavioral history and current status. For different students, it is essential to know, for example, their medical, developmental, social, home, familial, school, learning, assessment, and proficiency histories and status—at the beginning of the functional assessment process and before strategic instructional or intervention approaches are tried. What if, a student:

- Has been in four different schools over the past three years with three different literacy and mathematics curricula?
- Is on time-release Ritalin (taken in the morning before school starts)—and no one in the school knows this?
- Has previously received a specific intervention that did not work—the same intervention that the school is unknowingly about to implement again?
- Was taught, last year (in another school) by a long-term substitute who was teaching out-of-field and who was completely ineffective in the classroom?

Some national "experts" are recommending that a comprehensive review of a student's records, history, development, and progress only needs to occur after Tier 1 or even Tier 2 interventions are unsuccessful. To begin any strategic or intensive intervention—even in the general education classroom—without this important information about a student is inappropriate at best and unethical at worst.

5. There is a concern that the functional assessment approaches recommended still predominantly focus on either a student's motivational or emotional status.

The Functional Behavioral Assessment (FBA) process, as taught at most universities and/or as advocated nationally, has not kept abreast of research and applied practice. Beyond analyzing students' motivational or emotional difficulties, FBA approaches need to include possible reasons underlying a student's academic or social, emotional, or behavioral difficulties.

Response. Research and applied practice have identified seven "high-hit" reasons why students present with challenging behavior—four at the instructional level, and one each involving motivation, inconsistency, and peer- and common school area-related conditions. Functional assessments must evaluate for all seven of these possible domains, along with analyses in the instructional environment, and home and community.

In the context, for example, of a student's social, emotional, and behavioral interactions, these seven high-hit hypotheses are:

- Hypothesis #1 (Skills): Skill Deficit. A student has not been taught or has not learned and mastered the social, emotional, or behavioral skills needed to exhibit appropriate behavior and to prevent or avoid inappropriate behavior.

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- Hypothesis #2 (Skills): Speed of Acquisition . A student is learning and demonstrating some social, emotional, or behavioral skills, but s/he is not learning and mastering these skills at the same rate or pace as other students in the classroom.

- Hypothesis #3 (Skills): Transfer of Training/Generalization. A student is learning and demonstrating social, emotional, or behavioral skills when they are taught, but s/he is not transferring or applying these skills independently during real or actual situations.

- Hypothesis #4 (Skills): Conditions of Emotionality. A student has not been taught or has not mastered the skills and behaviors to cope with situations or circumstances that trigger high levels of emotionality.

- Hypothesis #5 (Accountability): Motivation/Performance Deficit. A student is not motivated to learn and/or apply his/her social, emotional, or behavioral skills.

- Hypothesis #6 (Consistency): Inconsistency. Inconsistency exists somewhere in the instructional, motivational, or transfer of training process. This could involve the inconsistent teaching or prompting of social, emotional, or behavioral skills; the inconsistent use of incentives, consequences, or accountability approaches; or inconsistency that is related to different peer, staff, setting, and/or situational expectations, interactions, or responses.

- Hypothesis #7 (Special Situation): Setting, Peer, Life Circumstances. A student is experiencing or reacting to significant past or present situations or circumstances in one or more common areas of the school; with one or more peers—involving significant levels of teasing, taunting, bullying, harassment, or physical aggression; or in some school, home, or community facet of his/her life. This problem is impacting his/her (a) social, emotional, or behavioral learning, mastery, or transfer; (b) motivation to use already-learned social, emotional, or behavioral skills; or (c) consistency or stability.

Most FBAs ask, "What is the function of a specific behavior for the student?" While an appropriate question, the answer only relates to student motivation (#5 above). This is because, in order for a behavior to have a "function" for a student (or an underlying reason for its presence—e.g., attention, control, power, revenge, etc.), the student needs to be demonstrating the behavior in order to "satisfied," attain, or accomplish that function.

Some FBAs ask, "Is this behavioral occurring because the student is not demonstrating emotional self-control?" While another appropriate question, these two questions (as noted above) do not cover the other five of the high-hit reasons described briefly above.

