Building Positive, Healthy, Inclusive Communities with Positive Behavior Support

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Matt J. Enyart, Jennifer A. Kurth and Daniel P. Davidson

Envisioning Positive, Healthy, and Inclusive Communities

Contemplate for a minute what it means to be fully included in your community. Is it simply having an address in the community? Are friends and a job included in the criteria? What feelings are associated with a sense of community belonging? Does everyone have a right to full inclusion in their communities? Is it possible for communities to ensure the inclusion of all citizens? Most professionals responsible for enabling the development and implementation of school, work, home, and community supports would respond affirmatively. Communities have diversified to offer a spectrum of federal, state, and locally funded supports and services for children, youth, families, and adults with various strengths and needs. This comprehensive array of academic, vocational, home, and community supports can address individualized needs and promote inclusion.

People with intellectual and developmental disabilities, however, may not always be purposefully considered when developing these supports. Limited resources, increased accountability, and disjointed community systems are common barriers community-support providers face when including adults with intellectual and developmental disabilities in all aspects of the community (Schalock, 2012). Additionally, long waiting lists for services and inadequate staff training often delay or reduce the effectiveness of support implementation. This dynamic, combined with inconsistent community-wide objectives, fragmented systems, lackluster practices, and ineffective program evaluation, can result in a support model which fails to meet the needs of all community members (Schalock, 2012). As a result of these shortcomings, community services and supports can become punitive, restrictive, and expensive (Nelson, Sprague, Jolivette, Smith, & Tobin, 2010a, Nelson, Jolivette, Leone, & Mathur, b; Schalock, 2012; Sprague et al., 2013). As a result, people with intellectual and developmental disabilities, as well as those who engage in challenging behaviors, may be denied full citizenship as they become secluded or excluded (Morningstar, Kurth, & Johnson 2016).

Across the USA, this reactive, exclusionary trend is reflected in the disproportionate number of incarcerated youth and adults with disabilities and behavioral health needs (Nelson et al., 2010a, b; Geis, 2013; Quinn, Rutherford, Leone, Osher, & Poirier, 2005). Equally concerning are the number of youth and adults with intellectual and developmental disabilities spending the majority of their time in secluded and segregated resource rooms, congregate living homes, and

M.J. Enyart (✉) · J.A. Kurth
University of Kansas, Lawrence, KS 66045, USA
e-mail: menyart@ku.edu

D.P. Davidson
Intermountain Centers for Human Development, Tucson, AZ 85748, USA

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"workshop" settings (Schalock, 2012). Both the American Association on Intellectual and Developmental Disability (AAIDD) and the World Health Organization (WHO) have adopted the social-ecological model of disability (Schalock, 2013). Through this lens, disability is defined as a mismatch between personal capacities and environmental demands (Thompson, Schalock, Agosta, Teninty, & Fortune, 2014). Within this conceptualization of disability, supports are necessary to bridge the gap between what is (a state of incongruence due to mismatch between the person's competence and the demands of the environment) and what could be (a meaningful life with positive outcomes; Thompson et al., 2009).

While the WHO, AAIDD, researchers, advocates, families, self-advocates, and many other stakeholders have begun to shift from disability models focusing on deficits, the majority of our communities and schools are still trailing behind in their understanding of disability and community supports. Existing policies, regulations, and service models are often driven by diagnosis and deficits versus strengths (Wehmeyer, 2013). Many professionals, organizations, and systems continue to place blame for both behavior and ability squarely on the shoulders of the person. Problems, challenges, and punitive responses are emphasized rather than strengths, teaching desired behavior, and utilizing positive interventions and supports. This tends to be especially true for people with intellectual and developmental disabilities (Schalock, 2012; Wehmeyer, 2013).

Environmental contexts affect everyone's ability to obtain optimum quality of life outcomes across home, work, school, and community settings (Carr et al., 2002a, b; Dunlap, Sailor, Horner, & Sugai, 2010). A person's skills, knowledge of surroundings, access to technology, and environmental modifications can be a bridge within each of these environmental settings (Thompson et al., 2014), if they are aligned with a person's support needs and the demands of the environment (Carr et al., 2002a, b; Dunlap et al., 2010).

