KMHPBS Annual Report – January, 2014

Kansas Mental Health Positive Behavior Support

Executive Summary of Progress and Accomplishments

What is the Kansas Mental Health and Positive Behavior Support Project?

Positive behavior support refers to a set of strategies and tools that are used to increase both quality of life and the likelihood that children and youth with mental health needs and challenging behavior will be able to live successfully in their home, school, and community settings. Experts describe positive behavior support as a team-based problem solving process for teaching social and communication skills and modifying situations and settings to remove the potential triggers of a child's problem behavior.

Figure 1. Levels of Training.

Four Levels of Integrated Training

1. **Awareness Training in PBS**
2. **Skill-building Training for Professionals in PBS (in-service)**
3. **Training Facilitators to Lead Teams**
4. **Training Experienced Leaders who will Provide Training in Areas 1-3**

The purpose of the Kansas Mental Health Positive & Behavior Support (KMHPBS) project was to introduce positive behavior support to mental health professionals across the state. The project included the layers of technical assistance listed in Figure 1.

Technical assistance is provided in positive behavior support on a continuum, since it is not necessary for every person to become an expert facilitator in the planning process. Instead, many mental health center professionals will benefit from an awareness level knowledge of positive behavior support so that they can participate effectively as team members in a child's planning process. Skill building trainings are used to increase the level of experience and knowledge of positive behavior support over time. A smaller number of individuals are selected within a mental health center to take on the role of facilitator. Organizations interested in establishing sustainable positive behavior support will design a training system so that one or more individuals within the center can lead implementation of technical assistance across the different layers of training in Figure 1.

"…it was a great experience… I…feel very fortunate that we've been able to bring in these tools [positive behavior support] into our center and I'm really excited moving forward to…continue to expand upon what we're doing now."

- Interview with mental health professional

Teaching individual professionals to facilitate positive behavior support plans for children is important but insufficient for significant and sustainable change within and across an organization. Policies within organizations, allocation of staff time, and many other systems variables can make it easier or more difficult for a person with expertise to facilitate positive behavior support with a child and her family. Addressing systems issues becomes essential for ensuring any type of evidence-based practice will be integrated into a mental health center.

"…we're completely bought in as we've made these two new positions …our two liaison people … it's really a matter of…utilizing them [PRTF Liaisons] to the best of our ability to continue to decrease those PRTF admits and to continue to try to empower some of those families that may just feel like they're at wits end, too, to make a difference in their lives, as seen in both of their live case studies."

- Interview with mental health participant

The KMHPBS project staff worked with each team to:

1) Establish internal expertise in positive behavior support within each center;
2) Outline a plan to use online materials first as an overview and later as a resource to train new staff members;
3) Create a small team within each center that established a long-term plan for ongoing expansion of positive behavior support and embedded tools and strategies into the center's meetings and processes;
4) Integrate positive behavior support data-based decision making systems; and
5) Equip mental health centers with the technology that can be used to provide support to families in their homes.

"The progress that both kids have made has been significant, and I think that data is going to drive future referrals and future case management staff to really work hard to try to make progress with those kids that are difficult, and try to, you know, get them to be where they're successful and they're able to function appropriately in the community setting." **- Interview with mental health participant**

This project provided mental health centers with the time and resources needed to assess how positive behavior support would be integrated within center practices, create ways in which positive behavior support could be introduced to new staff, and increase knowledge and understanding of positive behavior support principles over time among all staff members.

"…maybe we can kind of get rid of those tendencies where we have kids who stay in case management services for several years and we just continue to provide services… where this kind of gives us direction and gives them direction on where does this kid want to go, what's his goal…"
- Interview with mental health participant

A total of 21 mental health centers participated in the KMHPBS project. Figure 2 shows where these mental health centers are located.

Figure 2. Map of Participating Mental Health Centers.

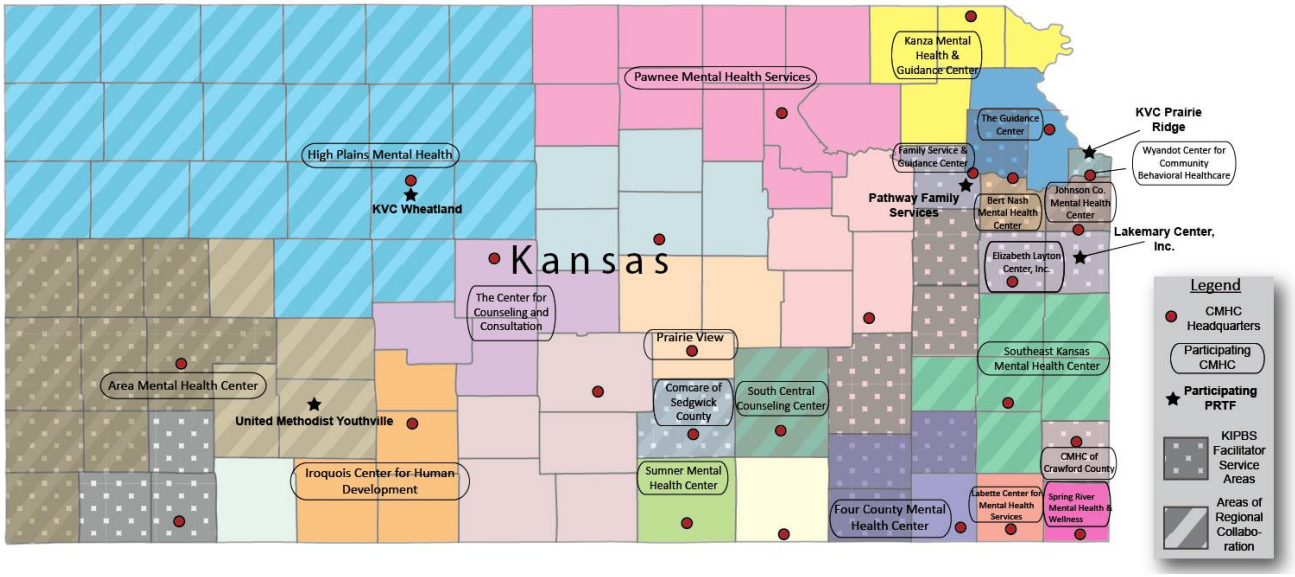
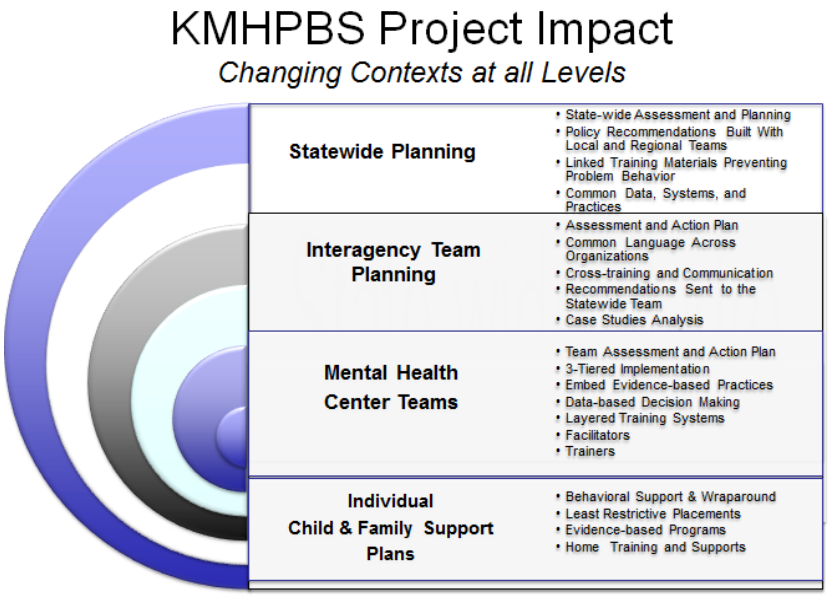


Figure 3 summarizes the implementation levels addressed within the KMHPBS project. The first level describes the individual child case studies that were facilitated by mental health professionals. Each mental health center identified one or more professionals who participated in the Kansas Institute for Positive Behavior positive behavior support certification training. A six-month training curriculum introduced these 28 professionals to the facilitation process.

Figure 3. Levels of Systems Change across the KMHPBS Project.



Individual Child Positive Behavior Support Plan

Each person learned to facilitate positive behavior support while working with a child. Data were collected to demonstrate effectiveness and impact of the positive behavior support plans. A total of 28 case study plans were evaluated using the following types of data:

> ***"I think it was a herculean task to train almost every single center in the state, and you all did and it and did it well."***
> **- Interview with mental health professional**

- Individual written plans describing the case studies completed by professionals;
- Direct observation data in a baseline and intervention single subject graph;
- Mentor observations conducted by a professional with behavioral expertise across a minimum of three onsite visits;
- Family and team quality of life and contextual fit survey data;
- Fidelity of implementation data for written plans; and
- Overall impact assessment of all data included in written plans.

> ***"…it's been very easy to keep it going 'cause it's been integrated… into the philosophy of what we do and how we do it and that these are important services."***
> **-Interview with mental health professional**

Team-based Assessment and Action Planning

An assessment and action-planning tool was used by mental health center teams to document progress implementing the key features of positive behavior support at a systems level. Each of the teams collected these data using the *KMHPBS Team Implementation Checklist*. Most teams are still in the process of reorganizing data-based decision making systems for reporting purposes. Stories describing how mental health centers are achieving this task are included in the Team Action Planning section of this report. Implementation of positive behavior support at a systems level is considered a two to three year process. Funds provided by Kansas Department for Aging and Disability Services (KDADS) allowed project staff to create the foundation for independent and ongoing problem solving-systems to continue expanding positive behavior support within mental health centers across the state.

Regional Interagency Planning

Five regions across the state were selected to participate in interagency collaboration at the regional level. Each of the interagency teams met two to three times during the year to create an action plan for building a common language for prevention of problem behavior, improving service coordination, and sharing important information about services for children. Each team completed a screening process by KMHPBS staff members resulting in the identification of children in need of positive behavior support plans across five regions in Kansas.

KMHPBS project staff members collaborated with mental health center professionals to facilitate nine regional interagency case studies. The identification of these cases studies took place after launching the interagency team meetings and introducing the regional teams to the overall planning process. The interagency planning activities started later than anticipated due to an overall delay of two months in acquiring KMHPBS project funds. Five case studies are currently still in the early stages of intervention. All nine of the plans continue, and are in various stages of implementation. These cases have continued to be supported at the request of the mental health centers until interventions are stable and transitioned to regional mental health professionals. Data were collected in the same manner described in the tertiary training for the 28 mental health professionals who are building expertise in positive behavior support.

Statewide Planning

KMHPBS project staff members have been assessing expertise across the state in order to identify and recruit professionals who show exemplary technical assistance skills. These individuals can provide communication links reporting progress in regional interagency planning and information about team-based action planning. KMHPBS project staff members are collaborating with key mental health professionals who were involved in the regional interagency process and/or participated in interviews and focus group sessions with project staff. Information gathered includes lessons learned in the field, perceptions about the impact of current statewide, regional, and local policies and how these factors may impact the ability to decrease out of home placements for children in communities across Kansas. This section of the report will describe progress made in this area.

Psychiatric Residential Treatment Facilities

In addition to technical assistance provided to the mental health centers listed in Figure 1, state leaders within KDADS identified five psychiatric residential treatment facilities (PRTFs) to receive a more limited introduction to positive behavior support at a facility level. Each of the five PRTFs received team-based training and technical assistance to implement facility-wide positive behavior support at year one. Two PRTF staff members participated in the training as part of the Kansas Institute for Positive Behavior Support training cohort. PRTF team members were invited to attend the online and onsite local awareness trainings that occurred across the state.

"I know that I'm looking a lot at my PRTF [psychiatric residential treatment facility] clients and my overutilizers of crisis. Especially the ones who have went to a PRTF or at risk of going to a PRTF…because we can send a kid to a PRTF…but if nothing changes in that home, nothing's going to change for that kid. We're going to send him back to the same environment and we're going to look at recidivism."

- Interview with mental health professional

An onsite observation, product, and interview scoring system based on the School-wide Evaluation Tool was modified for evaluation of PRTF facilities (i.e., the *Campus-wide Evaluation Tool*). One of the main outcome measures for PRTF implementation is based on incident reports. PRTF teams are working on

improving data systems this year. Number of restraints used, incident reports, injuries, and other outcome data will be used for data-based decision making. Several PRTFs are developing transition planning and family support tools and strategies as part of the positive behavior support process. Implementation of facility-wide positive behavior support is considered a long-term process. For this reason, year one implementation involves changing policies, modifying data systems and implementing interventions, while changes in the levels of problem behavior often occur during the second year of implementation.

Summary of Evaluation Data Gathered for the KMHPBS Project

- *Did professionals facilitate positive behavior support plans effectively as a result of the training provided?*
- *How effective was team-based action planning among the 21 mental health centers?*
- *How effective were the regional interagency case studies and what did the teams learn about strengths and barriers for implementing positive behavior support?*
- *What are the major recommendations that regional teams can provide to the state and what next steps are needed for statewide planning?*
- *Did the awareness training efforts change conceptual knowledge of positive behavior support?*
- *What evidence is available showing that mental health professionals found the KMHPBS project valuable?*

KMHPBS Information and Evaluation Data

The following sections provide more details about each of the major activities associated with this project.

Section 1: Activities Summary Table

Section 2: Effectiveness of Six-month Training for Professionals

Section 3: Effectiveness of Team-based Action Planning for 21 Mental Health Centers

Section 4: Effectiveness of Awareness Trainings

Section 5: Evaluation of Regional Interagency Case Studies and Regional Interagency Planning Teams

Section 6: Perceived Project Effectiveness and Use of Materials by Mental Health Professionals

Section 7: Psychiatric Residential Treatment Facility-wide Positive Behavior Support

KMHPBS Annual Report – January, 2014

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Section 1: Activities Summary Table

Kansas Mental Health Positive Behavior Support Project Summary of Project Activities June 2012-December 2013		
Project Preparation Activities	***Number of Instances***	***People Impacted***
PRTF Conference	2	60
Parent Support Worker Conference	1	15
Contacts to Identify and Build Kansas Advisory Board Members	18	18
Contact to Build National Advisory Board Members	20	16
Kansas Advisory Board Meeting	1	18
National Advisory Board Meeting	1	16
Meeting with Unified Training and Advisory Group	1	8
Meeting with KU SSW Regarding Wraparound initiatives	2	2
Content Consultation Meetings with Meme Heineman	4	14
TOTAL	**50**	**167**
Awareness and Orientation Activities	***Number of Instances***	***People Impacted***
Webinars with Community Mental Health Professionals	4	30
Presentation to CMHC-CBS Directors	2	26
Presentation to CMHC-Executive Directors	1	19
Governor's Mental Health Services Planning Council - Children's Subcommittee Members	1	12
Individual Meetings with CMHCs to Discuss Training Opportunities	26	52
Regional Meeting with CMHCs to Discuss Training Opportunities	1	6
Visit with PRTFs	5	25
TOTAL	**40**	**170**
Evaluation Activities	***Number of Instances***	***People Impacted***
Pre-Focus Groups with Mental Health Professionals	3	19
Pre-Interviews with Mental Health Professionals, Advocates, and Parents	15	15
Post-Focus Groups with Mental Health Professionals	2	6
Post-Interviews with Mental Health Professionals and Parents	10	10
Pre-Test for Online Awareness Modules	533	533
Post-Test for Online Awareness Modules	533	533
Evaluation of Awareness Level Onsite	618	618
TOTAL	**1,714**	**1,734**

Training Activities	*Number of Instances*	*People Impacted*
PRTF Trainings	5	35
CMHC Trainings	21	126
Technical Assistance During PBS Team Meetings	25	126
Awareness Level Onsite Trainings	7	618
Awareness Level Online Training	533	533
Intensive Level Onsite Classes	6	29
Intensive Level Online Classes	18	28
Intensive Level Follow-Up Webinars	3	28
Mentor Observations (Person Centered Planning)	28	56
Mentor Observations (Reliability)	28	56
Mentor Observations (Intervention)	28	56
Mentor Observations (Fidelity)	28	56
Regional Interagency Meetings/PATH Planning	10	65
Regional Case Study Planning/Facilitation/Support	320	640
TOTAL	**1,060**	**2,457**
Presentations	***Number of Instances***	***People Impacted***
Association of Positive Behavior Support (APBS)- Presentation	1	35
Association of Positive Behavior Support (APBS)- Poster	1	50
UTAG (Universal Training Advisory Group)	1	12
PBS Kansas	1	25
Douglas County Transition Council	1	12
National Alliance on Mental Illness of Kansas Conference	1	30
Additional/Miscellaneous Presentations	10	60
TOTAL	**16**	**224**
Products	***Number Issued***	***People Impacted***
Training Brochure Folders	500	500
Website *(www.kmhpbs.org)*	1	3,500
KMHPBS Project Overview Glossy	2,000	2,000
Introductory Presentation Materials	250	250
Awareness Level Online PBS Modules (5 core; 2 additional)	7	750
Awareness Level Module Printable Transcripts	21	750
Intensive Level Modules - Online Courses	9	28
Interview Audio Files/Transcripts	25	25
Focus Group Audio Files/Transcripts	5	5
Interview and Focus Group De-briefing Documents	25	25
Readiness Scale Tool	26	26
Campus-wide Evaluation Tool (adapted from School-wide Evaluation Tool)	5	5
Team Self-Assessment and Action Planning Tools for PBS Teams	26	200
Awareness Onsite Evaluation Tool	618	618
KMHPBS Case Study Selection Tool	25	25
Shared Drive Space on www.kmhpbs.org for PBS Teams and Regions	30	300
PBS Reference Card	5,000	5,000
Adapted PBS Caregiver Handbook	500	1,500

Sample Staff Survey for PBS Teams	26	2,600
Awareness Level PowerPoint Presentations	20	618
Team Training PowerPoint Presentations	26	225
Regional Interagency Power Point Presentations and PATH Plans	10	60
Statewide Planning PPT Presentations	10	25
KMHPBS Maps	1	500
PBS-To-Go Resource Boxes (with Tablets, Laptop, Portable Printer, Portable Projector, Seminal PBS Books, Caregiver Handbooks, Etc.)	26	2,000
TOTAL	**9,192**	**21,535**

Kansas Mental Health Positive Behavior Support

Section 2: Effectiveness of Tertiary Training

Description of KMHPBS Training and Timelines

This section of the report provides a summary for one of the main outcomes of the KMHPBS project. Twenty eight mental health professionals were identified with a minimum of one person from each of the centers participating in a six-month training in positive behavior support. These individuals were selected based on their roles within the center and an overall strategy for building capacity for behavior support. Once trained, these individuals will work within mental health center teams to continue training and building capacity of all staff members' knowledge of positive behavior support. Each center has developed an action plan for continuing to provide technical assistance for staff members, families, and the larger community.