And so, even when practitioners are completing functional assessments, many of them are conducting incomplete ones that result in either motivational or self-control-oriented interventions. For some students, this results in the selection and implementation of the wrong intervention approaches. Moreover, when these interventions (predictably) do not work, many

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times the conclusion is that the students have a more resistant, intensive, or significant problem—rather than recognizing that the interventions were not address the real reasons for the problem and, thus, could not have solved the problem.

6. There is a concern that a small number of "universal" Tier 2 interventions have been recommended nationally, and these are not linked to the results of a comprehensive functional assessment.

Check and Connect has been advocated for many years as, pretty much, the first (and, often, only) Tier 2 intervention for students demonstrating social, emotional, or behavioral problems (or identified as such by a behavioral screener). As such, Check and Connect has been used as a "universal" for all Tier 2 students, rather than a "strategic" Tier 2 intervention for only those students who would benefit from it (based on a functional assessment).

There are fifty or more Tier 2 interventions that strategically link to the functional assessment of the instructional environment (see #3 above), and/or to the seven high-hit reasons why students present with challenging behavior (see #5 above). Some of these interventions are mentioned Tier 3 interventions through PBIS, or they have not been mentioned at all.

Response. As noted earlier, there are seven "high-hit" reasons why most students (when it is a student-centered reason) demonstrate social, emotional, or behavioral difficulties. Each of these high-hit reasons can be linked to strategic (Tier 2) or intensive (Tier 3) instructional or intervention approaches that have the highest probability of resolving the student's difficulty.

The seven high-hit reasons are shown in Figure 1 below. Figure 2 identifies the instructional or intervention approach that will best address each of these high-hit reasons. For example, if a student has not learned or mastered the ability to control his or her emotions, this must be taught (High Hit Area 1). If a student has the ability to interact appropriately, but chooses (or is motivated) not to, motivational strategies or interventions are needed (High Hit Area 5). If a student demonstrates inappropriate behavior because s/he has been inconsistently reinforced for this behavior and allowed to "get away with it," then this inconsistency needs to be stopped, and an intervention must be implemented "past the history of this inconsistency."

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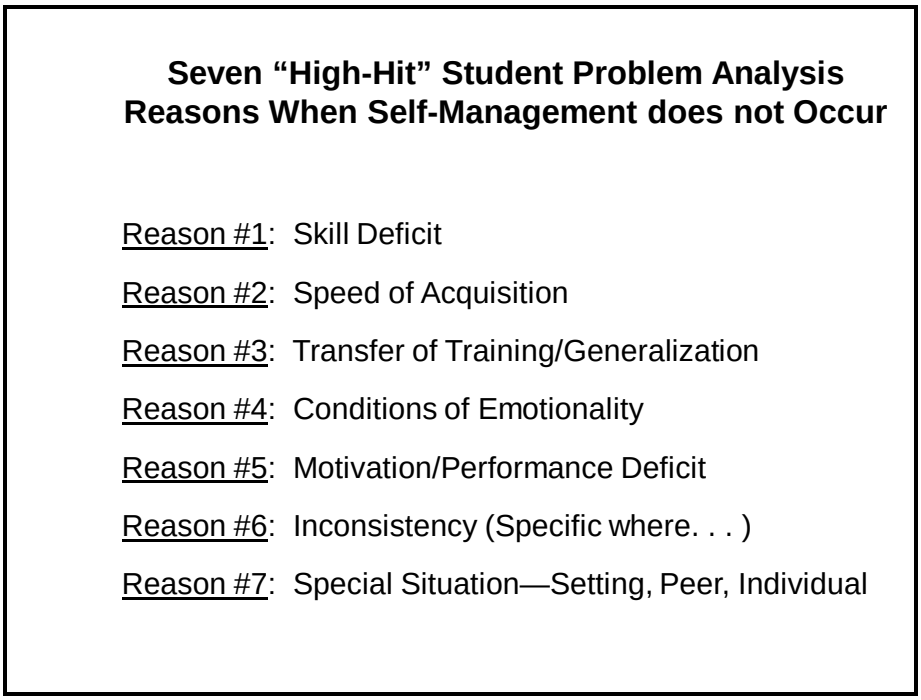

Figure 1.