There is a direct relationship between the behaviors each of us engage in and our environment, existing skills, internal emotional factors, and access to technology and supports (Carr et al., 2002a, b; Carr, 2007; Dunlap et al., 2010). Unfortunately, as a society we continue to struggle with delivering appropriate and necessary individualized environmental modifications, effective behavioral, therapeutic, and socio-emotional supports, and accommodations to those who need them (Freeman et al., 2015). In the absence of these effective community-based interventions, people exhibiting challenging behaviors are either pushed into secluded work, home, and school settings, or expelled outright from our communities and placed into psychiatric or correctional facilities. Recent school to prison pipeline research, for example, has highlighted that more than half of the current corrections population in the USA have disabilities which would have made them eligible for special education services as children (Geis, 2013; Krezmien, Leone, Zablocki, & Wells, 2010; Nelson et al., 2010a, b; Quinn et al., 2005). There are some indications the trend toward segregation and expulsion may be changing, however. For example, McLeskey, Landers, Williamson, and Hoppey (2012) examined trends in educational placement for students with disabilities and found a 93% increase in the number of students with high-incidence disabilities (e.g., learning disabilities) accessing the general education (inclusive) setting between 1990 and 2008.

Such trends reflect the increasing commitment to including people with disabilities in typical settings and activities in USA and international law. For example, Article 3 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) states persons with disabilities should have "full and effective participation and inclusion in society," including an inclusive education system (Article 24; United Nations Convention on the Rights of Persons with Disabilities [UNCRPD], 2016). The Americans with Disabilities Act (1990), as well as federal education law (Individuals with Disabilities Education Improvement Act, 2004) further protect the

rights to inclusive lives of children and adults with disabilities in the USA.

Despite these mandates, progress toward gaining full inclusion, particularly for people with intellectual and developmental disabilities, remains limited. For example, in an analysis of trends in accessing general education settings for school-age students with significant disabilities (e.g., autism, deaf-blindness, intellectual disability, and multiple disabilities), Morningstar, Kurth, and Johnson (2016) found US states have made remarkably little progress in educating more students in general education settings. Likewise, adults with disabilities struggle to gain access to work and living arrangements in their communities. Consequently, states across the country have faced scrutiny because adults with intellectual and developmental disabilities are predominantly secluded in sheltered workshops, earning subminimum wages, and living in group homes with roommates they did not choose (Wehmeyer, 2013).

Findings from implementation science, positive behavior support, and organizational psychology provide research-based solutions to this pervasive problem in our communities and schools. Yet, implementing and sustaining evidence and research-based practices is difficult without several critical features in place (Fixsen et al., 2005; Schalock, 2012). Across research studies and fields, the importance of organization culture, environmental context, strong administrative support, a long-term commitment to training, effective evaluation, and the willingness to reframe all systems and procedures are identified (Schalock, 2012). A review of implementation science research identified core implementation components include teaching, coaching, and performance measurement. Additionally, organizational components include the selection of the evidence-based practice, program evaluation, administration support, and system-level intervention. Also identified was the influence of social, economic, and political factors (Fixsen et al., 2005). Positive behavior support and organizational psychology both reflect these elements for successful implementation (Dunlap et al., 2010; Seligman, 2000; Seligman, Steen, Park, & Peterson, 2005). The majority of professionals within schools and human service organizations want to effectively support the youth or adults they work for. However, ineffective practices, organizations, or systems can result in low morale or a challenging culture (Schalock, 2012). Intellectual and developmental disability organizations face specific and significant challenges including dwindling resources, increased demand for services and supports, shifts from general to individualized supports, an increased emphasis on personal outcomes, calls for increased effectiveness and efficiency, resource allocation based on support needs, an emphasis on self-determination and self-direction, and pressure to utilize evidence-based practices (Schalock, 2012).

Given these challenges, it is not difficult to understand why there continues to be a trend of exclusion of people with intellectual and developmental disabilities. Positive behavior interventions and supports (PBIS) provides a proven framework, using multitiered interventions and a systematic, data-driven approach, which when implemented effectively, creates a mechanism for all people to achieve quality of life goals and be fully included across environments (Carr et al., 2002a, b; Dunlap et al., 2013). This chapter will describe how families, professionals, and organizations can utilize PBIS to achieve quality of life outcomes and contribute to the creation of positive, healthy, and inclusive communities.