This year, the KIPBS training system was significantly revised to decrease travel costs and to shorten the time necessary for completing the course. The new six-month training system was reorganized and streamlined based on evaluation data collected from prior KIPBS cohorts.

Training activities included:

- Onsite trainings in locations across Kansas;
- Webinars used to decrease travel costs;
- Online reading materials and assessments with an online instructor providing feedback;
- Implementation of a positive behavior support plan;
- Onsite mentoring and evaluation sessions to ensure professionals had the coaching necessary to facilitate positive behavior support meetings effectively; and
- A mid-term and final exam evaluating knowledge of positive behavior support.

"I'm really looking forward to imparting the strategies that we learned to our case managers so that we can have that success with other clients and families and then maybe working intensively with some families doing the PBS facilitation for them in the coming year."

- **Interview with mental health professional**

It is important to note that the launch date for the KMHPBS training was delayed twice, once on January 11, 2013, and again on February 2, 2013. The actual kick off for the tertiary training for the KMHPBS cohort occurred on April 26, 2013.

The delayed launch occurred because the KIPBS cohort training was linked with the mental health cohort and the funding for KIPBS was delayed by four months making it impossible to begin the tertiary training for both cohorts at the time originally planned.

> ***"I felt success the first time I tried it [positive behavior support]. And I know that's something that the case managers they got pretty excited about and that's something that those therapists got very excited about when I introduced this to them in their clinical meeting."*** **-Tertiary level mental health participant**

Professionals began identifying case studies in September, 2013 with the first meetings starting in late September to early October. Working in real settings with families can make it difficult to keep the positive behavior support case studies on a tight timeline. Meetings are scheduled with families and other professionals and often in a manner that results in some delays. Mental health professionals, therefore, had a shorter period of time overall to complete the written case studies and submit them for evaluation before the end of the project. For this reason, intervention data are still being gathered. Ideally, an additional month is needed to be able to provide follow-up data for the 28 case studies.

However, a number of plans were submitted with enough data to show progress being made across three case studies. These case studies are included in this section. See the KIPBS 10-year data report for a summary of what the cohort data will look like when these cases are fully completed. The next section introduces the key elements of positive behavior support.

> ***"I saw it [PBS] be successful very quickly which sold me over…we have applied it with all the students, we've applied it with the staff…for us to go from twenty-two kids down to five kids in a year and a half and the only thing that had changed was introduction of PBS I think that's pretty awesome."*** **- Interview with mental health professional in an alternative education program**

Description of Positive Behavior Support

Positive behavior support refers to a set of tools and processes for organizing the physical, social, educational, biomedical, and logistical supports needed to achieve basic lifestyle goals for individuals while reducing problem behaviors that pose barriers to these goals.

PBS emphasizes the importance of helping individuals (and their advocates) achieve a high quality of life and decreasing the occurrence of problem behavior by addressing four core defining features:

- The application of research-validated applied behavioral science;
- Integration of multiple intervention elements to provide ecologically valid, practical support;
- Commitment to socially important and durable lifestyle outcomes; and
- Implementation of support within family and organizational systems to ensure sustainable change over time.

Instead of a traditional consultant or expert-driven model, facilitation of positive behavior support planning emphasizes a team-based process for empowering the child, family and other team members to solve problems together. Mental health professionals in this project successfully facilitated planning processes and reported the data to demonstrate the effectiveness of the training system.

In the next section of this report, three individual case studies submitted by mental health professionals are presented. Although additional data are still necessary for a full evaluation of the positive behavior support plans for these children, the evaluation data gathered so far is promising.

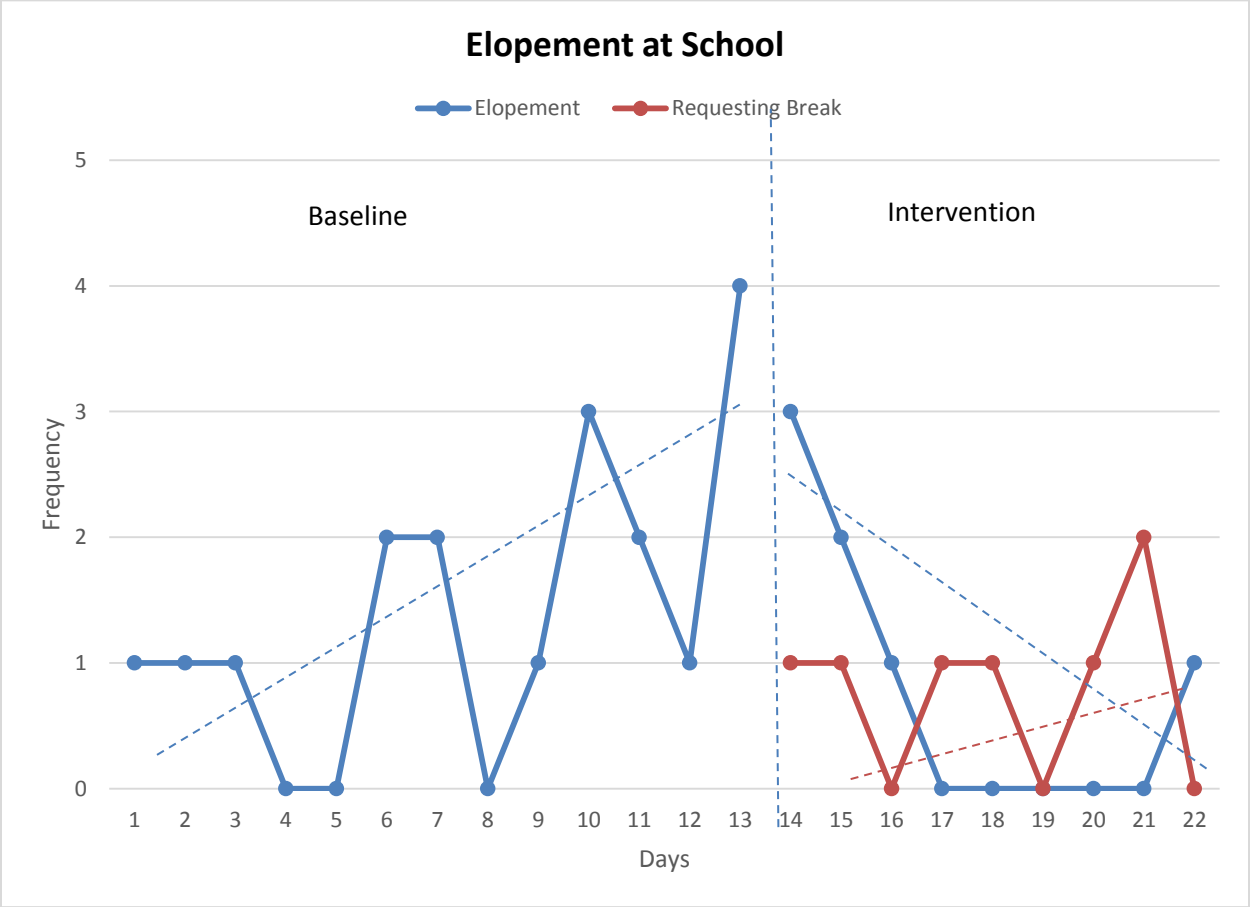
John's Story

John is a very energetic 11-year old boy with a fun sense of humor. John was born prematurely and suffers from expressive language disorder. He is also diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). John lives with his mother and his mother's boyfriend. He also has two sisters who no longer live in his home. John's biological father was sent to prison when he was three years old. His father now lives in another town but John does not have regular visitation with him. His father has never been involved in John's life on a consistent basis and struggles to follow through on visitation with him. His mother reported during the functional assessment interview that John has struggled with noncompliance, physical aggression, verbal aggression, impulse control, and difficulty sustaining focus and attention throughout his childhood. John takes several medications including Zoloft, Amitriptyline, Intuniv, Invega, and Strattera. John is reported to be in good physical health. Several indirect and direct measures were completed to better understand John's problem behavior and the events that precede and occur after it. Based on indirect measures and direct observations the following hypotheses were created.

Figure 1. Picture Represents John (All Information for This Case Study Was De-identified).

- When John is engaged in a preferred activity, when he is tired, or his father does not dad not arrive as expected, the likelihood that John will engage in noncompliance when asked to complete a non-preferred task increases. Examples of non-preferred tasks for John include taking a bath, cleaning his room or taking a shower. John engages in noncompliance and other problem behaviors in order to escape these non-preferred tasks.
- When John is engaging in a preferred activity, he is tired or his dad does not arrive as expected, he is more likely to engage in noncompliance or elope when asked to complete school work or assignments involving reading and/or writing. John's noncompliance and elopement occurs in order to escape from school work and assignments including reading and writing.

Figure 2. Data gathered Before and After Positive Behavior Support Plan Interventions.



Ben's Story

Figure 3. Picture Represents Ben (All Information for this Case Study was De-identified).

Ben is a very outgoing 10- year old boy who loves to help others, play soccer, and is very sweet and caring. He has lived with his mother and father for the past eight years. He has one older brother and one younger sister. Ben's mom reported that growing up, Ben was fairly healthy. He has suffered from asthma chronically over his lifetime, but has been controlled with medication. Ben does occasionally walk on his tip-toes, which is a concern for his mother. Ben is a typically developing child; however, he has been homeschooled for the past two years by his grandmother because he is several grade levels behind in reading and other subjects. Ben has recently enrolled back into the public school system and is receiving special education. He is in the 4th grade. Ben was referred by his mother due to his problem behaviors including noncompliance and aggressive behavior. Ben's problem behavior occurs when demands are given to him, especially household chores and other non-preferred tasks. In 2012, when Ben was 9-years old, a therapist from his mental health center began working with him to address these behavioral issues (noncompliance, tantrums, and aggression). Ben's problem behaviors became worse over the few months and the team felt a positive behavior support plan would be helpful. The team developed the following hypothesis based on Ben's functional assessment.

- When Ben does not sleep well, is bored or experiences an unpredictable schedule, and is given a demand or request by his parent, he will engage in noncompliance and aggressive behavior. Ben's noncompliance and aggression allows him to escape non-preferred tasks.
- When Ben does not sleep well, is overstimulated, or does not receive high levels of attention from his parents he is more likely to engage in aggression or noncompliance. This problem behavior occurs in order to gain attention from his parents.

Figure 4. Frequency of Ben's Noncompliance.

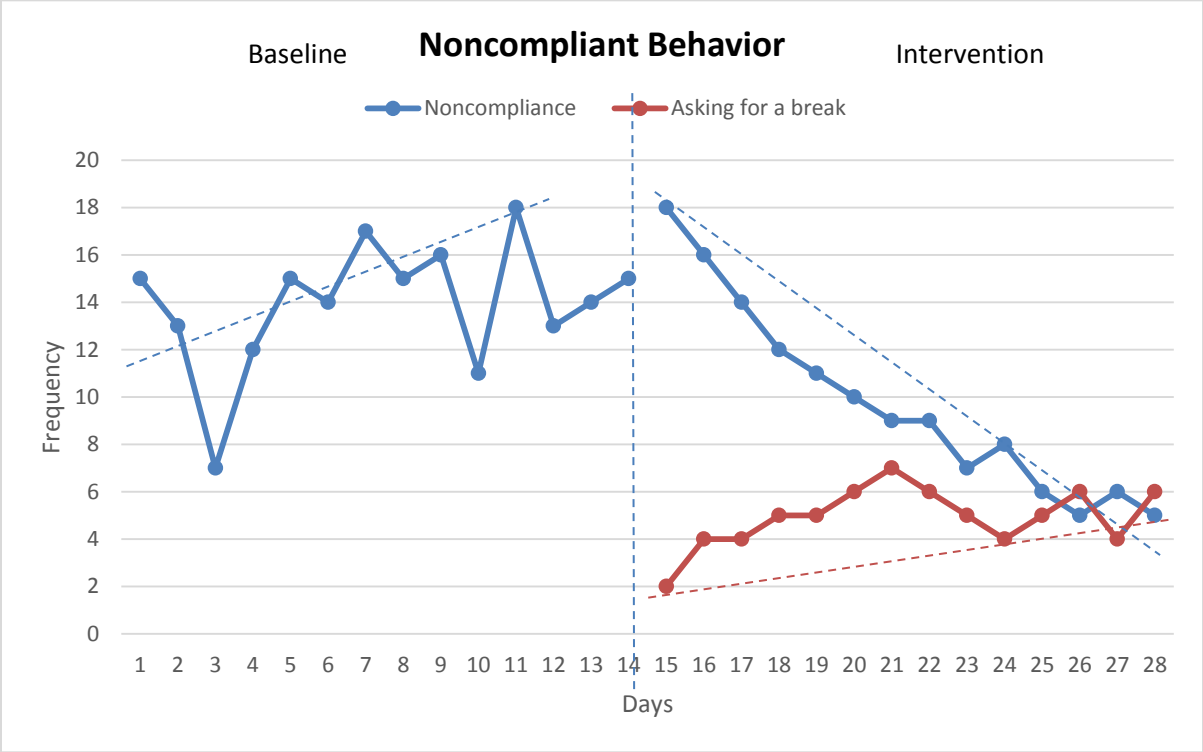
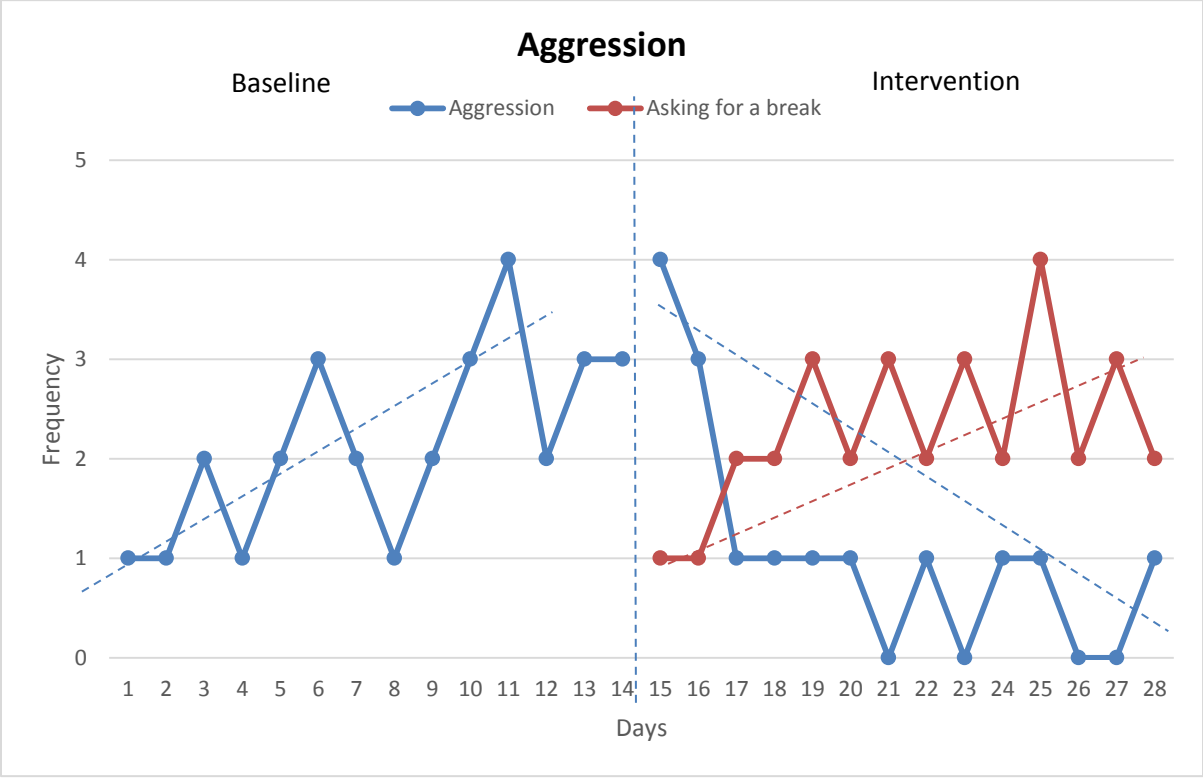


Figure 5. Frequency of Ben's Aggression.