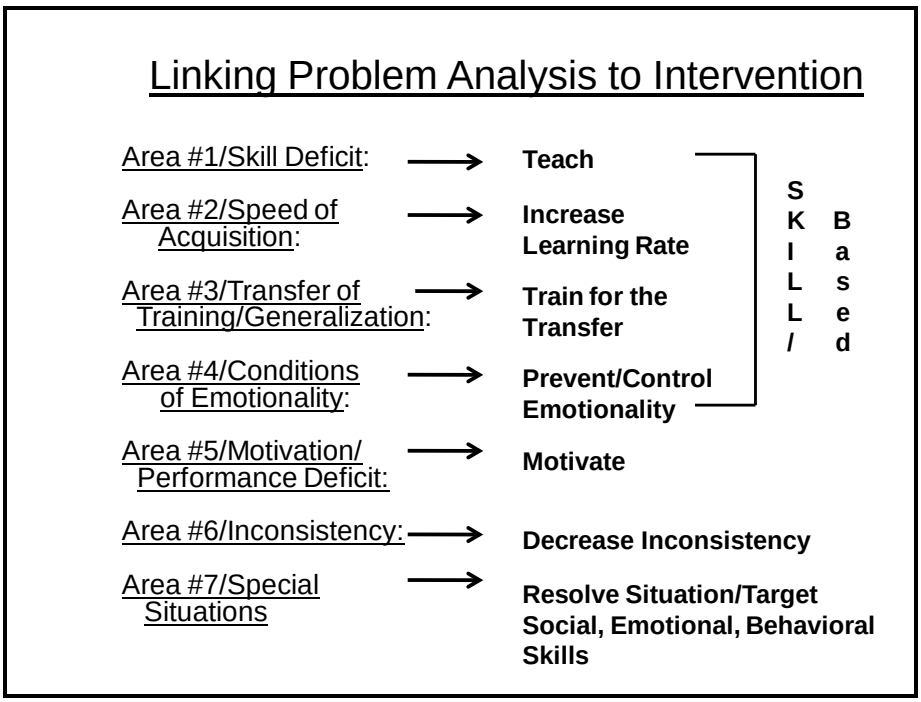

Figure 2.

Figure 3 shows a sampling of instructional or intervention approaches at the Tier 2 level—many of which has been empirically validated for 15 or more years, but few of which are identified in any formal sense at the national PBIS or RtI levels. These approaches can be connected to the high hit reasons shown in Figures 1 and 2.

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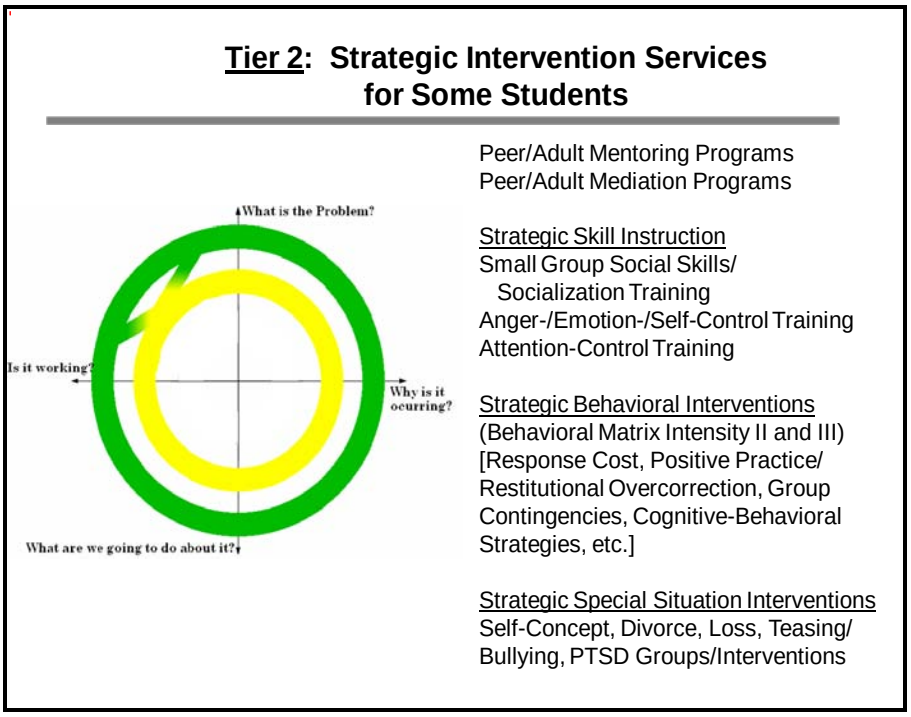