Description and Evolution of Positive Behavior Interventions and Supports

Positive behavior interventions and supports (PBIS) has long history of use in teaching skills and improving behavioral outcomes for people with intellectual and developmental disabilities. For example, PBIS strategies have been used to improve choice-making and quality of life outcomes (McClean & Grey, 2012), communication skills (Hetzroni & Roth, 2003), and self-management skills (Lee, Poston, & Poston, 2007). PBIS has been effectively utilized in a variety of settings, including school (e.g., Ross &

Horner, 2014), home (e.g., Buschbacher, Fox, & Clarke, 2004), and across the lifespan (Carr et al., 2002a, b). However, providing individualized supports for *all* students in a community, including those with infrequent problem behaviors, is resource-prohibitive and unduly time consuming. As a result, system-wide approaches to behavior problems have been developed (Crimmins & Farrell, 2006).

System-wide approaches, including school-wide positive behavioral interventions and supports (SWPBIS) and organization-wide positive behavioral interventions and supports (OWPBIS), have been meticulously assembled and researched within schools, organizations, and community settings. Both are applied through a multitiered continuum, focusing on teaching positive, prosocial behavior skills to all students or members of a school or organization (Hawken & O'Neill, 2006; Walker et al., 1996). Specific evaluation procedures and practices exist within each tier, including universal (tier 1), targeted (tier 2), and intensive (tier 3; Sugai, Simonsen, Bradshaw, Horner, & Lewis, 2014).

Universal interventions involve clear and consistent expectations which are systematically taught, reinforced, and corrected for all service recipients and staff. An example of universal expectations would be posting and reviewing lunchroom expectations with all students before they enter the lunchroom. When people engage in desired expectations, they are reinforced verbally with positive, specific praise. Approximately, 80% of students or community members respond well to these types of universal interventions. Targeted interventions include interventions for people who are not responding to universal interventions (expected to be approximately 10–15% of people). An example would be a providing additional scheduled times throughout a person's day to teach and reinforce expectations. This could include a specific prosocial skill development curriculum or an additional lesson and reinforcement on expectations in the lunchroom. Intensive interventions are provided when universal and targeted interventions are not effective in reducing challenging behavior and increasing desired behaviors. Intensive interventions include the completion of a functional behavior assessment and the creation of function-based interventions. Approximately, 5% of students or community members will require intensive interventions. It is important to note that even receiving targeted or intensive interventions, students or community members should also continue to be exposed to universal interventions, which are the starting point for determining the need for targeted or intensive interventions. Ultimately, the primary concern of PBIS across all three tiers is to improve the quality of life of people served, the organization, and the community as a whole.

Today, critical features of PBIS as a multitiered framework have been well defined. Perhaps the most critical of these features is the dedication to adapting and contextualizing PBIS procedures, practices, and evaluation to support people across environments, systems, and the lifespan. Committed to the continual expansion of PBIS, researchers collaborate closely with stakeholders as they use available research and data to modify features without jeopardizing the science (Carr et al., 2002a, b; Dunlap et al., 2010; O'Neill, Albin, Storey, Horner, & Sprague, 2015). Today, PBIS procedures, practices, and evaluation are being adapted, utilized, and researched in juvenile correction facilities, mental health centers, psychiatric residential treatment facilities, intellectual and developmental disability organizations, and other alternative settings (Carr et al., 2002a, b; Dunlap et al., 2010; Nelson et al., 2010a, b; O'Neill et al., 2015; Sprague et al., 2013).

While PBIS has resulted in positive outcomes for youth in schools and organizations (Horner, Sugai, & Anderson, 2010), significantly less progress has been made regarding home and community PBIS research, practice, and policy. In part, this has been due the limited funding community-based, adult services organizations have received (Rizzolo, Friedman, Lulinski-Norris, & Braddock, 2013). However, researchers are now able to draw from the SWPBIS research to reinvest in home and community applications of PBIS in collaboration with lessons learned from positive psychology, quality of life, and person-centered planning. Each is strengths-based and focused on

improving outcomes for marginalized populations in communities. And, with a primary objective of improving quality of life, PBIS is uniquely situated to improve outcomes for people with intellectual and developmental disabilities.