Luke's Story

Luke is an overall health 10-year old boy who is caring, considerate, and intelligent. He has a diagnosis of Attention Deficit/Hyperactivity Disorder-Predominantly Inattentive Type. He lives with his mother, step-father, and sister. He does not have any contact with his biological father at this time. Currently, his parents are trying to obtain more stable housing for the family. The family has moved several times, which has made it difficult for Luke and his family to build natural supports. Due to frequent moves, Luke has switched schools five times since Kindergarten which has made it difficult for him to both make and keep friends. Luke was referred for positive behavior support due to the following problem behaviors: raising his voice/yelling, property destruction, and social withdrawal. Luke has a few friends but would like to make more. He has trouble knowing how to initiate a conversation with his peers and tends to play alone by himself.

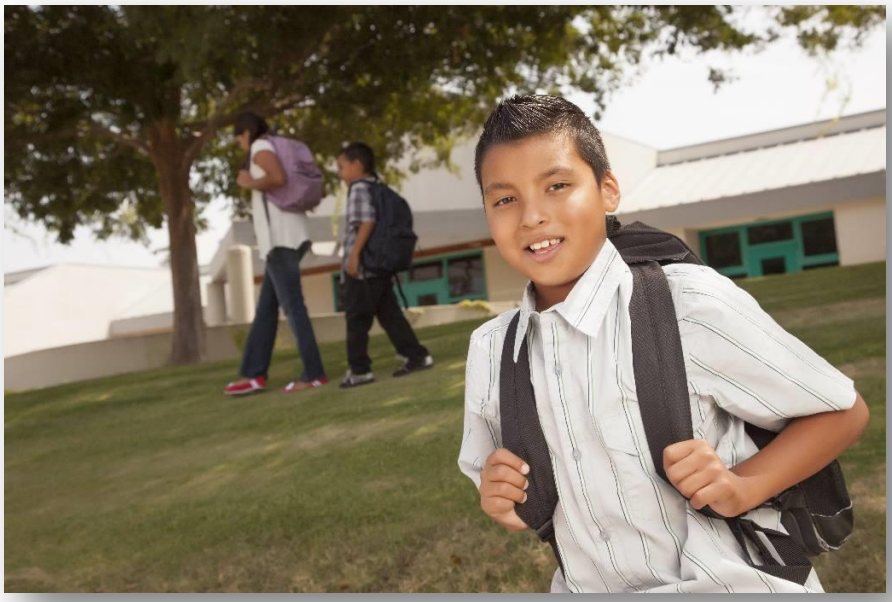
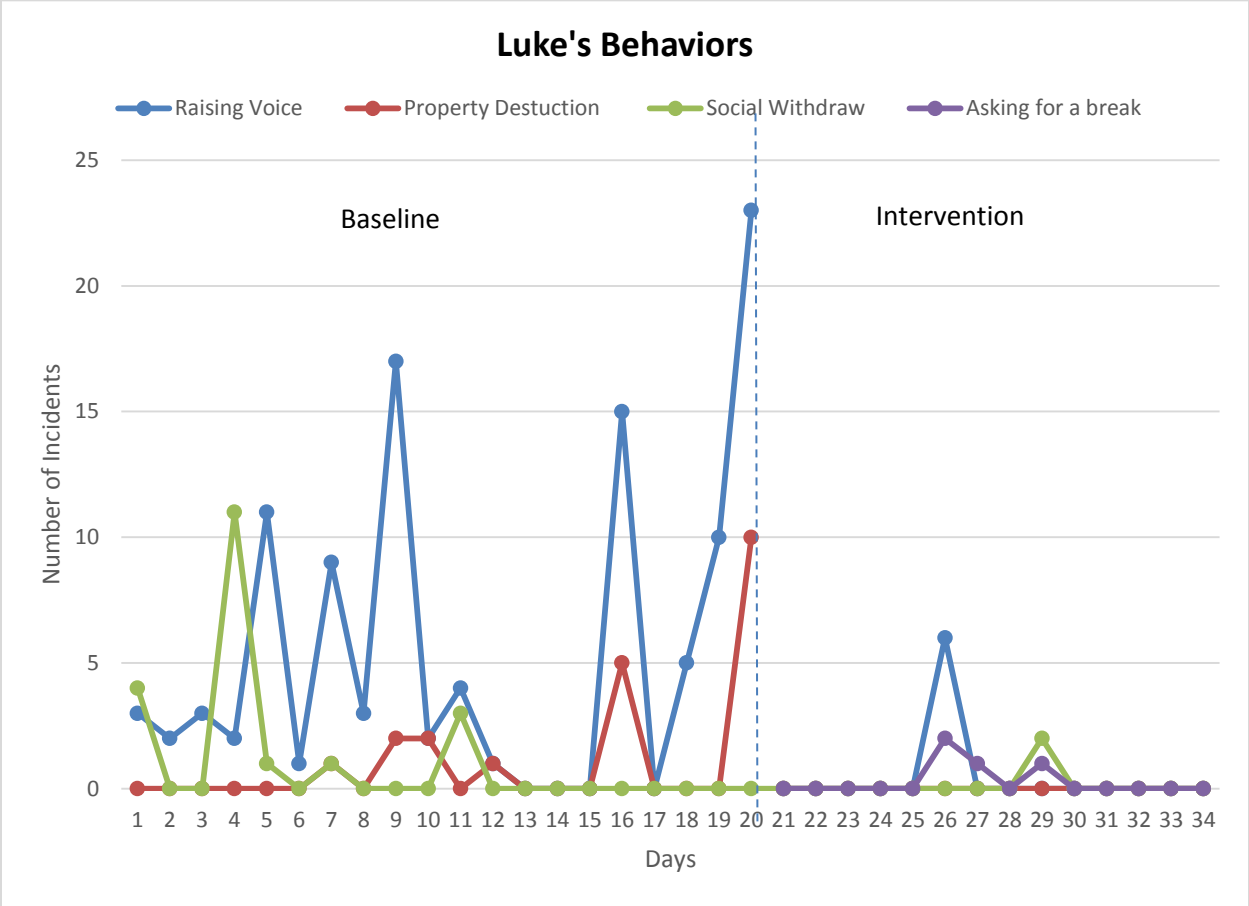


Figure 6. Picture Represents Luke (All Information from this Case Study was De-identified).

The functional assessment process completed by Luke and his team includes the following hypotheses.

- When Luke does not have enough sleep the night before and is given a request by an adult (for example, being asked to complete school work), he is more likely to destroy property and yell loudly. These behaviors allow Luke to escape from demands given to him by adults.
- When Luke does not have enough sleep the night before or he is not feeling well, he will engage in social withdrawal when asked to join structured activities with his peers.

Figure 7. Number of Luke's Problem Behaviors.



Evaluating Positive Behavior Support Tertiary Training

At this time, 28 professionals either already have or are expected to submit case study data as part of the final certification process to be eligible to bill Medicaid for positive behavior support services. Professionals completed a positive behavior support plan, collected, and reported the data for evaluation. Each person was observed by someone with behavioral expertise while facilitating positive behavior support with children. The next section describes the main characteristics of the children who are receiving positive behavior support plans facilitated by mental health professionals.

"I know just thinking about the case study that I've been most involved with… we had a kiddo that was very nonverbal…he has a form of autism…when I first started engaging with the family to even get him to look at me or speak to me…he wouldn't even answer with a yes or a no or he wouldn't even shake or nod his head…and the first person-centered planning meeting we had for him…he absolutely wouldn't quit talking! I mean, he was interrupting us and stopping us as we were talking which was wonderful and it was a wonderful…wonderful problem to have because like I said before, I couldn't get him to talk to me at all."

- Interview with mental health center professional

Demographic Describing Children Currently Involved in Positive Behavior Support Plans

Table 1 provides information about age, type of diagnoses reported, gender, and geographic location. Children receiving positive behavior support were mostly males (two females) with a mean age of 8.77 (range from 6-12 years). The most common diagnosis for children receiving positive behavior support was Attention Deficit and Hyperactivity Disorder (ADHD).

Table 1. Case Study Demographic Data Summary for KMHPBS

Characteristics of Children Receiving Positive Behavior Support

Training Case Study Demographics (Submitted)		*N* = 22
Gender	Male	20
	Female	2
Age	0 to 10	15
	11 to 21	7
	Mean Age	8.77
	Range	6-12
Counties	Douglas	2
	Johnson	2
	Allen, Butler, Ford, Leavenworth, Labette, Jackson, Ellis, Johnson, Ford, Sedgwick, Shawnee, Wyandotte	1 each
	Other	7
Diagnoses Represented (most have multiple)	ADHD	16
	Oppositional-Defiant Disorder (ODD)	6
	Disruptive Disorder	3
	Anxiety Disorder	3
	Asperger's Syndrome	1
	Bipolar Disorder	1
	Other	22

"We learned quite a bit from the class and a lot of useful things that we'll be able to use with our own clients."
- Interview with mental health professional

Reporting Evaluation Results Across All Positive Behavior Support Plans

Each plan that is submitted by mental health professionals are then scored by instructors as part of the requirements of the training program. These plans are referred to as case studies in this report when describing work completed by professionals in training. Case study data collected by professionals in training include a number of outcome measures. The evaluation of a plan typically includes

- Direct observation measures of problem behavior;
- Direct observation measures of communication and/or social behaviors;
- Quality of life data for the focus person and his or her family (caregivers); and
- Multiple measures of the impact of the implementation of the plan on the focus person, team members and caregivers.

Decreases in Problem Behavior Associated with the Positive Behavior Support Plans

Every case study that is submitted includes direct observation data similar to the information reported in John's, Ben's, and Luke's stories. Direct observation data were collected measuring problem behavior and the introduction of new social and communication skills for replacing problem behavior before and after the positive behavior support interventions were implemented.

An expert in positive behavior support reviewed each graph from the 28 case studies and scored the plan on a 1-5 scale with "1" no change, and "5" indicating significant change occurred.

Table 2. Results of 5-Point Likert-type Rating Scale to Evaluate Impact of Direct Observation Data.

Results of Impact Evaluation Tool		
Problem Behavior Rating 5 = Significant decrease; 4 = Some decrease; 3 = No change; 2 = Some increase; 1 = Significant increase; N/A = no data available **Replacement Behavior Rating** 5 = Significant increase; 4 = Some increase; 3 = No change; 2 = Some decrease; 1 = Significant decrease; N/A = no data available		
	Problem Behavior	**Replacement Behavior**
John	Noncompliance 4/5 Aggression 5/5	Asking for a break 4/5
Ben	Noncompliance 5/5 Aggression 5/5	Requesting help 5/5
Luke	Property Destruction 5/5 Yelling 5/5 Social Withdraw 5/5	Asking for a break 4/5

In addition to the rating scale evaluating the effectiveness of direct observation data, the following data are gathered and aggregated for each positive behavior support plan.

Evaluation of Quality of Life Impact for the Child and Family (Survey)

A quality of life survey specific to the child and his family (caregivers), is given to family and team members to complete after the positive behavior support plan is implemented. This tool was adapted from a longer evaluation created by Kincaid, Knoster, Harrower, Shannon, & Bustamante (2002) called the *Positive Behavior Support Evaluation*.

How Well the Plan Fits the Child and Family (Survey)

Survey data assessing how well the PBS plan fit the values, resources and skills of the persons involved in the PBS process are also gathered by professionals in training. All of the child's team members are asked to complete the survey called the *Self-Assessment of Contextual Fit* survey (Horner, Albin, Borgmeier, & Salantine, 2003).

Family and Team Member Satisfaction (Survey)

After wraparound or person-centered planning begins, all professionals are asked to gather satisfaction data using the *Person-Centered Planning Process Satisfaction Survey* (Abery, McBride, & Rotholz, 1999).

Overall Impact Across All Measures

KIPBS Impact Assessment

The *KIPBS Impact Assessment* is used to evaluate the types of changes that occur in the lives of children and adults due to the implementation of function-based interventions. Each case study is evaluated using the *KIPBS Impact Assessment* and these data are then aggregated for evaluation purposes. The areas of impact reviewed and scored include:

- The degree to which problem behaviors decreased based on visual graphs described in the written case study plan;
- The degree to which appropriate behaviors increased based on visual graphs described in the written plan;
- How closely the hypothesis statement regarding the function maintaining problem behavior was linked to interventions; and
- Anecdotal, descriptive, and survey information about how the PBS plan impacted both the focus individual and those supporting him/her who participated on the team (e.g., parents, extended family member, teachers, agency staff, community members, others).

The impact measure also provides a way in which to summarize the results of the three surveys described earlier that professionals ask families and team members to complete:

- *Person-centered Planning Process Satisfaction Survey* (Abery, McBride, & Rotholz, 1999);
- *Self-Assessment of Contextual Fit* (Horner, Albin, Borgmeier, & Salantine, 2003); and
- *Quality of Life Survey* (adapted from the *Positive Behavior Support Evaluation* by Kincaid, Knoster, Harrower, Shannon, & Bustamante, 2002).

The scores on the KIPBS impact assessment will be available within one month to see how the impact assessment is reported. Please review the KIPBS 10 year evaluation report.

How Well Professionals Implemented the Key Features of Positive Behavior Support

Written PCP and PBS plans completed by KIPBS professionals in training are reviewed by instructors with a background in person-centered planning/wraparound, applied behavior analysis, and positive behavior support. The 45 Item *PC-PBS Checklist* is based upon the self-assessment tool developed by Horner and his colleagues (2000) and contains 45 items related to both positive behavior support and person-centered planning. Examples of items on the *PC-PBS Checklist* include *Data presented support each hypothesis, Intervention plan addresses possible function of problem behavior,* and *The planning is undertaken with the involvement of the person's circle of support.*

Instructors use the checklist to provide feedback to all professionals in training on case study components that are in progress. A fidelity measure was developed for the *PC-PBC Checklist* that employs a three-point scoring scale (In Place = 2 points, Partially in Place = 1 point, Not in Place = 0 points). Scoring involves calculating average percent of the total possible points that can be awarded for three sections of the checklist, as well as for the entire 45-item checklist (i.e., there are 90 total possible points).

An example of how evaluation data are summarized is available in the KIPBS 10-year evaluation report. All project tools are available upon request and can be found in the online training modules at www.kipbs.org.

Comments from Mental Health Professionals about the Tertiary Training

Mental health professionals who participated in the six-month training found the experience to be very helpful. One person indicated that:

> *"… I think my "aha moment" came when I was working with my live case study and I was using some of the tools we were given for identifying the function of the behavior… and what interventions to put in place, and I was trying to figure out if he was trying to get attention or escape from things, and then when I used one of the tools, it just clicked for me and then, all of a sudden, I'm like "aha! it's this," and I knew what I needed to do next and that was a really good feeling cause I can't tell you how many times we've had case managers say "I just don't know what to do with this kid."*

Another professional felt that the case study approach was an important way to be able to really understand the positive behavior support process:

> *"Well, I think through the intensive student process and being able to do the live case study, it really brought PBS to life for me in working with a family that, in the beginning, really felt they were not able to be successful in doing the things as a family that they wanted to do, and that their quality of life was really suffering and being able to put the PBS strategies in place with the family that I worked with and see their success and how they were able to achieve their goals of a family and see success was a really rewarding and satisfying experience."*

Kansas Mental Health Positive Behavior Support

Section 3: Effectiveness of Team-based Action

Systems change is a key part of implementing any new evidence-based practice within an organization. Research indicates that introducing new evidence-based practices using a workshop or training event without a process for evaluating policies, training systems, how meeting are organized, and other organizational issues will decrease the likelihood of effective and sustainable practice.