Figure 3.

Finally, Figure 4 shows that, while Tier 3 may include some additional interventions, many Tier 3 interventions are Tier 2 interventions implemented at more intensive levels of service delivery. Critically, the essence of the multi-tiered continuum (see below) is not the place of service delivery or the number of students being served. Instead, the tiers reflect the intensity of services, supports, strategies, and programs that students need to be successful.

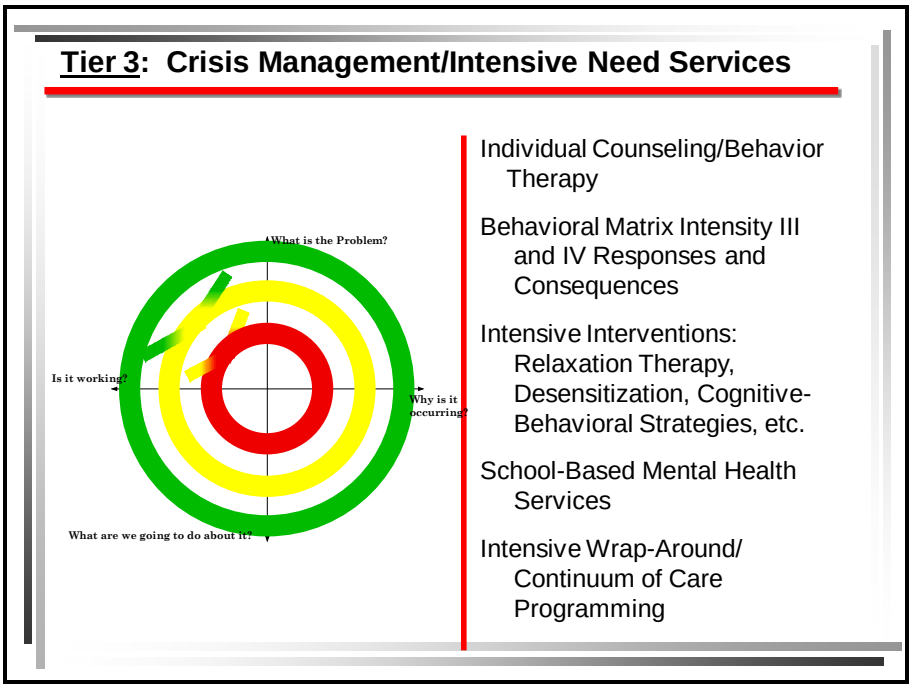

Figure 4.

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7. There is a concern that: when Tier 2 interventions are unsuccessful, it is assumed that the student has a more serious or "resistant" problem than first thought, and Tier 3 interventions are (largely immediately) implemented for/with the student.

When Tier 2 interventions are unsuccessful, the current national mindset results in a conclusion that the student needs more intensive, Tier 3 intervention. That is, rather than complete another functional assessment to determine why the Tier 2 instructional or intervention approach did not work, a student-focused conclusion is drawn and more intensive interventions are tried.