Foundations of Positive Behavior Interventions and Supports

Throughout history, humanity has not always been kind to people who do not readily respond to the environmental, social, or behavioral expectations placed upon them (Wehmeyer, 2013). For those who have, or who are perceived to have, intellectual and developmental disabilities, experiences including isolation in institutional settings, the denial of access to communities, sterilization, and living in subhuman conditions are all too common (Smith & Wehmeyer, 2012). Prior to the 1960s in the USA, people with intellectual and developmental disabilities were largely relegated to institutions, often living in deplorable conditions (Blatt & Kaplan, 1966). As these conditions came into public view during the civil rights movement of the 1960s, applied behavior analysis (ABA) research emerged demonstrating that all people, regardless of the significance of their disability, could learn. However, ABA (at the time) relied heavily on the use of aversive techniques such as slapping, pinching, and even shocking people with intellectual and developmental disabilities to achieve these learning results. Many in the ABA field felt the new, fast growing discipline of ABA lacked oversight and should only be used when carefully balanced with values.

While this debate ensued, researchers Nirje (1969) and Wolfensberger, Nirje, Olshansky, Perske, and Roos (1972) focused on community inclusion and social roles of people with intellectual and developmental disabilities. Their work defining the normalization principle described how the value placed on people is reflected in how and where they are represented in the community. People perceived as having low social worth are treated poorly and not included in or accepted as "normal" within their communities. Normalization researchers believed everyone has a right to the same opportunities and that people with disabilities should not be excluded (Nirje 1969; Wolfensberger et al., 1972). A group of like-minded ABA researchers looking for an alternative to aversive techniques, with an increased focus on inclusion, joined Nirje and Wolfensberger to lay the foundations of PBIS. Their goal for PBIS was to develop a technology that was preventative and changed the environmental context, leading to rapid, consistent, durable, and generalized change in problem behavior, while facilitating the development of broad improvements in quality of life with ecological validity (Carr et al., 2002a, b; Dunlap et al., 2010; O'Neill et al. 2015).

Implementing PBIS Across Settings

Firmly rooted in applied behavior analysis, PBIS procedures and tools, particularly when implemented at the intensive, individualized level, include functional behavior assessments (FBA), function-based interventions, and knowledge of setting events, operations, value of available consequences, competing behavior response options, and maintaining consequences (Sugai et al., 1999). Intensive positive behavior support interventions use strategies associated with applied behavior analysis, person-centered planning, and improving quality of life. The primary features and overall process are the same regardless of the individual. However, PBIS requires that interventions are contextualized to meet the needs of the person, their environment, and available resources.

Intensive PBIS interventions start with a functional behavior assessment (FBA) to determine the function of a problem behavior for the person. Observations are completed across environments, times of day, and with various support staff or family members. The FBA requires close attention to the setting event, antecedent, behavior, and consequence. Setting events can be anything that alters the likelihood of behavior by momentarily altering the value of

a reinforcer or punisher (Horner, Vaughn, Day, & Ard, 1996). For example, a setting event could be a crowded or loud room. A person with hypersensitivity to sound or crowds may be more likely to engage in physically aggressive behavior when these setting events are present in order to communicate that they want to escape the noise, particularly if no other communication supports are in place. Setting events are like primers or slow triggers—they set the stage, making an antecedent more or less likely to elicit a problem behavior. Antecedents, also called fast triggers, are what occur immediately before the behavior occurs. For example, a person with hypersensitivity to sounds and crowds might shove someone immediately after they entered his personal space and said "hello," if they are in a loud, noisy room. Saying "hello" is the antecedent in this case because it triggered the problem behavior (shoving). The person would not shove another when greeted, however, if they were in a quiet place (setting event). Nor would he shove if a person did not say "hello" and entered his personal space (antecedent).

In completing the FBA, the observer takes detailed notes to operationalize the behavior. A clear operational definition of the behavior increases the likelihood all team members observe and record the challenging behavior in the same way. This is critical in determining the function of the behavior and when collecting pre- and post-intervention data. For the purpose of conducting the FBA, the consequence is any response immediately following the behavior. If the person described previously was removed from the noisy and crowded room after shoving his fellow party guest, thus escaping from the crowd and noise, he is accessing a reinforcing consequence (or what he hoped to achieve—avoid the noise and crowd). Observations should occur across environments, at different times, and with different people. In addition to observing challenging behaviors, the observer should also work to identify the person's preferences, strengths, and where, when, and which events do *not* elicit challenging behaviors.

Collectively, these operationalized behaviors and comprehensive observations are all considered to develop a hypothesis to explain the function of each of the behaviors. This should be done carefully as it is possible the same behavior may serve a different function in a different environment, at an alternative time of day, or with another support provider. Each person's person-centered planning team, those who know the person best, should be actively involved in hypothesizing the function of the behaviors and should assist with creating function-based interventions.