In addition to providing a layered training system, the goal of the Kansas Mental Health and Positive Behavior Support (KMHPBS) project was to support mental health center teams as they assess how positive behavior support can be embedded with other important practices. Teams of five or more professionals representing the

> ***"And, I think we're going to see extreme benefit in our organization because we have a plan to meet with our case managers monthly and provide training to them on using PBS in their daily case management activities."***
>
> **- Interview with Mental Health**

mental health center staff (administrators, case managers, parent support specialists, clinicians, wraparound facilitators, program managers and PRTF liaisons) assessed how positive behavior support fits with the center's mission, policies, training systems, and meeting processes.

Research on systems change in positive behavior support indicates administrator leadership is essential for successful team-based action planning. Strong administrator leadership in the team-based process ensures staff members have the guidance they need to move forward and make decisions. In addition, it is important to consider leaders at all levels within a system. Significant change in an organizational practice occurs when there is leadership and support for positive behavior support at all levels within the mental health center.

> ***"…it kind of gave us a guidance tool. It gave us some kind of goals, it gave us like really a lot of direction, and then having our administrative people – you know we have our…clinical director and our executive director, and our CBS [Community based Service] director -- having them…on our team as we move forward … I guess, to start implementing it."***
> **- Interview with Mental Health Professional**

Another key concept in positive behavior support is the emphasis on guiding team-based action planning using consensus-building activities where all staff members have a chance to participate in the development of new interventions within the center.

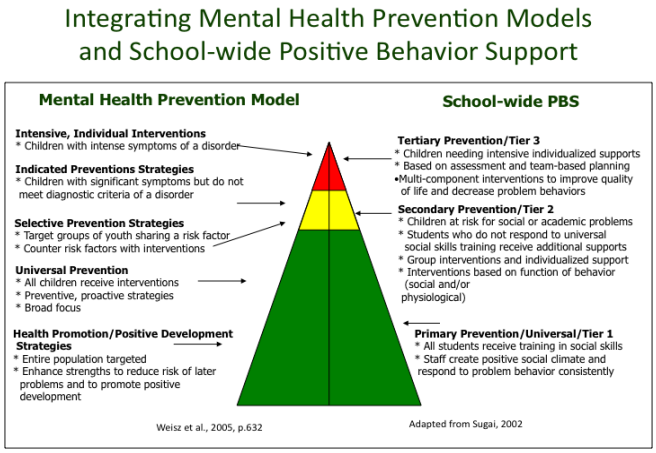
> ***"…and…I see people really buying into it now. I'm so happy. It's just going to be a real benefit for our consumers."***
>
> **- Interview with Mental Health Professional**

A lead contact person was identified at each of the mental health centers. Lead contacts were mental health professionals who communicated with KMHPBS staff, ensured meetings for the team were scheduled, and prompted the team to complete evaluation data during meetings. Key contacts for six of the 21 teams were CBS Directors. Other lead contacts were case managers, parent support specialists, clinicians, wraparound facilitators, program managers and PRTF liaisons. Teams participating in the center's self-assessment and action planning were given the message from project staff that

> ***"So, I just really like that teamwork attitude of, 'Hey, mental health centers, we know you're doing good stuff. We've seen some o' the stuff you're doing…some of it's already had aspects of PBS in it. Let's see how we can even expand upon that and … with what you're doing in your center'. And I just thought that was a really good message throughout."***
>
> **- Interview with Mental Health Participant**

positive behavior support is meant to be integrated with the strengths that already are contributing to effective outcomes with each center. In addition, positive behavior support must be integrated with the other practices considered to be essential by the mental health center staff. The benefit of positive behavior support is that the three-tiered model (see Figure 1) provides centers with a way to align different prevention levels and assess what areas might need more attention. In addition, positive behavior support emphasizes the use of data to guide interventions and to ensure teams are "working smarter, not harder" with limited resources.

Figure 1. A Three-Tiered Models for the Prevention of Problem Behavior.



KMHPBS staff spent one full day with each center (between March 12, 2014 and November 7, 2013) across the state. Intermediate level positive behavior support training (with a special emphasis on the layered nature of technical assistance for different job roles) was provided to teams during the first part of the day. Teams assessed the different types of primary prevention (for the whole community), secondary prevention (for at-risk youth and families), and tertiary prevention and individualized supports that were currently being implemented. Table 1 shows the types of interventions and settings relevant to primary, secondary, and tertiary prevention that were discussed by mental health center teams.

Table 1. Examples of Primary, Secondary, and Tertiary Prevention Interventions and Where Positive Behavior Support is Implemented.

PBS Tiered Layer	Most Common Practices in CMHCs
Primary Prevention (Prevention or Services Available in the Community)	Mental Health First Aid, Outreach Presentations to Area Schools on Various Topics (Bullying Prevention, Cyber Safety, etc., Resource Fairs
Targeted Supports (Interventions for At-Risk Youth and Families)	Psychosocial Groups for Children Served in the Community Based Service (CBS) Program, Parent Support Groups
Individualized Intensive Supports	SED Waiver Services; Attendant Care at School and in the Community

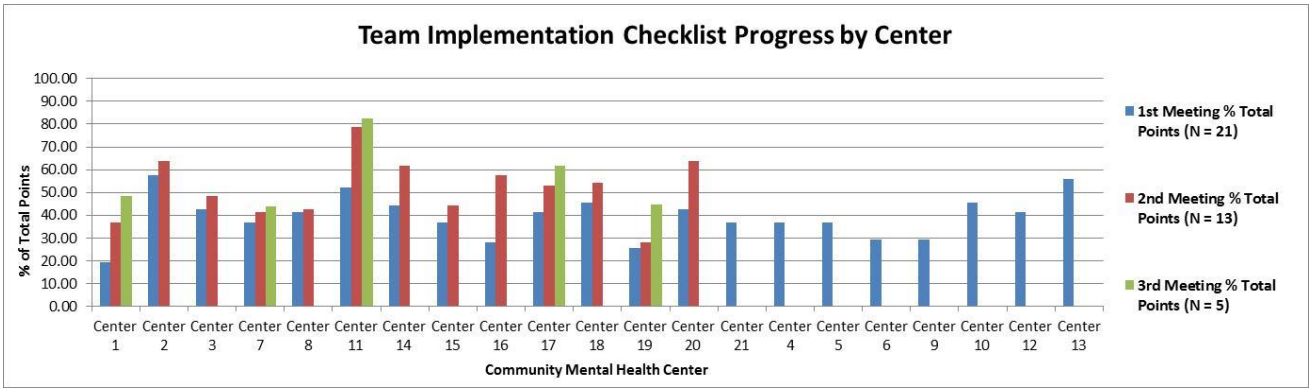
KMHPBS staff created a team implementation checklist for mental health center teams to guide their progress. Teams completed 34 items and scored the extent to which assessment and action planning had occurred for each item. An example of one of the checklist items included *The administrator is actively involved, Benchmarks for expansion of PBS across the center are documented across a two-year period of time,* and *A plan is in place for communicating PBS to staff and family members.*

> ***"And I think probably the most valuable thing to us, as we discussed along the way, there are things that have overlapped, things like wraparound, person-centered planning, etc."***
>
> **- Interview with Mental Health Professional**

Teams were not expected to finish the entire checklist in one year. In fact, most positive behavior support efforts across different types of systems focus on organizational change as a two to three year process. The goal of the KMHPBS team was to create sustainable meetings and a direction for centers to move towards in implementing positive behavior support after funding for the KMHPBS project ends.

A total of 34 items were included in the KMHPBS Team Implementation Checklist (TIC). For each item, coaches for each team would enter a "0" if the action had not yet started, "1" for actions that were in process but not completed, and "2" for items that had been completed. Figure 2 shows the action planning process on the TIC for the 21 participating centers. The y axis shows the overall average percent completed on the TIC and the x axis lists the centers participating.

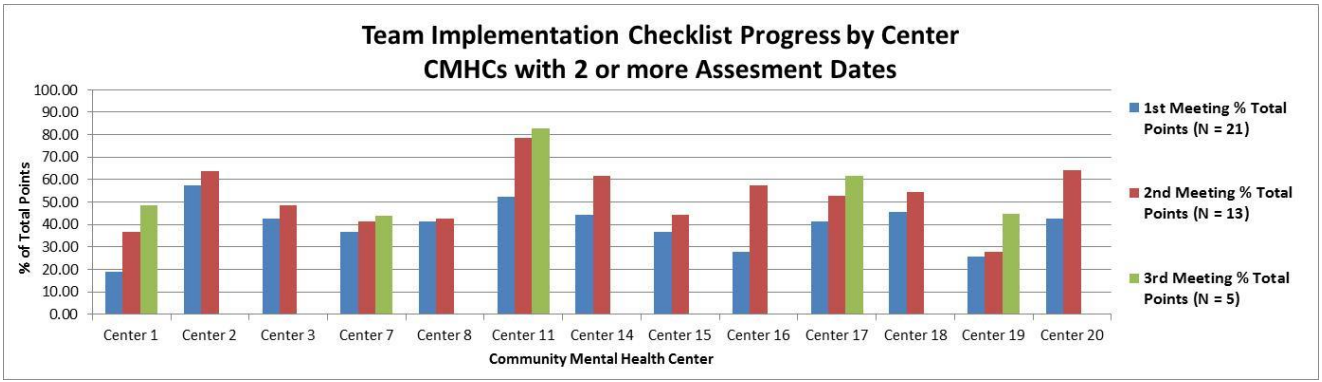
Figure 2. Average Percent Scores on the Team Implementation Checklist Results by Center.



Centers are reported in an anonymous fashion to show progress taking place. Some centers completed more than one TIC across up to three meetings. The schedule and travel time involved in training across the state resulted in some centers starting the process earlier than others. However, all centers were told that the important goal was to create a steady meeting process that fits within the center's resources. Teams were encouraged to move at a pace that ensured all staff members had a chance to participate in

the decision making process. All of the mental health centers participating completed at least one TIC with guidance from KMHPBS staff members.

Figure 3. Centers that Completed Two or More Meetings Using the Team Implementation Checklist.



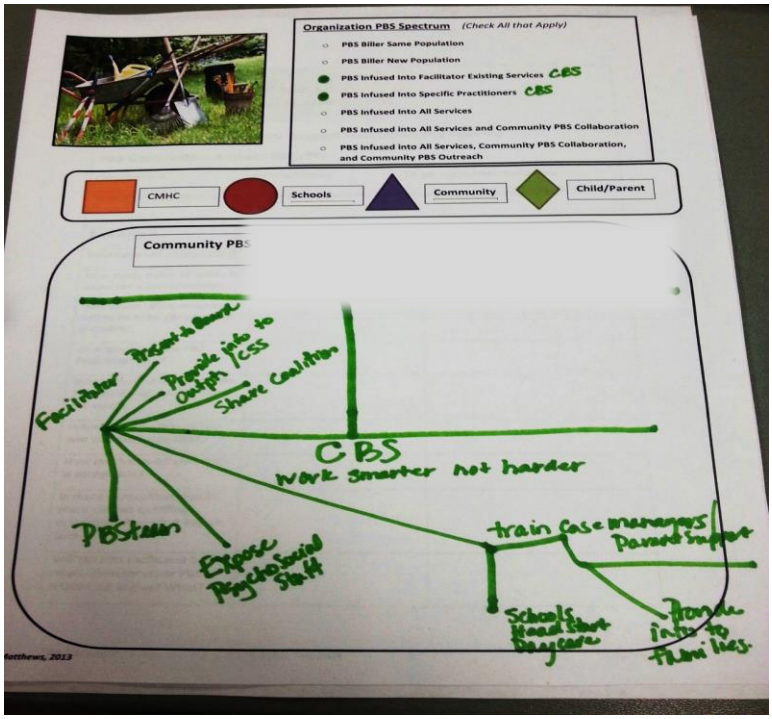
Thirteen centers were able to complete two or more TIC assessments during the time of the project. Data for these centers appear in Figure 3. Five centers were able to complete the TIC assessment three times while the remaining eight completed two TIC assessments. KMHPBS staff assisted teams by graphing the data and reporting this back to the teams so that they could use the data for decision making and celebrate progress.

Examples of Outcomes Related to Team-based Action Planning

Although CBS Directors had been involved in previous strategic planning efforts in their agencies, most of the individuals participating in the team process reported that this was the first organization-wide, outcome-oriented plan in which they had ever participated. Action plan implementation varied across centers based on the creative ideas of team members. A number of systems change activities were built into the intensive level training as a way for professionals in training to bring structured problem solving back to the rest of the team.

For instance, two assignments prompted professionals to work directly with their teams on systems change activities. One activity involved creating a presentation that could be used to introduce new staff or community members to positive behavior support. These presentations included summaries of how centers were already implementing parts of the primary, secondary, and tertiary prevention model. Many teams reported that they were using the presentations for awareness-level orientation for staff and community partners.

Figure 4. Visuals Created Showing an Activity for Embedding Positive Behavior Support within a Mental Health Center.



> ***"It just was a matter of me understanding. It was just, like, a change in my way of thinking—not even changing. Just letting me see a different way…to see situations."***
>
> **- Interview with mental health participant**

A second assignment (presented at the intensive level graduation) was to diagram ways positive behavior support could be integrated with their organizational structure (i.e. how graduates could mentor other center staff members, which populations of children would be initially impacted, which staff would have access to positive behavior support tools, etc.) These diagrams were brought back to teams to become part of the brainstorming process in their center-wide implementation efforts (see Figure 4). Figures 5 and 6 include examples of social expectations created by one center for staff members (Figure 5) and for children (Figure 6).

Figure 5. Social expectations Taught to Staff at a Primary Prevention Level.

> ***"I think we forget as adults, just 'cause we're adults…we still like to know that people see that we're doing something good."***
>
> ***- Interview with mental health professional***

Figure 6. Social Expectations Taught to Children.

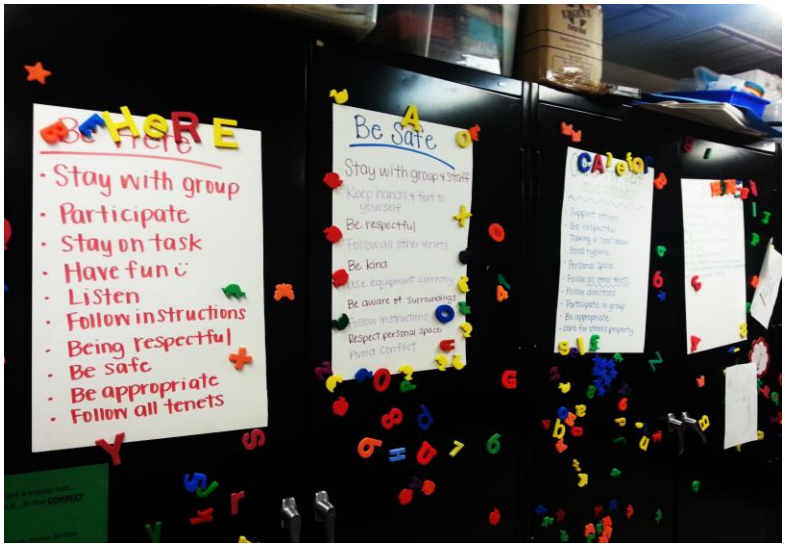
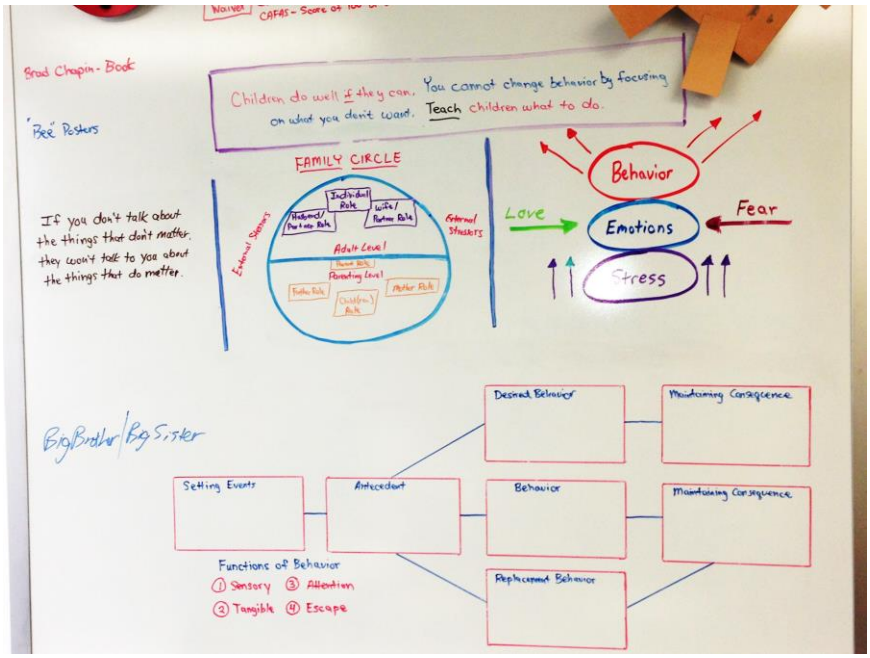


Figure 7. Visual Showing a Problem Solving Strategy Used by Team Members to Assist With Problem Solving When a Child Engages in Problem Behavior.