Response. Especially at the Tier 2 level, a data-based analysis needs to be completed whenever a specific instructional or intervention approach has not been successful for/with a student. In addition to the possibility that the student might need more intensive services, supports, strategies, or programs, there are a number of additional hypotheses to explain why a strategic, Tier 2 instructional or intervention approach has been unsuccessful.

Among these hypotheses are the following:

- The best or right interventions for the problem,
- Implemented with the correct level of treatment or implementation intensity,
- Implemented with the correct level of treatment or implementation integrity,
- Implemented long enough;
- Focused on the right short-term or long-term outcomes—or sequence of outcomes, or
- Evaluated with the right evaluations or evaluation approaches, or the evaluations were not sensitive enough to pick up the outcomes.

To immediately assume that an intervention did not work because of the student—and then to increase the intensity of the intervention or intervention process—is inappropriate. Unsuccessful interventions must be analyzed to determine why they have not produced desired results. As noted above, some interventions simply have not been implemented long enough, or they may need to be fine-turned or clinically adjusted in order to succeed.

Using another medical analogy, medical doctors do not immediately increase the dosage of a medication when a patient is not getting better, or hospitalize a patient because out-patient services are not working. Instead, they re-analyze the data, and re-analyze the patient and his/her response to the initial intervention. They then make an informed decision as to what is not working and what, strategically, now needs to be done.

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8. There is a concern that: treatment integrity has been emphasized to the exclusion of treatment intensity.

While treatment or implementation integrity—the degree that a strategic or intensive instructional or intervention approach has been correctly implemented as designed, validated, and intended—is critical to the potential success of any approach, treatment or implementation intensity has not received equal attention or emphasis.

Response. When strategic or intensive instructional or interventions approaches are implemented for students with academic or social, emotional, or behavioral difficulties, it is essential that they be implemented with the correct level or degree of treatment or implementation intensity. Critically, treatment intensity varies across a number of different dimensions. Moreover, a specific instructional or intervention approach may require attention to one or more of these dimensions. Some examples of intensity include the following:

- The Intensity of Individualization. Intensity may vary by the number of students (e.g., an entire classroom, a group of students from the same classroom or grade-level, or just a single student) whose needs call for a specific instructional or intervention service, support, strategy, or program.

- The Intensity of Time. The intensity of time relates to the frequency and/or duration of a service, support, strategy, or program—that is, how many times an hour, day, week, or month it must be provided, and for how long.

- The Intensity of Setting, Teacher Expertise, or Teacher Need for Consultant Expertise. Intensity may vary by whether the instruction or intervention can be implemented (a) in a general education classroom versus another more specialized classroom setting, (b) by a general classroom teacher versus a teacher with more specialized skills, and/or (c) by a general classroom or specialized teacher independently versus with the assistance of an expert from a related, but more specialized or multidisciplinary profession.

- The Intensity of Assessment, Progress Monitoring, and Instruction/Intervention. The intensity of assessment or progress monitoring can vary, for example, by the number of areas to assess, the complexity of or time involved in administering the assessments, or the frequency of the administrations. The instruction or intervention focus can vary, for example, by breadth or depth. Breadth might involve the number of different curricular areas that need to be addressed by the instruction or intervention. Depth might involve the number of specific areas within a single curricular area—for example, a student with difficulties in one versus all five areas of literacy.

- The Intensity of Teacher-Student Instructional Interactions. The intensity of teacher-student instruction involves the interactions needed to successfully implement some instructional or intervention approaches. Although a separate category, the intensity of teacher-student instructional interactions is closely tied to individualization and related time factors. Nonetheless, examples of instructional interactions here may include the approaches (and student's) need for:

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- Teacher proximity
- Explicit and frequent feedback
- Opportunities for student initiated questions
- Observation of individual students
- Opportunities for student practice
- Opportunities for student interaction

Clearly, the appropriate levels of treatment intensity for any instructional or intervention approach need to be planned prior to implementation and then executed accordingly. Next, both treatment intensity and treatment integrity need to be evaluated to determine that they were present throughout implementation. Finally, if not appropriately present, the lack of treatment intensity or integrity must be considered as a primary reason for an approach's lack of success—if that turns out to be the case.