Once the functions of a behavior are identified, the team should identify the desired behavior and replacement behavior or skill to be taught. Importantly, the replacement behavior should serve the same function as the problem behavior. In our example, teaching the person to request more personal space or to choose not to go to crowded, noisy environments may be necessary. Teaching replacement skills is critical to individualized positive behavior support interventions. By teaching the person the behavior or prosocial skills needed to effectively achieve the same or a similar maintaining consequence, and making environmental adjustments as needed, we are not just addressing one challenging behavior but are improving a person's skillset and increasing the tools each person has to achieve their desired quality of life. Individualized PBIS is strengths-based and driven by a person-centered plan in which a person is ensured their voice and choice as they identify their dream for the future and collaborate with their team to identify their goals and related action steps.

The end result of the individualized PBIS process is a comprehensive plan that includes tenants of individualized planning, applied behavior analysis, and measurable quality of life outcomes. These plans should be dynamic, sustainable, and linked to the settings the person values. One strategy for doing so is use of the life outcomes through integrated systems (LOTIS) wheel. The LOTIS wheel is a framework to implement multitiered PBIS interventions across home, school, work, and community contexts by embedding quality of life domains across each context (Freeman et al., 2015). As a planning

tool, person-centered teams work through each of the domains and identify the individual needs and universal, targeted, or intensive supports to achieve domain-related goals.

Promoting Strengths-Based Approaches for All Members of the Team

The role of support providers in promoting quality of life and implementing PBIS is critical and in addition to the focus on implementing individualized or organization-wide PBIS, it is also important to understand the impact of acting as a change agent (i.e., support provider) on quality of life for this support providers, and the impact this has on people with intellectual and developmental disabilities. People providing support and instruction often experience substantial impacts on their own quality of life.

Support providers, particularly parents, can be at risk of experiencing reduced quality of life related to their children's problem behaviors and the inherent difficulty associated with managing these behaviors, while maintaining their child's dignity if appropriate supports are not in place. The presence of challenging behaviors, including self-injury and aggression, has be associated with family breakdown and financial strain without appropriate supports, as the management of these behaviors can be labor- and resource-intensive (Oliver, Petty, Ruddick, & Bacarese-Hamilton, 2012). Parents of children who engage in challenging behavior report experiencing chronic stress, which in turn can be associated with coercive parenting practices and the entrenchment of problem behaviors (Singh et al., 2007), again, when effective supports are not in place. Finally, parents of children who engage in frequent problem behaviors can also experience isolation, exhaustion, concerns about their safety and the safety of other family members, home expenses, a difficulty to fulfill need for respite care, and limited professional supports (Hodgetts, Nicholas, & Zwaigenbaum, 2013). Together, these experiences can result in threats to the quality of life of those who support people who demonstrate challenging behaviors at home and at school, necessitating greater focus on strengths-based supports such as those emerging in positive psychology and PBIS to address challenging behaviors and the needs of all members of the support team.

Paid support providers, including school teachers and community-based support providers, also can experience threats to their quality of life by virtue of challenging behaviors. For example, student problem behavior affects teacher stress levels and can negatively impact the student–teacher relationship (Schaubman, Stetson, & Plog, 2011). Likewise, student challenging behavior can impact teacher emotional well-being, with challenging behavior associated with increased teacher burnout and emotional exhaustion when not effectively addressed (Hastings & Brown, 2002). Additionally, people working with students who engage in aggressive behaviors, usually due to lack of communication and other supports, are at risk of physical harm (Finlayson, Jackson, Mantry, Morrison, & Cooper, 2015; Langone, Luiselli, Galvin, & Hamill, 2014). Furthermore, paid support providers can be at risk of financial hardships by virtue of their profession. Teachers and community-support providers (e.g., job coaches, group home managers) often experience low pay, limited career ladder opportunities, and an overall low status compared to non-caregiving professions.

Functional Behavior Assessment and PBIS in Context

With these challenges in mind, the potential benefits of positive psychology in supporting all members of the support team in implementing PBIS to impact quality of life outcomes for people with intellectual and developmental disabilities cannot be understated. One aspect of positive psychology involves "benefit finding," defined as identifying the positive effects that result from a traumatic event (Helgeson, Reynolds, & Tomich, 2006), such as the presence of challenging behaviors, or the broad range

of positive changes that emerge following stress (Bower, Hales, Tate, Rubin, Benjamin, & Ward, 2008). Benefit finding has been studied in many areas of human trauma or adversity, including with people that experience cancer, parents of children with severe health problems, people who have experienced heart attacks, war veterans, people with HIV/AIDS, people with Alzheimer's disease (Farran, Miller, Kaufman, Donner, & Fogg, 1999) and with Asperger syndrome (Pakenham, Sofronoff, & Samios, 2004).