"Like, we're doing supervision or something…we're talking about a tough…kid or something then I can just point. It's just, like, it's our reminder. It's like, Okay…what do you think is the function of the behaviors…"

- Interview with mental health professional

Figure 7 above is a picture of a white board on the wall in a mental health professional's office. The professional interviewed showed the white board to project staff and described how he uses it to help other staff and family members to think about the reasons why a child may be engaging in problem behavior. The professional noted that this helps families and staff become more involved in designing interventions that will directly address the needs of a child.

> ***"And what I also learned about with the PBS process is that look of, "Okay, how are we going to sustain this? And that that purposeful planning of when do we see transitions coming down the road for this kid, we're going to also train new team members that may be coming onboard so that the kid has the consistency throughout, you know?"***
> **- Interview with mental health professional**

Qualitative Comments Related to Team-based Action Planning

A total of eighteen pre-project transcripts were documented as part of this evaluation project reflecting both focus groups and interviews. These transcripts included 29 professionals, two advocates and two family members participating in the pre-project qualitative evaluation for the KMHPBS project. Twelve transcripts reflecting 16 professionals and one family member participating in focus group and interviews were gathered during the post project time period. Ten professionals participated in both pre and post interviews or focus group sessions. The recorded transcripts were coded by major themes. The quotes in this section reflect the conversations that occurred within the interviews that were gathered. This section of the report provides comments specifically related to team-based action planning.

> ***"And I really appreciated that attitude the whole way through is what can we help you do to expand upon what you're already doing, get you more support, get you more information, get you more resources. And I think because that attitude centers were much more open to say, 'Okay, what can we do with this?'"***
> **- Interview with mental health professional**

Each center was encouraged to use the tools and processes after the project ended to continue working on positive behavior support. Many of the professionals interviewed indicated that they will continue working on strategies for teaching staff about positive behavior support, improving on data-based decision making systems, and embedding positive behavior support into the different levels within the center. One person noted that:

"I have a lot of interest in keeping that going…that's something that I plan on keeping that on the radar of all the children's case managers…making sure that my monthly supervision's … dedicated to talking about PBS…making sure they [staff members] feel comfortable using the data forms, making sure

they know how to use them, they've been trained to use them, get feedback on from them on how that's looking when they go to the therapist with that information."

Another professional indicated that:

"I plan on being at clinical supervisions with therapists and saying, "'How are you using it [positive behavior support]? Are you seeing…' you know? I plan on having those discussions with families… I definitely plan on keeping this language alive within our center."

Team members who were interviewed indicated a high level of interest in positive behavior support, in part because the individual case studies provided a real context for showing the positive changes in a child's behavior:

"…when I talked about what had happened with my case study and how the child responded so positively to the PCP[person-centered planning] process…they were really excited and what I thought was just going to take…twenty minutes or so we ended up spending forty-five minutes that first introductory time I talked to them and they had me pull up on my computer [for]the kids' PCP because they wanted to see what it looked like, they got very excited about it."

Some of the individuals interviewed discussed interest in targeting areas within the center that they felt would benefit most from the positive behavior support process:

"I know that I'm looking a lot at my PRTF clients and my overutilizers of crisis. Especially the ones who have went to a PRFT or at risk of going to a PRTF where the issue is more, I would say, in the home. Cause we can send a kid to a PRTF, they can work the program, they can learn the skills, but if nothing change in that home, nothing's going to change for that kid. We're going to send him back to the same environment and we're going to look at recidivism."

In some cases, professionals who were interviewed described specific job roles and the role positive behavior support will have for those individuals:

"…we're completely bought in as we've made these two new positions pretty much for our two liaison people. And…its' really a matter of…utilizing them [PRTF Liaisons] to the best of our ability to continue to decrease those PRTF admits and to continue to try to empower some of those families that may just feel like they're at wits end, too, to make a difference in their lives, as seen in both of their live case studies."

Another professional interviewed indicated that:

> *"I really feel like PBS is going to give case managers some direction…maybe we can kind of get rid of those tendencies where we have kids who stay in case management services for several years and we just continue to provide services…where this [positive behavior support] kind of gives us direction and gives them direction on where does this kid want to go, what's his goal, what does he want to be when he grows up, and kind of gives him a place, a new starting place for some of those kids…*"

The mental health professionals interviewed clearly indicated that their teams were moving forward to expand the knowledge and awareness across staff members:

> *"I think that's what I like about it [positive behavior support] so much…but if I can teach them [entry level staff] this…they're gonna be gosh darn effective and it's something that they can apply across the board with all of their clients and um as opposed to some o' the narrow trainings that we've had in the past…"*

Many individuals interviewed responded enthusiastically when they heard that the centers would be receiving technology that could be used to provide support to families in their homes. Here is one description explaining how a team will be using these resources:

> *"I see our parent-support specialist right off the bat using our 'to-go box' for our center and taking that into the home with the families and being able to use that with the families …if they're asking the family, 'Oh, you know, can you collect some data for me?' You know? Okay, here's the even recording form and it is printing that off right then in the home and having those materials. Because we're a six county agency…being able to have access to…the forms…and a "to-go box" they can slap in a car and go…"*

Perceptions of the Team-based Action Planning in Positive Behavior Support

Some individuals identified specific parts of positive behavior support they felt were the most valuable:

> *"I think by doing that [data-based decision making], the therapists are going to get much better data about what's going on with the kids. And I love that PBS gives you the framework to look at what is the function of the behavior…And I think I think as a mental health center as a whole we're always trying to help families get their needs met but this gives us a more scientific way to actually go about doing that"*

One individual indicated that she had observed changes occurring with the center as a result of the positive behavior support process:

> *I've noticed certainly in our wraparound's a much more kind o' strength based and youth focused kind of…format. Much more positive experience and I think it has been for the kids…as we get into diagnosis and problems and interventions. Now we're talking more about strengths and what they like and what they want to do. And that's been a very nice…very nice change.*

While another individual interviewed indicated that:

> *"…this [the KMHPBS Project] has just given us more tools and ways to work with kids. It's given us more ideas, especially for the kids who we're kind of at a dead end with, where we've tried everything, and so I think that's going to be great."*

> ***"…but I can't not have PBS because I've seen it…and the kids cannot not have PBS. They just can't."***
>
> **- Interview with mental health professional**

Kansas Mental Health Positive Behavior Support

Section 4: Effectiveness of Awareness Trainings

This report summarizes the results of the pre-post survey of mental health professionals that participated in the KMHPBS project.

Pre-Post Evaluation of Conceptual Knowledge

This section summarizes the results of the pre-post assessment of awareness-level positive behavior support knowledge among mental health center participants. Mental health professionals were invited to complete a pre-test of conceptual knowledge about positive behavior support before participating in any of the KMHPBS project activities. The survey consisted of 22 multiple-choice questions. The questions were selected from a larger initial pool based upon the results of pilot testing with small groups at mental health centers. Questions with a range of difficulty were selected in order to measure changes in knowledge over the course of the awareness training activities. The pre-test awareness data and scores also helped project staff members evaluate the level of information most mental health staff members already had about positive behavior support

Each center identified staff that would participate in the awareness trainings. The number of staff per center that was expected to complete the trainings was outlined in each agency's subcontract with KU. Center directors received a request to have participating staff register and complete a knowledge survey before participating in any of the trainings. Participants completed the registration process and survey via a link to a server maintained by KU and data were automatically downloaded into an excel file for analysis. Directors were then prompted to request that all staff complete the online post project survey once they finished the awareness online trainings.

Percentage of items correct scores were calculated for those participants with data for at least 18 of the 22 items. The average percent correct at Time 1 was 64% (*SD* = 17%). At Time 2, the average percent correct was 75%. (*SD* = 15%). Thus, on average, training participants scored 11% better on the post-test of PBS knowledge after completing the awareness training activities. The total score data for the overall participants was analyzed for statistical significance with a two-tailed t-test, and the practical significance of the effect was estimated using the Cohen's (1988) *d*, a measure of effect size. This increase in the total score from the beginning of the awareness training was statistically significant $t(364) = 14.62$, $d = .52$. These results suggest a moderate effect of increased conceptual knowledge of positive behavior support for those who participated in the KMHPBS awareness training activities.

Results of correct responses for all of the individual questions on the pre-post test of awareness level PBS knowledge are broken down by question in Table 1. As indicated in the Table below, of the 22 items measuring Awareness-Level PBS knowledge, results indicated that participants demonstrated increased knowledge on 91% (20/22) of the questions asked on the post-test. Increases in correct responses from pretest to posttest ranged from 4% to 34% depending upon the question.

Table 1. PBS Awareness Pre-Test and Post-Test Questions and Percent Correct Before and After KMHPBS Awareness Training.

Question Text	Percent of Participants Answering Correctly before Awareness Training (Pre-test)	Percent of Participants Answering Correctly after Awareness Training (Post-test)	Average Improvement in Percent Correct after Completing Awareness Training
Item 1: Which of the following best describes positive behavior support?	88% 332/379	96% 362/377	8%
Item 2: Which of the following are examples of the features of collaborative planning?	58% 221/381	77% 288/376	19%
Item 3: What are the two primary objectives when implementing positive behavior support?	71% 270/381	92% 344/376	21%
Item 4: Which of the following choices includes all of the "Big C's" of collaborative planning?	45% 170/378	77% 290/377	32%
Item 5: Which of the following are steps in collaborative planning?	52% 199/381	66% 247/376	14%
Item 6: All of the following are important characteristics of the person-centered and wraparound planning process, *except:*	91% 346/379	97% 366/376	6%
Item 7: Which of the following *best illustrates* an operational definition for the behavior of hitting?	46% 173/380	63% 238/377	17%
Item 8: What information *is not* included in a functional behavioral assessment?	44% 168/382	78% 294/377	34%
Item 9: A new functional behavior assessment will include what features?	52% 197/380	72% 270/377	20%
Item 10: What is *the most important* reason to use evidence-based practices when building a positive behavior support plan?	85% 324/380	89% 335/375	4%
Item 11: Building positive behavior support plans based on direct observation data enable teams to do all of the following, *except for:*	76% 286/379	86% 324/377	10%
Item 12: Which of the following best illustrates an example of an "Antecedent-	85% 322/379	93% 352/377	8%

Behavior-Consequence" (ABC) pattern?			
Item 13: Identify the antecedent in the following pattern: *Billy is asked to do a chore, he screams at his caregiver, his caregiver turns and walks away.*	79% 298/379	94% 357/378	15%
Item 14: Which of the following items is an example of a function that maintains problem behavior?	40% 150/379	54% 204/377	14%
Item 15: Replacement behaviors include all of the following characteristics, *except:*	55% 207/378	59% 221/376	4%
Item 16: Why is it important to assess fidelity of implementation for positive behavior support interventions?	60% 226/379	57% 214/375	-3%
Item 17: Accurate data collection helps us to do all of the following, *except:*	53% 201/379	46% 171/376	-7%
Item 18: Behavioral data summarizing the frequency of an individual's aggression depicts an increasing trend line after two weeks of intervention. Which of the following may be factors to consider?	71% 269/379	78% 295/378	7%
Item 19: Select the item that *is not* a strategy for overcoming obstacles during the positive behavior support process.	71% 269/379	80% 301/376	9%
Item 20: If a parent informs you that the school refuses to follow the behavior plan, an appropriate response would be to:	68% 258/379	76% 287/378	8%
Item 21: Strategies that promote generalization include the following, *except:*	35% 132/381	39% 146/378	4%
Item 22: Which of the following *best illustrates* sustainability within a positive behavior support plan?	77% 292/378	89% 337/377	12%

Kansas Mental Health Positive Behavior Support

Section 5: Evaluation of Regional Interagency Case Studies and Regional Interagency Planning Teams

Introduction to Regional Systems Change

This section will provides information about the following Kansas Mental Health and Positive Behavior Support (KMHPBS) Project activities:

- Regional case study demonstrations of positive behavior support,
- Regional interagency action planning, and
- Implications for statewide planning.

This report is organized into these three activities starting with regional case studies.

> ***"And when I put out there that I was looking for a family…to do the regional case study…I had two or three therapists kind of fighting over which family we were going to…do the regional case study because they were so interested in how it was going with the live case study [tertiary case study] to start with…"***
>
> **- Interview with mental health professional**

Regional Case Study Demonstrations

KMHPBS project staff members collaborated with mental health center professionals by facilitating nine positive behavior support plans with children in the same area as the five regional interagency teams that were identified. The results of these plans are referred to as regional case studies in this report. The identification of these cases studies took place after launching the interagency team meetings and introducing the regional teams to the overall planning process. Project staff members used a screening process to identify two children in need of positive behavior support plans.

The purpose of the tool was to aid in the assessment of the estimated risk of future admission or readmission to residential out-of-home inpatient treatment settings (i.e., Psychiatric Residential Treatment Facilities; PRTFs) for children and adolescents. The criteria used for assessing risk from the tool were selected based partly upon empirical research findings from a 2010 study of over 175,000 Kansas children conducted by the Social Work Department at the University of Kansas. The results of

this large study provided estimates of the variables associated with increased risk of admission and readmission to PRTF settings in the State of Kansas (Akin, Bryson, Gomi, Moore, Parkinson-Arnold, & Tullis, 2010).

Specific clinical and practical considerations were also taken into account in order to increase the likelihood that the case study families and teams would be able to commit to positive behavior support planning and intervention process. This evaluation tool was used by project staff in collaboration with mental health professionals to produce a risk assessment for an individual consumer.

Thirteen children were initially identified for positive behavior support plans. However, four dropped out due to a variety of factors early in the planning process. In one instance, an unexpected parental custody change interfered with the child's participation. Another family moved out of the region just as the positive behavior support planning started and a third family was unable to commit to the frequency of the needed the planning meetings. One child was admitted to a PRTF because of significant physical aggression at the beginning of the PBS process before any interventions were implemented. As a result there are a total of nine positive behavior support plans associated with regional planning.

The identification of these cases studies took place after launching the interagency team meetings and introducing the regional teams to the overall planning process. The interagency planning activities started later than anticipated due to an overall delay of two months in acquiring KMHPBS project funds.

The positive behavior support plans for the nine children are almost complete. Full impact and fidelity data evaluating the plans will be available within approximately one month. All nine are currently in the last stages of implementation. *Support for these cases have continued at the request of the mental health centers until interventions are stable and transitioned to regional mental health professionals.* Evaluation data were collected in the same manner described for the case studies submitted by the 28 mental health professionals as part of the KIPBS certification training.

Demographic information for the nine cases studies appear in Table 1. Six males and three female children from ages 7 to 13 are participating in positive behavior support planning with their families and mental health professionals across seven counties. Types of diagnoses reported for these children included: ADHD, Asperger's Syndrome, PDD-NOS, Disruptive Disorder and Mood Disorder.

Table 1. Demographic information for Children Receiving Positive Behavior Support.

Demographics of Regional Case Studies

Information On The Cases		N = 9
Gender	M	6
	F	3
Age	0 to 10	7
	11 to 21	2
	Mean Age	9.66
	Range	7-13
Counties	Douglas	2
	Wyandotte	2
	Anderson, Sedgwick, Ellis, Russell, Ford	1 each
Diagnoses Represented	ADHD	2
	Asperger Syndrome	2
	PDD-NOS	1
	Disruptive Disorder	2
	Mood Disorder	2

In the next section, preliminary data for one of the nine children is presented as an example of the data that will be available within one month. All regional case study plans show the type of direct observation data that are used as part of the evaluation process in Billy's story (in the next section of this report). KMHPBS staff evaluated other variables associated with positive behavior support plan effectiveness and aggregated the data for reporting purposes. Information about the overall evaluation process is included in section two, and in the KIPBS 10 Year evaluation report.

"It's hard for the parents to kind of step back and say, 'Okay, they're not doing this just to make me mad. They're not doing this… to be a pain in my side or something like that.' They're doing it because it serves a purpose and to teach parents…that's…why they're doing it. So, let's figure out why they're doing it…and try to find something else that still meets their needs but is okay for you, you know?"

- Interview with mental health professional

Billy's Story: How Positive Behavior Support Plans Are Evaluated

Figure 1. Picture represents Billy (All data for this case study were deidentified).

Billy is a 13-year old boy who wants to be a farmer when he grows up. He lives at home with his mother, step father, and three sisters. He attends the local middle school, goes to church with his family, and participates in Special Olympics. His biological father passed away several years ago in an accident. This was a difficult time for Billy and he is still gets upset about it sometimes. Billy has a diagnosis of ADHD and Asperger's. He also has diabetes and takes medications for seizures. He is currently taking the following medications: Haldol, Seroquel, Vyvanse, Lunesta, Zonegran, Metformin, Lamictal, and Fish Oil.

Billy was referred as a regional case study due to problem behaviors including screaming, property destruction, stealing, physical aggression, and back talking. Billy screams loudly when he becomes upset about something. This behavior, in turn, leads to property destruction and sometimes physical aggression such as hitting and kicking other people. Property destruction has resulted in damage (holes made in the walls) to buildings. Billy has been known to throw cups full of liquid on cars, and has destroyed personal items owned by other people. Billy also "back talks" after being given instructions by adults.