9. There is a concern that: a number of principles guiding the multi-tiered PBIS and RtI systems have been recommended, but have not been empirically validated. Some of these recommendations have resulted in ineffective or inappropriate services for students.

Some of the guiding principles advocated by some national PBIS and RtI experts include assertions that have not been empirically validated, and that have resulted in ineffective or inappropriate processes, procedures, and services for students. Among them are the following:

- That specific percentages of students (e.g., 80-85%, 10-15%, and 3-8%) will or should populate Tiers 1, 2, and 3, respectively.
- That Tier 1 services are delivered to all students, Tier 2 to some students, and Tier 3 individually to a few students.
- That Tier 2 and 3 services are delivered less and less (if at all) in the general education classroom where all students are educated (instead of pull-out or less restrictive classroom settings).
- That Tier 1 largely involves core instruction, Tier 2 adds supplemental services (core instruction plus 30 minutes), and Tier 3 involves supplemental services delivered to individual students.
- That a student must be non-responsive to Tier 1 and then Tier 2 interventions in order to receive Tier 3 services, and must be successful in Tier 2 services, after receiving Tier 3 services, in order to return to Tier 1 services.

Response. There is no research to validate a multi-tiered system where 80% of the students, for example, are in Tier 1, 15% in Tier 2, and 5% in Tier 3. This approach has resulted in schools where, for example, 30% of the students at a specific grade level are receiving Tier 2 pull-out or supplementary services—when those services should be integrated into the school's Tier 1 core instructional services in the general education classrooms (and probably should have been delivered earlier).

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Beyond this, when multi-tiered systems are organized around the number of students receiving services (Tier 1—All Students, Tier 2—Some Students in Supplemental Instruction Groups, Tier 3—Individual Students receiving Intensive Interventions), it has resulted in service delivery systems focused more on who is getting services, rather than what services, supports, strategies, and programs they need to get. This has inadvertently resulted in the tiers becoming labels ("she is a Tier 2 student," "he is a Tier 3 student"). And, it has resulted in schools that have created lock-step intervention "stages" that students are fit into, rather than student-centered instructional or intervention approaches that students are strategically grouped into—and out of when they have successfully mastered the needed skills or skill sets. Finally, when the multi-tiered system is organized around percentages of students, schools and staff begin to focus on the student and the severity of their "problems," rather than on the services and supports needed to help students be academically successful and behaviorally sound.

Next, when multi-tiered systems are organized around the place of services, fewer services are delivered or integrated in the general education classroom by the regular classroom teacher, and more services are delivered in more segregated, less restrictive environment settings. In addition, when Tier 2 or 3 service are delivered out of the general education classroom (and functional assessments have not been conducted), some students may be taken out of the settings that have specific conditions (e.g., the teacher, peers, specific instructional or grouping patterns, larger number of students that make it more difficult to ask for help) that are triggering their difficulties.

Continuing on, there is no empirical evidence supporting the "universal" process being advocated that Tier 1 largely involves core instruction, Tier 2 adds supplemental services (core instruction plus 30 minutes), and Tier 3 involves supplemental services delivered to individual students. Once again, when students are demonstrating significant or persistent academic or behavioral difficulties in Tier 1, a functional assessment process must proceed to determine why the student is having the difficulty. It is inappropriate to put all students into Tier 2—"Core Instruction plus 30 minutes of Supplemental Services" when some students (based on the functional assessments) need (a) more effective instruction; (b) prerequisite skill remediation; (c) modifications of the core instruction materials; (d) accommodations; (e) a different core instructional approach or curriculum; or (f) immediate intensive (Tier 3) intervention.

Expanding on the latter point above, it is unconscionable to permit multi-tiered systems to exist where a student must be non-responsive to Tier 1 and then Tier 2 interventions in order to receive Tier 3 services. This reinforces the "wait-for-the-student-to-fail" approaches of past years. Clearly, if a student needs immediate Tier 3 services, then those should be delivered.