Strengths-based outcomes and perspectives on raising a child with a disability have been identified (Hebert & Koulouglioti, 2010). For example, Scorgie and Sobsey (2000) relate how parents identify benefits associated with having a child with a disability, including learning about themselves, feeling greater success and confidence, developing compassion, and feeling stronger spiritual convictions and a stronger sense of what is important in life. Often, parents identify the contributions that their child makes to their family and the world, stating they would not change their child (Myers, Mackintosh, & Goin-Kochel, 2009). Positive psychology research focused on building on character strengths, such as that described in Chap. 13, provides important information for building on these identified strengths, rather than focusing on challenges.

Yet many support providers, including family members and paid providers, lack access to effective strengths-based supports and interventions. However, emerging research from PBIS and positive psychology, when considered together, provide direction for support teams implementing individualized supports. These include the following:

1. **Conduct quality FBAs within relevant contexts that include analysis of the interaction between people with intellectual and developmental disabilities and their support providers (sometimes called coercion analysis)**. Lucyshyn et al. (2004) demonstrated how coercion analysis within typical family routines could be used to see how the parent–child interaction influenced behavior. They observed parent–child interactions to better understand how parent attention may have been reinforcing child behavior problems in some routines and escape from parent demands reinforced others. They also found evidence to suggest that the temporary termination of child behaviors reinforced parental behavior. This pattern, sometimes called a coercion cycle, occurs when parents and children "train" each other to act in certain ways. For example, when parents demand compliance, children increase their problem behaviors, and parents reduce their demands. This cycle can be changed, but must be identified to enable change and strengths-based interventions.
2. **Develop Behavior Support Plans** that:
   (a) Include functionally equivalent replacement behaviors so that support providers can enable people with intellectual and developmental disabilities to communicate what they want and reduce the need for challenging behavior.
   (b) Focus on prevention so that support providers have fewer challenging behaviors to address.
   (c) Replace support provider person with intellectual and developmental disability coercion cycles with interaction patterns that support the positive and effective behavior of both.
   (d) Allow for supports that enable all parties to find the relevance of the plan to their own personal goals.
3. **Enable support providers and people with intellectual and developmental disabilities to identify and define positive things in life**. In a Web-based study by Seligman et al. (2005), the authors evaluated the influence of various exercises on participants' happiness, including the following, each of which could be embedded in PBIS interventions:
   (a) **Complete a gratitude visit**. Write and deliver a letter of gratitude to someone who has been kind, but has not been properly thanked.

(b) **Identify three good things in life**. List three things that went well each day, every night, for one week. Then, provide a causal explanation for each good thing.
(c) **Describe you at your best**. Write about a time you were at your best. Reflect on the personal strengths you displayed. Then, review the story once every day for a week and reflect on the strengths identified.
(d) **Use signature strengths in a new way**. Complete an inventory of character strengths online at (www.authentichappiness.org) and receive individualized feedback about your top five "signature" strengths. Use one of these top strengths in a new and different way every day for one week.

4. **Enable support providers to see how following the behavior support plan can provide them with opportunities to experience positive outcomes aligned with their strengths identified in the previous step.**

(a) If support providers want to be more compassionate, then provide strategies to address this, such as acknowledging the feelings of a person with an intellectual or developmental disability after the episode is over (not during).
(b) If support providers want to be more patient, provide strategies to ignore (as long as this is not dangerous) challenging behaviors, allowing them to dissipate naturally.
(c) If support providers want to be more effective, teach prompting strategies for replacement and alternate behaviors.
(d) If support providers want to be more firm, teach them not to give into demands, but instead to solicit replacement behaviors and reinforce those.
(e) If support providers want to be more confident. then provide strategies for prevention, including changing the environment.