> ***"I think it's been a great…a great experience…it's impressive to me…I think [Regional Trainer's Name has] been over…Sundays and…I mean, this has been supported…it's been an intensive kind of…and you didn't feel like you were just kind o' out there on your own. I think that's great."***
>
> **- Interview with mental health professional**

Billy's behaviors have occurred at home, school, and in the community. Due to his behavior, Billy has a history of PRTF and acute inpatient psychiatric care stays. He had three mental health screens in 2012, one in 2011, and two in 2010. At the beginning of the PBS process, before interventions could be fully implemented with support to the family, Billy was admitted to an acute inpatient psychiatric care stay due to aggressive behavior towards his step-father. He transitioned back home on November 10, 2013.

The KIPBS facilitator worked with Billy and his team including his parents, mental health staff, and the professionals in the acute care setting to create a transition plan to for making Billy's transition home a success.

Billy's team identified the following behaviors to assess respecting physical boundaries, and property destruction. The team conducted an assessment with Billy and his team to understand why he was engaging in problem behavior. Assessment included interviews with individuals in Billy's life across home, school, and community settings, direct observations, and record reviews. The family indicated that Billy's tendency to invade other individual's personal space (physical boundaries) is causing the most stress in the family and indicated that this behavior tends to escalate into more serious aggression and property destruction. Billy engages in this behavior more often when he is in a public setting, feels anxious, or is having issues related to his diabetes or medications.

> ***"…it's been helpful to be able to say, "He really gets upset when surprises happen. When, you know…let's look at this is what…triggers those kind of behaviors…"***
>
> **- Interview with mental health professional involved in regional case study**

The team's hypothesis was that Billy would invade another person's physical space or boundary in order to escape a demand. The team decided to target invasion of physical boundaries as the primary focus for the positive behavior support plan. The team also collected direct observation data on the rate of property destruction.

Billy is more likely to engage in problem behavior when he is asked to do something or when he is told he can't have an item or activity. Specific function-based interventions were designed and tailored for specific routines the family identified as most problematic. In addition to learning to request items that Billy wanted, he was taught to wait for longer periods of time before being given access to preferred task when other non-preferred activities were occurring.

The graphs shown in this report target two key problematic routines for the family and show the impact of the interventions implemented. Figures 2 and 3 report decreases in both invasion of boundaries and property destruction from baseline to intervention.

Figure 2. Rate of Billy's Problem Behavior: Invasion of Physical Boundaries in the Evening.

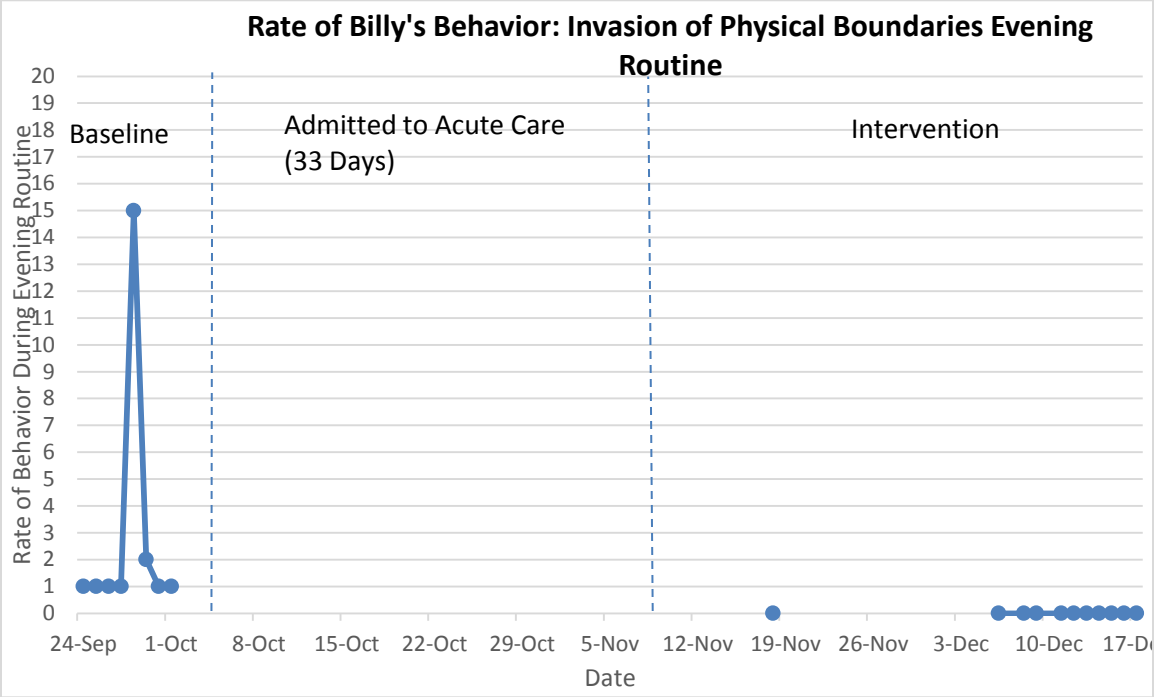


Figure 3. Rate of Billy's Problem Behavior: Property Destruction in the Evening.

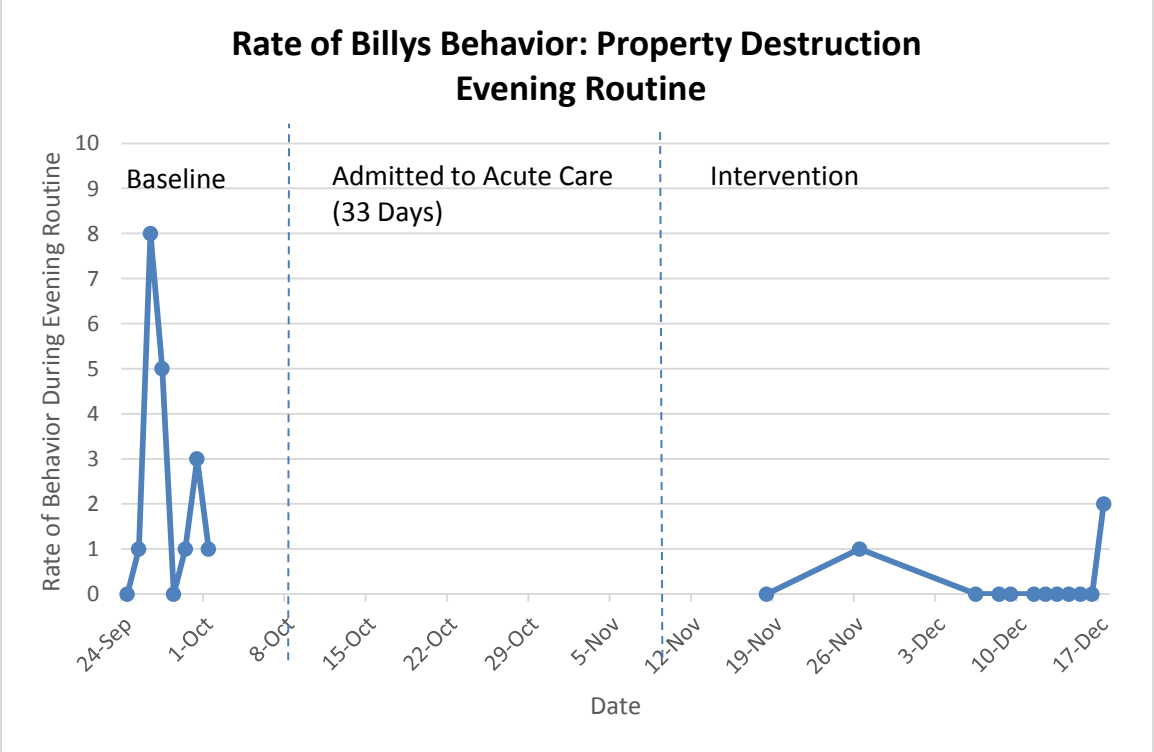


Figure 4. Rate of Billy's Problem Behavior: Physical Boundaries-After School Routine.

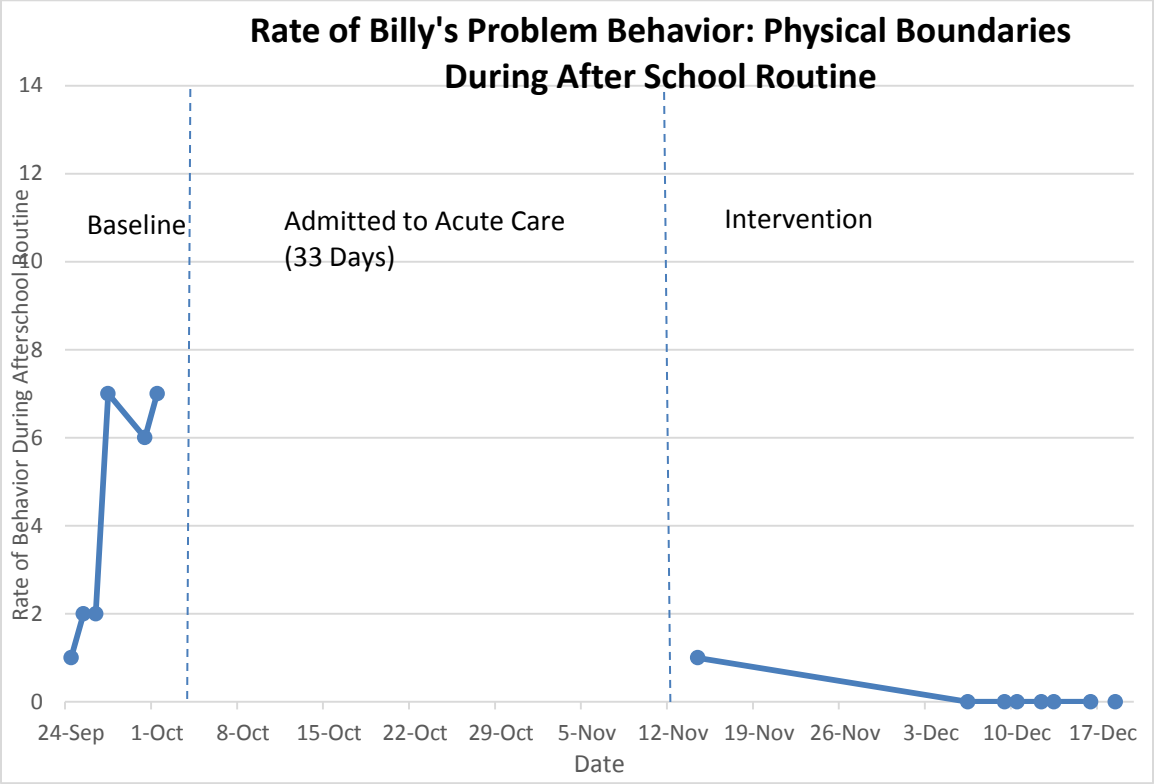
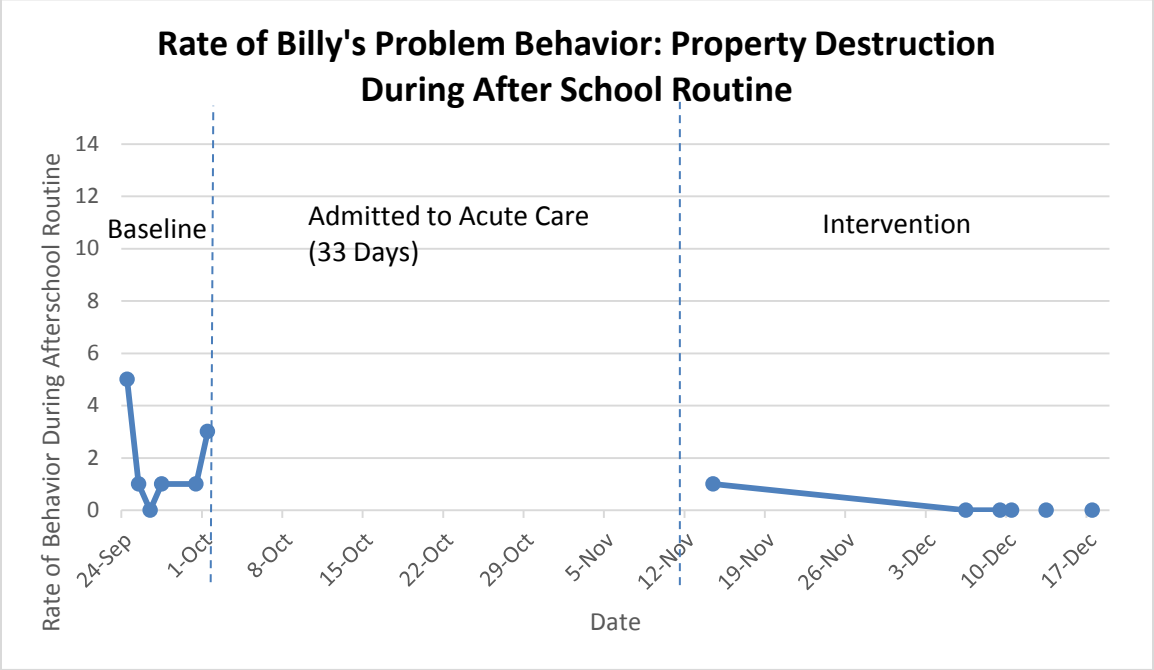


Figure 5. Rate of Billy's Problem Behavior: Property Destruction -After School Routine.



Overall, Figures 2 through 5 show progress was made when the positive behavior support plan was implemented during two of the most problematic routines. Additional data are needed, however, to be able to evaluate the results of this positive behavior support plan given the acute hospital stay happened just prior to full implementation of interventions.

However, Billy's mother reported that the afternoon routine is much easier to accomplish after implementing the positive behavior support interventions. In particular, she mentioned that encouraging Billy to wear headphones during the travel period really helped to block out noise that made the routine more aversive for Billy.

> *"… having… ideas written out for in the in the van when we're traveling. What's being responsible, being respectful, being safe…in the bathroom, what's respect, you know, around the meal table. They're all kind of thinking about what they can be…in a positive way versus "Stop doing this, stop do—"you know?" …*"

The professional working with Billy and KMHPBS said one of the benefits of the plan is that there are now ways to focus on what Billy should do rather than reacting to the occurrence of problem behavior. By teaching positive social expectations, Billy knows and receives prompts before problems occur to engage in positive social behavior. The PBS facilitator guided the team to use social expectations that were taught during Billy's stay in the acute care hospital as part of the transition plan. This helped establish consistency as Billy moved back in to his home.

The professional mentioned that she appreciated having someone available that could work on the transition plan while Billing was in acute care. She indicated that:

> *"Just… turning that from a negative home setting to a more positive. It's just been very nice to see. I had…those parents and that youth in here the other evening and…it was a very different feel to that session which was which was great."*

The rest of Billy's evaluation data will be available in approximately one month and will provide more information about changes in quality of life and the extent to which Billy's plan was a good fit for his team. In the next section of this report, the regional interagency action planning process will be described.

Evaluation of the Regional Interagency Action Plans

Figure 6 describes some of the challenges encountered by families, administrators, and providers as they struggle to provide effective supports and services to children. Children at risk for out of home placement often receive services from multiple agencies making communication and coordination more challenging. One professional interviewed said that:

> *"…if the family is working with all these different people and getting all these different messages, then it's really difficult to stay on the same page."*

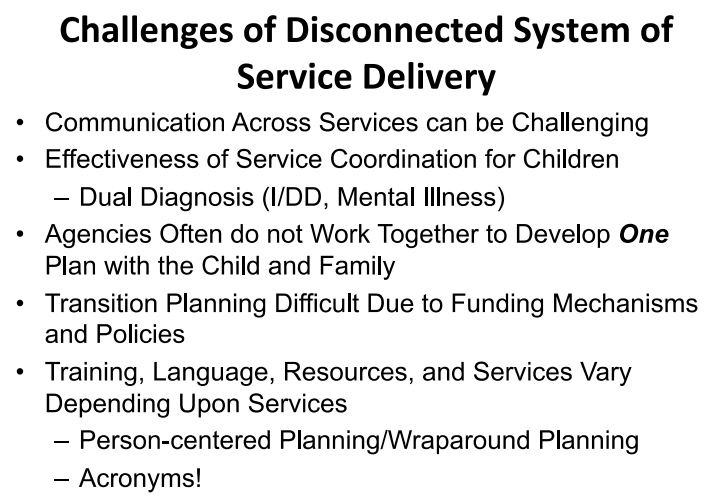
Some of the major challenges that include communicating across agencies, especially with certain types of children and the fact that agencies have different reporting system that families must navigate. Transition planning tends to be one of the most commonly reported issues as many professionals believe that families need support in the home to ensure they have the experience and tools for supporting children who engaging in challenging behavior. For instance, one person interviewed said:

> *"…Ideally we would like to develop the [transition] plan prior to them coming out…but we don't always have notice that they're coming out…there are times that we might get a notice that says, "Hey, this child's being discharged tomorrow." And what we get is a discharge summary with some recommendations from the PRTF…but nothing in advance."*

Another challenge associated with service delivery is the need for better communication. Professionals from different agencies receive training from different fields of study and use different terms and strategies in meetings based on their knowledge and experience. Communication in interagency meetings can be challenging for this reason. For instance, professionals in the intellectual and developmental disability field tend to use person-centered planning while those in mental health are facilitating wraparound.