Conversely, multi-tiered systems should not require students to be successful in Tier 2 services, after receiving Tier 3 services, in order to return to Tier 1 services. If a student moves into a school district so far behind his or her peers in a specific academic area (e.g., due to a recent move and a long-term medical absence from the previous school), they may need intensive, all-inclusive Tier 3 supports in that area in order to "catch up." Once they have caught up, if they can be successful, they might move immediately back into the Tier 1 core curriculum in their general education classroom.

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Summary. A different perspective of the multi-tiered system is to organize the tiers around the intensity of services, supports, strategies, or programs needed by students to address specifically-identified problems. For example, if a school or district defines intensity by the expertise of the professionals providing the more strategic or intensive services, then a class of students who are receiving services in their general education classroom with the direct or indirect help of a school psychologist, law enforcement representative, associate superintendent of student services, and/or their parents (for example, to resolve a series of racially-motivated incidents of harassment) could be said to be receiving Tier 2 or 3 services—depending on how available or how the district characterizes the intensity of these services and supports.

Similarly, a classroom where the teacher is receiving consultative support from a school psychologist due to poor classroom management (because, for example, virtually every student has been sent to the principal's office by that teacher at least twice in the last month) might be said to be receiving Tier 1 or Tier 2 services—again depending on how they are defined by the school.

Next, a student who has lost his entire family and home due to a tornado, might be receiving weekly Tier 3 post traumatic stress syndrome (PTSD) services from a private psychologist, supported daily by a school psychologist. And yet, that student may be functioning successfully in his or her full time regular classroom and general education program. Here, it appears that the student is receiving Tier 3 social, emotional, and behavioral services, and yet the student still is full time in a Tier 1 academic program.

Finally, that same student, impacted so tragically by the tornado, might need to be psychiatrically hospitalized (a different Tier 3 service) for a time to deal with the tragedy, and then return to his or her regular classroom (Tier 1)—with minimal supports—two weeks after successfully receiving these intensive services. Here, the student has moved from a Tier 1 status, immediately to a Tier 3 level of services and supports, and then immediately back to his or her original Tier 1 status. That is, it is not appropriate to require a Tier 1 to Tier 2 to Tier 3 lock-step process on the front end, or a Tier 3 to Tier 2 to Tier 1 "return" process on the back end. The intensity of services, supports, programs, or strategies is dictated by the student's status, need, and availability of interventions that can be implemented with integrity and intensity.

10. There is a concern that: a number of principles and practices guiding the PBIS implementation system have been recommended nationally that have not been empirically validated or field-tested. Some of these practices have resulted in ineffective or inappropriate services for students.

Some of the guiding principles and practices advocated by some national PBIS experts include assertions that have not been empirically validated, and that have resulted in ineffective or inappropriate processes, procedures, and services for students. They include:

- That the "validity" of the PBIS process is represented by the number of schools who are reportedly implementing these processes.

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- That the hallmark outcome "validating" PBIS processes involve Office Discipline Referrals and/or student suspensions or expulsions.
- That the focus of PBIS primary (or Tier 1) implementation should exclusively or largely be on student behavior in the common areas of a school.
- That social skills instruction should be a Tier 2 intervention—implemented after a student demonstrates problematic social, emotional, or behavior interactions in the classroom or common area of a school.

Response. Nationally—in conferences, testimony to Congress, and annual and other technical reports, more attention has been focused on the number of schools "doing PBIS," than on the quality, sustainability, and cost-/time-effectiveness of its implementation outcomes. Critically, given the thousands of schools "doing PBIS," it is easy to find a small percentage of schools demonstrating positive outcomes. The ultimate question is, "Do the vast majority of PBIS schools demonstrate consistent, sustainable (multi-year) student and staff outcomes as defined, in advanced, by the initiative or project?" At this time, the answer to this question appears to be "No." And yet, the touted number of schools doing PBIS schools has somehow legitimized the approach.