5. **Enable support providers and people with intellectual and developmental disabilities to experience the success of using their strengths**. Promote greater recognition not only of the success associated with changes in the behavior of people with intellectual and developmental disability, which is not always immediate, but also in the support provider. If the definition of success also includes measures of how well the support provider used their character strengths, then support providers can experience reinforcement and quality of life, alongside people with intellectual and developmental disabilities.
6. **Enable support providers and people with intellectual and developmental disabilities to use approaches developed in positive psychology, including mindfulness (see** Chap. 6**), building on character strengths (see** Chap. 13**), and promoting autonomous motivation (see** Chap. 19**) to experience positive outcomes**. Using these approaches enhances the well-being of all members of the team and can facilitate environmental contexts that reduce the need for problem behavior.
7. **Enable support providers and people with intellectual and developmental disabilities to self-monitor their own behavior, thoughts, feelings, and use of strengths**. Create strategies that support providers can use to monitor the things they want to change or build on in themselves (e.g., reminders to practice, using a rating scale to self-evaluation, etc.). Questions such as the following can be useful:

(a) Did I acknowledge the person's feelings only after the episode ended?
(b) Did my praise outweigh my criticism?
(c) Did I prompt the replacement behavior?
(d) Did I identify ways to redesign the environment to make problem behavior less effective?
(e) Do I feel more confident about my ability to handle difficult situations?

Creating Positive Culture and Consistent Expectations in Organizations

Organizations, just as individuals, all have their own personalities, characteristics, and behaviors, each of which creates unique environmental demands for all people within the organization. Some organizations can feel warm and welcoming with happy, productive employees. Others can feel cold and unapproachable with low morale and inconsistent outcomes. Whether a business focuses on painting houses, developing Web sites, or helping humans achieve their goals, they all require similar core systems, practices, and data to achieve their objectives. Organization-wide PBIS (OWPBIS) and school-wide PBIS describe the universal implementation phase as a time when leadership teams are developed to systematically improve quality of life and decrease problem behaviors for all of those served by the organization (Sugai & Horner, 2010). As described previously, there is a need to focus on the behavior and needs of all people in the organization, not just those served by the organization, when implementing OWPBIS. In this section, we describe how support providers, who often work in challenging circumstances, can be supported to find happiness and meaning in their work through OWPBIS and positive psychology.

Finding Happiness and Optimism in Challenging Work

Positive psychology informs us of the importance of happiness, personal meaning, and purpose in one's life. When contextualized in the support provision relationship associated with delivery of PBIS, there are several implications. Sometimes, work itself is intrinsically motivating. Such work is "marked by the interest, curiosity, continued learning, and spirit of challenge experienced by an employee when stimulated by the work itself rather than external outcomes (Deci & Ryan, 1985)" (Guo, Liao, Liao, & Zhang, 2014, p. 733). However, any work environment and activity can also be stressful, and demands associated with the environment and activities can limit one's motivation. Promoting happiness in such environments can be enhanced by "keeping a balance between being consumed by a job that seems overwhelming with no relief in sight and the 'perfect' job environment" (Davidhizar & Hart, 2006, p. 67).

So what makes difficult work rewarding? Locke and Latham (1990) assert work that is challenging and focused on specific goals is most rewarding to employees. Employees must be committed to the goals, and some value must be associated with goal attainment (e.g., money, personal meaning). When employees have clear goals and high intrinsic motivation to achieving those goals, employees persist longer at tasks. Likewise, completing tasks in which employees feel successful contribute to more self- and task-satisfaction, pride in performance, and sense of achievement. Finally, employees who are satisfied tend to stay on the job and be good citizens (e.g., help co-workers, do extra work), while dissatisfied employees are more likely to quit, be absent, file grievances, and put in less effort. Together, these findings suggest the importance of setting specific, challenging goals to guide the work of PBIS support providers. This may include goals for how the support provider will set up the environment for improved success to enhance individual outcomes (such as those described in previous sections), or specific goals for how a support provider will react to and support a person with an intellectual and developmental disability when faced with a challenging behavior.

The work of providing support has several unique challenges that contribute to high staff turnover and low employee motivation (e.g., low pay, low status). Further, the skills required for such work are largely unrecognized, often go unnoticed, and are poorly rewarded (Payne, 2009). Support providers may experience poor working conditions and a lack of organizational support (Johnson, 2015). Consequently, many support providers may feel emotionally involved with their work, but in a nonsupportive

organization context can become emotionally exhausted, and have difficulty separating from the support role (Johnson, 2015), all of which can lead to less positive outcomes for the person with an intellectual or developmental disability.