> ***"Just being able to kind of have that common language, I think that's gonna be real important, even with PRTFs, but even if we're not going to be able to work linked in directly to the PRTF and work directly with the kid, but if they, some of them are using PBS language and discharging, how much more beneficial that's going to be for [PRTF Liaisons] as they plan this kid's initial plan when he gets out of the PRTF, or in JJA custody or the foster care system."***
>
> **- Interview with mental health professional**

Figure 6. Challenges Mentioned by Families and Mental Health Professionals in interviews and focus groups.



Five regions across the state were invited to participate in interagency collaboration at the regional level. The goal of these meetings was to assess the strengths of the community and to create plans for improving collaboration across services. Each of the interagency teams met 2-3 times during the year to create an action plan for creating a common language for prevention, improving service coordination, and sharing important information about services for children.

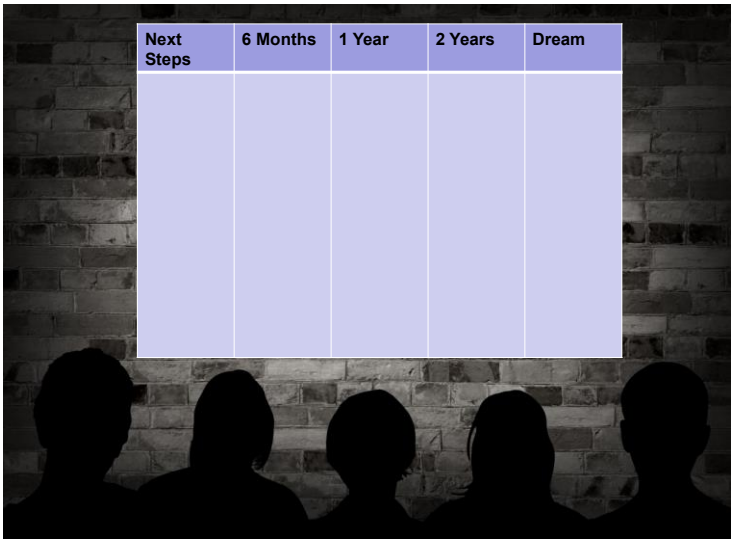
One regional interagency team that was particularly interested in creating a common language of prevention. This regional team included professionals representing:

- 4 schools districts,
- 3 mental health centers,
- Developmental disability organization,
- Department of corrections representation,
- Correctional facility for children and youth,
- Psychiatric residential treatment facility, and
- Higher education.

Together, the team created an organizational plan (see Figure 7 for an example of the tool used by the team). The first step was to place a planning tool on the wall that helped the group in the brainstorming process. The team spent time talking about what the "dream" would be for the team if they could improve interagency collaboration. Based on the dream, the team identified three goals that could be

accomplished given the nature of the group's resources which would be sustainable after the KMHPBS project ended.

Figure 7. Planning Tool Used by Regional Interagency Teams for Brainstorming.



Once the two-year goals were identified, the team wrote goals that needed to be met within one year. Six month goals and next steps were offered as a way to begin implementing the regional action plan. Figure 8 provides an example of the activities and goals outlined across each area of this regional action plan.

Figure 8. Example of an Action Plan for a Regional Interagency Team.

Positive Behavior Support Interagency PATH Example				
Next Steps	**6 Months Goals**	**1 Year Goals**	**2 Year Goals**	**Dream**
Identify What Services Will Become Part Of Interagency Agreements Initial Meetings Scheduled To Discuss Interagency Agreements Identify Missing Stakeholders And Invite To Next Meeting Establish Meeting Schedule Create Smaller Working Teams To Address Each Long-term Goal Each Group Implementing PBS Shares Data During	Meetings Held To Finalize Interagency Agreements Draft Copy Of Interagency Agreement Documents Shared Finalize Self-assessment of All Data Sources Team Has Gathered Marketing Plan Is Outlined And First Implementation Steps Accomplished Political And Administrative Leaders Targeted And Listed Case Study Examples At the Individual and Systems Level Are Finalized for Dissemination….	Written Interagency Agreements Are Finalized First Draft Copies Of Easy To Read Summaries Describing Positive Behavior Support Evidence Completed Dissemination Plan Is Established To Share Summaries of Data Team Identifies Concern Across Interagency Partners, Intervention Is Implemented, And Data Gathered Presentations And Meetings Scheduled With Target Political And Administrative Leaders Evaluation Of Marketing Plan Is…..	Interagency Agreement Unifies Meeting And Report Systems For Individuals Receiving Multiple Services Summarized Data Are Available Across Services (And By Service) In Simple Format For Broad Dissemination Marketing Plan Has Disseminated Key Information To Administrators, Political, and Community Leaders	Families Receive Prevention-based Services (Instead Of Crisis-driven Services) Individuals Receive Coordinated Services-Early Childhood Through The Lifespan- The Community Implements Positive Behavior Support Strategies To Prevent Problem behavior Transition Services Are In Place To Help Individuals In Transition Plans For Children Are Aligned Across Services Data And Communication Systems Are Aligned Across Services Data Are Used At The Local Level For Decision Making

Another regional team has focused on reaching out to other organizations where children tend to spend more time. For instance, in one region, the team is implementing a plan for teaching staff at the local library the social skills that are linked with the social expectations taught within the mental health center. One professional described how this will provide opportunities for children to practice new skills in real community settings.

> *"'Bring 'em on over here.' You know? …and let them practice some of the stuff you're working with and let me know what you're doing so I can kind o' help out. And so, I thought that was awesome. We definitely have not had that before."*

The five teams have created strategies for tracking the action-planning process described in Figure 8 and to report the progress made on the implementation efforts that are now taking place. Since these plans just started, the data are not yet available to report significant outcomes. However, the planning process established provides the tools and resources for team members to continue working on these action-plans after the project ends.

Purpose of Completing Regional Case Studies and Regional Interagency Action Plans

The original reason for completing positive behavior support plans at the regional level for local children at risk for out of home placement was to provide a concrete example for each of the teams to learn more about strengths and barriers associated with preventing problem behavior. Themes and issues occurring across the de-identified regional case studies help teams improve service coordination, consider policy changes, and implement training and technical assistance within participating agencies and systems. In addition, the regional areas can use the information gathered to provide information about lessons learned to the state for larger statewide planning purposes.

Information gathered from the regional case studies were consistent with the qualitative interviews and focus group sessions conducted as part of this project. The information gained by implementing the regional interagency cases studies and action-planning sessions are included in the next section of the report.

Statewide Planning: Recommendations for Consideration

1) It Takes a Village to Raise a Child: Decreasing in Out of Home Placements for Children with Interagency Collaboration

Professionals participating in regional case studies, interagency planning, and interviews for this project emphasize that stronger interagency communication and coordination is a key way to decrease out of home placements for children engaging in problem behavior. Many children who engage in problem behavior do so across home, school, and community settings. To prevent out of home placements,

education and human service systems must work together with families and the local community to design coordinated interventions that follow a child through his day.

An earlier qualitative study funded by the state evaluated whether professionals working with children and adults across the home and community based service waivers felt they received adequate training and technical assistance to decrease and prevent problem behavior. A common theme voiced by many professionals in that earlier study was that providers needed ongoing training in positive behavior support so that practices could be maintained when staff attrition occurred within organizations.

Regional interagency teams participating in the KMHPBS project have articulated the need for:

- Shared training materials that can be used across home, school, and community settings in an ongoing manner,
- A common language to increase the ability of different services to communicate and share intervention strategies, and
- Improved communication to assist with transition planning for children to ensure problem behaviors do not escalate due to a failure of consistent plan implementation.

An important reason for interagency collaboration is that the perception of community members can either increase or decrease the likelihood a child will be recommended for out of home placement. One parent described the importance of collaboration when it works well:

> *"And so, I think that's the biggest thing, is trying to get people to know that it is very hard, raising a child with very high needs, but if you can work as a team, the possibilities, you know, cause right now we're doing really well, and I really do believe some of the reasons why is from everybody coming in, giving me some more input and advice on things, and then everybody showing up to these meetings and talking and actually getting to communicate, you know, what's working, what's not. And that's the biggest part of that, is just making sure that you've worked together."*

Several individuals interviewed described how the perceptions of the community can lead to increases in out of home placements in some areas of the state. Family members, judges, professionals, and other community members felt that it is important to change the perceptions people have about out of home placement. One person stated that:

> *"____County…court system is not is not very tolerant and their perception…is…that…yanking a kid from the home or recommending a PRTF placement is the way to go. That's kind of the perception of the judges here. So, we've been really working hard on trying to change some of those attitudes and perceptions."*

One professional interviewed said that perceptions about PRTF placement can be influenced by individuals working within human services may not fully understand how important it is to prevent out of home placement. This person said that in some situations,

"The caseworker will sometimes plant in the parents mind that a PRTF is an option if all else fails, because they're not held accountable to keep kids out of PRTFs, where we are. You know, we work toward doing everything we can in the community, and then that sabotages our efforts if that case manager is giving the parent information that, "no, no, this is really an option for you" and really pushing it. So that's a hindrance for us."

Sometimes community members can be especially helpful because of the personal experiences they have with children with disabilities. For instance, a parent interviewed describe how she always checked for a local police officer during crises with her child because she knew one officer in particular had a family member with a disability:

"Most of the time, I was lucky enough the police officer that mainly was on call during the times that I did call, he had a brother who has disabilities, so he kind of really knew how to talk to [son's name] and how to get him to see the right side, without having to do anything other than just talk. That was one of the good things that I liked, was if I called in, my first question is to dispatch, "is so-and-so officer working? If you could please dispatch him here." And the minute he would hear the name and everything, he knew exactly what he was walking into. He knew how to approach [son's name]; he knew what to do."

Finding a police officer who knows how to interact with a youth in ways that won't escalate problem behavior and create an even bigger crisis is not an easy task according to a number of professionals in Kansas interviewed about challenging behavior during the earlier waiver study described earlier in this report.

Some of the participants interviewed described how perceptions within the community impact the efforts of interagency teams to keep children in their home, school and community. These individuals said that overall perceptions of mental illness has changed over time. Several people with focus group sessions and interviews described the stigma that follows children who have been diagnosed with mental illness: *"In _____ County, I have lived here, well, 20 years, and just the impact of people understanding what mental health is, it's becoming weird."* One advocate indicated that because of this stigma, families are less likely to seek out assistance when their child has a mental illness.

Unfortunately, without early intervention, these same children may not receive any type of services until a crisis results in out of home placement. One person interviewed said when parents have reached the end of their ability to cope with a child's problem behavior, it can be difficult to talk about strategies for supporting children in the home. An advocate interviewed said that:

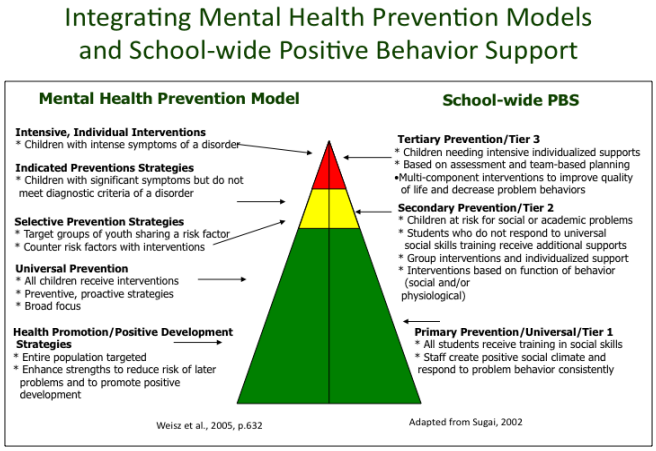
"I think one of the barriers is, that sometimes the families are so fed up by the time they get to us, their only goal is to get them out of their home, and then they get very angry with us and we keep saying, the least restrictive thing possible is in your home, let's try to support you, let's try to provide these services, and then they're very resistant to receiving those services."

An important goal is to establish early intervention strategies to support families before problem behavior has escalated to these intense levels. Implementing primary prevention strategies in home, school, and community settings may provide one way to reach out to families. Teaching universal social

skills interventions for all children before problem behaviors become a challenge is now becoming an expected part of the school environment.

One participant indicated that: *"The kids tell us how do you even expect us to walk back into a school where people are talking that we're mental now…?"* In this type of context, children returning from more restrictive placements may be more likely to seek to escape the school setting by engaging in problem behavior that results in both in-school and out-of-school suspension, and expulsion. Students may be seeking to escape the social humiliation they experience at school. Mental health professionals collaborating with schools teams implementing positive behavior support can help change cultural views that help to create these stigmas children with mental illness experience. These types of primary prevention strategies help to reduce the likelihood of problem behavior.

Figure 8. A Three-Tiered Model for the Prevention of Problem Behavior.



Kansas education and human service settings have already been taking a lead in moving prevention-based problem solving into education, early childhood, mental health, intellectual and developmental disabilities, and other organizations. The Kansas Department of Education uses a triangle model (see Figure 8) for preventing problem behavior that is similar to public health model used within the KMHPBS project for mental health centers and PRTFs.

KSDE leaders are encouraging all schools to implement a multi-tiered system of support (MTSS) for both behavior and academics. Several early childhood organizations in Kansas have led positive behavior support implementation at a systems level and have received national recognition for these implementation efforts. A total of 21 mental health centers in Kansas are now implementing a three-tiered model of prevention and an increasing number of organizations for individuals with intellectual and developmental disabilities are using positive behavior support strategies. Interest in positive behavior support has been growing in several juvenile justice organizations with some early demonstrations now becoming available.

The increasing number of organizations implementing positive behavior support using a three-tiered prevention model creates a unique opportunity in Kansas to build a common language for the prevention of problem behavior across communities. A number of regions are now working at a regional

interagency level using positive behavior support as a foundation for building a common language for prevention across agencies.

These communities are assessing the extent to which different agencies are working together to implement primary, secondary, and tertiary prevention for children and families. This is an important time for assisting education and human service organizations in building community-wide prevention systems that will decrease the need for more expensive and restrictive placements for children engaging in problem behavior.

However, there are very few resources available for mental health professionals to engage in this type of activity. As one person interviewed point out:

"… the phrase that is used in a lot of places is … you have to create a common language… a common purpose…I don't know that that happens…via state-wide coordination. I…think that's…something that's a little difficult to pull off and…that maybe the state of Kansas…has just kind of said well if regions and localities can…do that then… that's great. That's not necessarily a state-wide initiative to…create…a seamless system and…get rid of any kind of geographic variability and in how services are delivered and in how effective they are."

- Interview with Professional

> *"…probably the biggest single complaint I hear about mental health centers across the state is that they don't have enough time to be as involved in the child's community as they need to be. And, you know, cause basically, if the child is not physically in my office, or physically in the building, I can't get paid for working on the child's case."*

<u>Recommendations for Statewide Planning</u>

One recommendation for statewide leaders that could be addressed within statewide planning is to take advantage of the pockets of innovation occurring across the state and to encourage exemplary regional leadership. A unified plan by the state to encourage interagency collaboration would highlight the need for this important process and would provide reinforcement for regional teams that are taking a lead role in preventing problem behavior at the community level. Statewide planning efforts should consider:

- Providing access to interagency tools, processes, and local success stories via the state's website,
- Creating a common language for prevention of problem behavior that could be shared at the regional level,
- Using the limited resources for training and technical assistance to provide instruction across services (mental health, early childhood, intellectual and developmental disabilities, juvenile justice, etc.), and
- Investing in training professionals who have the skills to facilitate local regional teams and can take a leadership role at the local level.

2) In-Home Family Support Services are Needed to Prevent Out of Home Placements

One of the most consistent messages from the individuals participating in the KMHPBS project was that unless families receive training and support within their homes, there will be an ongoing cycle of out of home placement for children with the most challenging problem behaviors. Many of the individuals interviewed including professionals, advocates, and family members talked about the difficulties associated with the interruption of mental health services when a child has been placed temporarily in a Psychiatric Residential Treatment Facility (PRTF). Individuals described how valuable it was for families when they could receive training and technical assistance from PRTFs. Several individuals indicated that this made a huge difference for families struggling to keep their children at home.