Beyond this, the "benchmark" PBIS criterion of success has largely been the number of Office Discipline Referrals (ODRs) and/or student suspensions or expulsions in a school. Critically, ODR data cannot reliably or causally evaluate PBIS success. Even if these data could reflect causality, according to its national leaders, there is no standard PBIS implementation blueprint or protocol that all PBIS schools must adhere to. Thus, there is no way to demonstrate or replicate certain PBIS activities as directly contributing to or being necessary for PBIS success, nor are there reliable or valid ways to compare or evaluate results across most implementing schools.

Expanding briefly: While important when evaluating a positive behavioral support initiative, ODR data, without external corroboration, are not reliable according to SAMHSA and its National Registry of Evidence-based Programs and Practices. Indeed, ODRs are simply like a reading on a thermometer. ODRs can go up and down, for example: (a) if an administrator tells his or her staff to stop sending students to the office for disciplinary reasons, or if that administrator ties ODRs to personnel evaluations; (b) if staff members decide to "express their dissatisfaction" with the support they are receiving for disruptive students by sending them to the office three to five times per day for a period of three weeks; (c) if these disruptive students are eventually sent to an alternative program; and so on.

But ODR data, by definition, also reflect only inappropriate student behavior that is so significant that it warrants sending the student out of the classroom to the principal's office. ODR data do not measure or reflect the degree of appropriate student behavior that may or may not be occurring in a setting, nor do they measure situations where a student's behavior is inappropriate—but not at the level that warrants an office referral.

Finally, ODR data cannot effectively represent PBIS success when many ODRs occur due to inappropriate student behavior in the classroom, and most PBIS schools focus largely on student behavior in the common areas of the school.

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The ultimate point is that ODRs are not the most reliable or valid indicators of the impact or success of a school-wide positive behavioral support initiative. And so, additional indicators and outcomes are needed to more comprehensively measure PBS impact or success. Among those suggested are the following:

1. High levels of positive classroom and school interactions among and across students and staff, positive classroom and school climate, and school safety.
2. High levels of positive and effective interpersonal, social problem-solving, conflict prevention and resolution, and emotional coping skills/behaviors by all students—all leading to student self-management.
3. High levels of critical thinking, reasoning, and problem-solving skills by all students.
4. High levels of academic engagement and academic achievement for all students.
5. Consistently effective instruction and classroom management across all teachers/ instructional support staff.
6. Low levels of classroom discipline problems, discipline problems that need to involve the school principal, or discipline problems that require student suspensions or expulsions.
7. High levels of teacher confidence– relative to instruction, classroom management, and in helping students with academic or behavior problems.
8. High levels of parent and community support and involvement in school safety, effective classroom instruction and management, and student self-management.

Critically, these goals and outcomes should be the primary focus of a multi-tiered positive behavioral support system, and they should be explicitly targeted at the Tier 1 level. As such, given the stated importance of teaching students positive and effective interpersonal, social problem-solving, conflict prevention and resolution, and emotional coping skills and behaviors, the need for all students—from preschool through high school—to be taught these skills as part of a scaffolded, integrated "Health, Mental Health, and Wellness" curriculum is apparent. And yet, it took over 15 years for PBIS leaders to acknowledge the importance of a social, emotional, and/or behavioral skills program or curriculum. Moreover, even now, they typically recommend that students with skill-based problems in these areas receive small group Tier 2 interventions where they can learn these skills—some of them for the first time.

In other words, rather than teach these skills to all students so that, for example, Goals 1, 2, 3, 4, and 6 above can be accomplished in a preventative way, the mode of operation, instead, appears to suggest that schools wait for the students to fail interpersonally, view them as a group of students who need remediation, and provide more specialized, expensive, segregated services—that will still need to be transferred into their classroom and other school settings. Clearly, this makes no sense. And yet, it represents the "deficit focused" mindset of the PBIS initiative during its first twenty years—a mindset that has focused more on decreasing or eliminating inappropriate student behavior, rather than teaching, reinforcing, and facilitating students' appropriate social, emotional, and behavioral development, progress, and self-management.

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