Emerging research in positive psychology and agency in work may be informative in improving the conditions and quality of life of support providers, and enhancing the outcomes of people with intellectual and developmental disabilities. Agency is "the capacity [of a support provider] to make an impact or exert power" (Gourd, 2016, p. 6). Most support providers have agency within constraints. For example, PBIS policies may require support providers to act on a behavior when it is deemed dangerous to the person or to others. Because this notion of "danger to self and others" is ill-defined, support providers have the choice to act based on their own convictions and philosophies. In these situations, support providers may reproduce the status quo or may use this as an opportunity to build communication skills, identify motivating factors, and improve the quality of life of the person served. Promoting greater agency can lead to greater motivation and more positive outcomes for everyone.

Directions for Future Research and Practice

In this chapter, we have discussed the relationship between positive psychology, PBIS, and quality of life outcomes. We have focused on how to put functional behavior assessment in context with a particular focus on the roles and well-being of support providers and the need for creating positive cultures and consistent expectations within organizations. Each of these factors is critical to create supportive environments that promote positive outcomes for all members of a community. However, ongoing work is needed to integrate PBIS and tenants of positive psychology.

Enhance the Focus on Quality of Life Outcomes

Much of the PBIS literature remains focused on devising interventions and measuring the fidelity of those interventions, with the focus on changing the behavior and skills of the person with an intellectual or developmental disability. However, this does not bring enough attention to the desired quality of life outcomes for the person, nor the relationship of the person to the members of the support team and their experiences and outcomes. Understanding the support team and the organizations that provide support not only benefits the person, but also all members of the support team. Integrating OWPBIS and positive psychology strategies can potentially further enhance individual quality of life, as well as support provider and organizational outcomes, and further research and practice strategies are needed.

Moving Research into Practice

The challenge of bridging the research to practice gap is well established (e.g., Hood, 2002; Shonkoff & Bales, 2011). Researchers struggle to effectively disseminate research findings, and practitioners struggle to translate research into practice (Cook, Cook, & Landrum, 2013). Thus, the field of implementation science has emerged (Fixsen et al., 2005). Implementation science is focused on what will be implemented, how it will be implemented, and who will do the work of implementation (Ogden & Fixsen, 2014). Ogden and Fixsen summarize obstacles and facilitators of implementation as being associated with "characteristics of the innovation itself, the provider, the practitioner adopting the practice, the client or consumer, and the inner and outer concept of the service delivery organization" (p. 5). Thus, establishing a strong contextual fit between the support provider, the intervention,

and the service recipient is critical. Yet how this can be done, at scale, is not well understood. Lessons learned from implementation science, including the importance of finding a good balance between treatment integrity and local adaptation, and responding constructively to variability and focusing on continuous improvement will all be critical to fully implementing PBIS in communities.

The expansion of organization-wide PBIS, the critical role of quality of life, the combination of the two as represented in the LOTIS wheel framework, and additional strategies from positive psychology outlined in this chapter, all require additional research and evaluation within the context of intellectual and developmental disabilities organizations, other human service organizations, and communities as a whole. Careful, ongoing evaluation and research is needed as researchers, practitioners, policy makers, and advocates collaborate to build positive, healthy, and inclusive communities.

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Author Biographies

Matt J. Enyart M.S.Ed., is the Director of the Kansas Institute for Positive Behavior Support, at the University of Kansas. He has more than twenty-five years of experience promoting and supporting full inclusion for individuals with intellectual and developmental disabilities. His research and work focuses include applications of the PBS framework and multi-tiered interventions within community and alternative settings, inclusive community and education practices, individualized planning models, and quality of life evaluation.

Jennifer A. Kurth Ph.D., is an Assistant Professor in the Department of Special Education, and Principal Investigator at the Kansas Institute of Positive Behavior Support, at the University of Kansas. Her research focuses on inclusive education practices, and inclusive teacher preparation, for learners with extensive and pervasive support needs.

Daniel P. Davidson Ph.D., BCBA-D is the Director of Program Training for Intermountain Centers for Human Development in Arizona. Prior to that he was the Positive Behavior Support program director at the Institute for Human Development at Northern Arizona University. There he created the state's first BACB®-approved Graduate Certificate program and directed PBISAz, building the state's capacity to support schools and districts in their efforts to implement Positive Behavior Intervention and Supports. Through his students, his advocacy, his consultation and his example, Dan has translated research to practice for parents, teachers and other caregivers, helping them reduce challenging behavior, improve relationships, and live up to their own highest expectations.