Mental health professionals cannot support family members during the time period when a child is in an out of home placement. In fact, mental health professionals described the child's case as actually closed during the time the child is in an out of home placement until they are back in their home setting. One person said that:

> "*No wonder we have this revolving door. We don't fix anything. We send them there for a few days, and like, okay, you're doing better, go home …There's something wrong with that."*

Another participant in the study said… *"I think that's the biggest gap and the saddest situation that we have. When children are at PRTFs and, then our billing stops. Our interaction with the family ends."* Several individuals interviewed indicated that by not providing support to families that *"the problems they left in the system are probably still going to be there when they return."* When asked about barriers, one person indicated that: *"… well, the big one obviously…is when you move a kid out of a home…you know, you…left behind the [family] system and you're going to put this kid back in this system."*

Another person interviewed highlighted the time lost when children are placed within a PRTF placement:

> *"…you know, usually within a week to two weeks it's like, "Okay, you now we're rolling up our sleeves and we're doing…what we were working on before they went. You know, but we lost three months…It's like, three months went by… we gotta break, you know…is basically all it was…now we're back where we were…?*

Several of the people interviewed indicated that family support in the home is an essential ingredient for successfully preventing problem behavior and out of home placement. *As one person explained:*

> *"I always thought if I start in any kind of program, I would call it, 'There's no place like home'. You know, Dorothy, Wizard of Oz…because it's true. That's where the problems are. But that's also where our best solutions are. And so, if we can make that work, I think we can save ourselves a lot o' grief."*

Those interviewed emphasized the need for support in the home. For instance one person said "…*if they [interventions] are not implemented in the home, it's much more difficult for that change to be sustained."*

Recommendations for Statewide Planning

A second recommendation for statewide leaders that could be addressed within statewide planning is evaluate whether funds already associated with mental health services via the SED waiver and out of home placement could be re-distributed in a manner that emphasizes the need for onsite training to families of children at-risk for out of home placement.

> ***"She came in today for an intake – come to find out she'd left the detention center six weeks ago. She's been in the community for six weeks with absolutely no mental health support."***
> ***- Interview with mental health professional***

Types of support might include:

- Change in waiver services emphasizing in-home family training and technical assistance,
- Establish screening processes to identify children early before serious problem behaviors escalate resulting in out of home placement, and
- Outline clear expectations for transition planning that would improve communication, re-allocate funds toward onsite in-home family technical assistance by PRTF providers before out of home placements are necessary.

3) Dedicate Resources for Transition Planning to Prevent Out of Home Placement Recidivism

> ***"…Ideally we would like to develop the plan prior to them coming out…but we don't always have notice that they're coming out. Um, there are times that we might get a notice that says, "Hey, this child's being discharged tomorrow."***
> ***- Interview with mental health professional***

Most of the mental health, PRTF, and family members interviewed expressed positive experiences collaborating across different services. However, one type of communication breakdown was frequently described by professionals living in different areas across the state of Kansas. This communication issue was commonly associated with children transitioning back into the home and community. One person said that:

> *"….a parent will call me and say, so-and-so's getting out today. And they have no prior warning. Or, they had a meeting and they're looking at next week…for me, transition means a step-down type program, getting us involved, you know, and getting supports in place. Sometimes we don't have that opportunity. It's real quick and you're strangling. So, I think where we are more reactive, you cannot do the same quality work as when you have a few minutes to pull everybody together and, or even pull up your plan of care and start again. But, there's no step down process. It's hospital. Home."*

Communication problems appeared across and between different organizations and agencies and appear to be a natural challenge for transition planning. "*…but for some of the kids—particularly foster care kids…if they're coming back to our area, we may not even know that they're getting discharged 'til they land on our doorstep."* In some cases, the communication issues related to transition are sporadic: *"Well, sometimes, you know, we'll get a heads-up that somebody's coming home from the contractor,*

and sometimes we won't." A person described this situation saying that communication about an upcoming transition is not always a problem: *"Well…sometimes not. Sometimes we get like a day or two notice and then we're really left scrambling but…that's happened occasionally and enough that it's really irritating."*

A number of mental health professionals described how important family involvement was for ensuring children were successful living in their home and community. One individual stated that *"…because without that [family involvement], you know, we….just really spin our wheels. We can we can do brilliant work. But if it's not transitioned to the home, it's really…ineffective."*

> ***"I think this community has worked really well at trying to keep my son in the home. That's, you know, if it wouldn't been for _____Organization, I mean, you know, they've been wonderful to me, they've been, you know, trying to help me try—like I said, we're all just trying to keep [son's name] in the home."***
>
> **- Interview with parent**

Recommendations for Statewide Planning

The last recommendation for statewide leaders that could be addressed within statewide planning is evaluate whether funds already associated with mental health services via the SED waiver and out of home placement funds could be re-distributed in a manner that provides clear guidelines and expectations for transition plans. Considerations might include:

- Policy and procedures outlining key features of transition plans,
- Establish strategies for improving communication about transition dates across family and agencies providing services, and
- Provide onsite technical assistance to families when a child is transitioning back into the home and community.

Kansas Mental Health Positive Behavior Support

Section 6: Perceived Effectiveness of the Project by Mental Health Professionals

Summary of Evaluation Data from Surveys Completed by Participants of the Onsite Workshops

Full day training events were scheduled in four locations across the state of Kansas including Hays, Topeka, Wichita, and Parsons. These trainings introduced the core concepts related to person-centered planning and positive behavior support at an awareness level. The rooms included round tables with approximately five to eight people sitting at each table. This organization helped to encourage collaboration during scheduled activities that were held throughout the day. A total of 618 community mental health professionals and other regional stakeholders attended the trainings.

Qualitative interview data were collected before the first trainings and used to design the awareness training. The survey evaluated perceived satisfaction with the awareness trainings and was distributed after each of the five training events. Table 1 shows the evaluation questions that were asked in the satisfaction surveys.

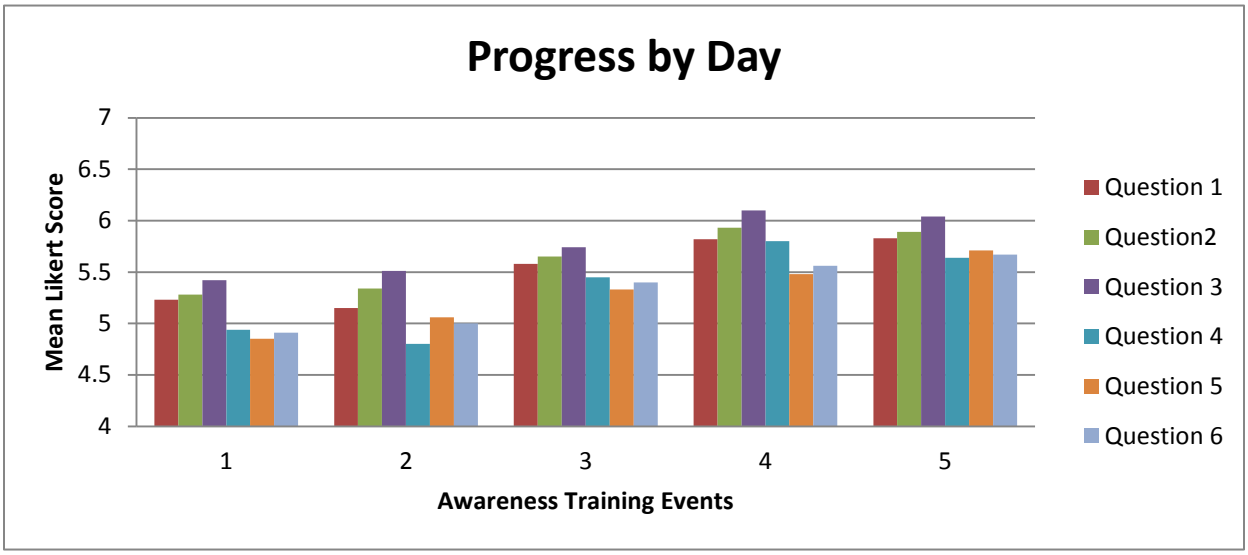
Figure 1. Picture Taken at an Awareness Training.

Table 1. Awareness Onsite Evaluation Questions and Rating Scale Information.

Awareness Onsite Event Evaluation Questions		
1) The organization of the event was:		
Excellent (7)	Neutral (4)	Poor (1)
2) The objectives for the event were:		
Clearly Evident (7)	Neutral (4)	Vague (1)
3) The work of the presenters was:		
Excellent (7)	Neutral (4)	Poor (1)
4) The group discussions/activities were:		
Very Helpful (7)	Neutral (4)	Not Helpful (1)
5) My attendance at this event should prove to be:		
Very Beneficial (7)	Neutral (4)	Not Beneficial (1)
6) Overall, I consider this event to be:		
Excellent (7)	Neutral (4)	Poor (1)

The data presented in Figure 2 summarizes the results of each of the main items of the survey.

Figure 2. Evaluation of KMHPBS Awareness Onsite Training Events Across Six Items.



KMHPBS staff members analyzed survey data after each training and used it to improve each subsequent training. For example, more activities and tools were introduced in later trainings and interactive components including videos and games were used to facilitate learning. Attendees represented a broad spectrum of community mental health professionals and regional stakeholders making the training challenging. Educational background, job positions, and other factors made it more challenging to provide a level of instruction that met everyone's needs. This led to some diversity in scoring patterns.

Figure 3. Picture of an awareness training participant.

"I'd like to have tools that we take from the training. Don't just give me a book. Give me something that I can use. I want the visuals; I want things that I can interact with my family. I would like to take something that I saw in the training and be able to present it to a family."

- Interview from mental health center professional -pre project interview

Traffic Statistics Report for the KMHPBS Website (www.kmhpbs.org)
October-December 2013
Quarterly Summary of KMHPBS Website Statistics

The data presented in this section of the report provides information about the usage patterns of mental health professionals and other stakeholder on the www.kmhpbs.org website. The website was launched immediately at the beginning of the project. However, the website was refined over time with significant revisions occurring to the website throughout the year. Table 1 reports the hits, total visits, unique visitors, return, visitors, and page views during KMHPBS project time period.

Table 1. Annual Website Usage Patterns for www.kmhpbs.org.

KMHPBS Website Statistics by Year					
Year	**Hits**	**Total Visits**	**Unique Visits**	**Return Visits**	**Page Views**
2012*	36,356	1,397	994	403	9,362
2013**	N/A	4,955	2,445	2,510	52,469
* Website first online 7/1/2012 - Development and Testing Occurred During July and August, 2012 ** Through December 31, 2013					
2012-2013*	36,356	6,352	3,439	2,913	61,831

Figure 1. Total Visits and Page Views for www.kmhpbs.org.

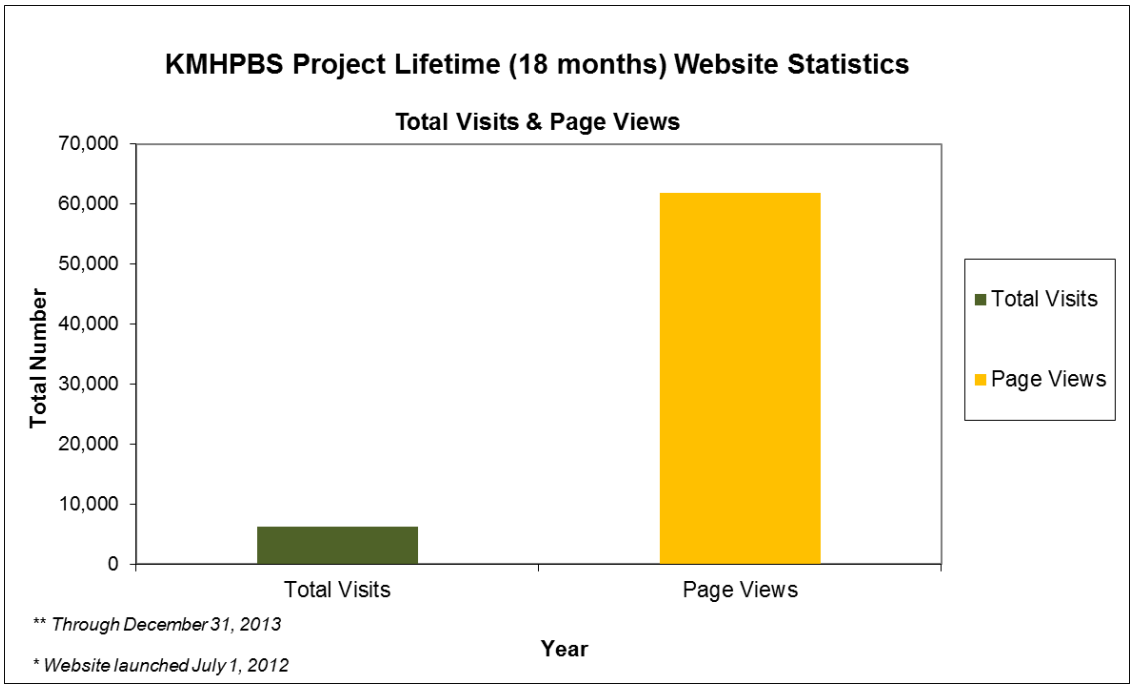


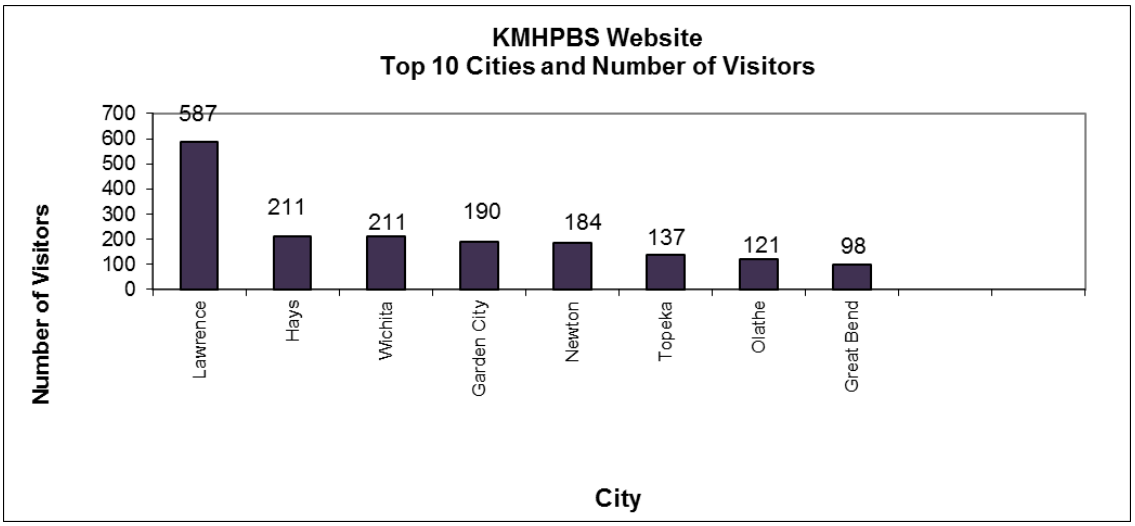
Table 2. Overall Monthly Usage Patterns for www.kmhpbs.org.

Overall Summary of Monthly Website Traffic Facts 2012-2013

KMHPBS.ORG					
Updated: 12/31/2013 (Site launch date 7/1/2012; Changed web traffic analytics provider 1/1/2013)					
Date	**Total Visitors**	**Unique Visitors**	**Return Visitors**	**Page Views**	**Hits**
Jul-12	290	165	125	3,665	16,887
Aug-12	213	142	71	2,737	9,909
Sep-12	115	96	19	595	2,066
Oct-12	274	200	74	1,045	3,790
Nov-12	259	193	66	760	2,379
Dec-12	246	198	48	560	1,325
Jan-13	68	40	28	463	N/A
Feb-13	49	35	14	278	N/A
Mar-13	87	54	33	498	N/A
Apr-13	222	88	134	1,353	N/A
May-13	110	76	34	473	N/A
Jun-13	107	60	47	476	N/A
Jul-13	172	112	60	719	N/A
Aug-13	321	208	113	5,594	N/A
Sep-13	848	417	431	7,315	N/A
Oct-13	1,295	549	746	13,697	N/A
Nov-13	832	381	451	9,724	N/A
Dec-13	844	425	419	11,879	N/A

Figure 2. Visitors to www.kmhpbs.org by City.

Visitors by Cities – October-December, 2013



Tables 5 and 6. Referring domain and key phrase searches.

Referring Domains and Key Phrase Searches – October-December, 2013

Referring domains	Referrals
direct	2,313
google	370
bing	104
yahoo	41
us-mg6.mail.yahoo.com/neo/launch	19
inboxdollars.com/search/infospace	18
kmhpbs.kipbs-dev.deptsec.ku.edu/resources/training-materials	18
us-mg5.mail.yahoo.com/neo/launch	13
kmhpbs.kipbs-dev.deptsec.ku.edu/resources/training-materials/fidelity-tools-for-pbs	11
www.seoanalyses.com	10
Total	2,917

Keywords	Count
(not set)	2,450
(not provided)	266
kmhpbs	63
www.kmhpbs.org	33
kmhpbs.org	28
http:/kmhpbs.org	12
ku positive behavior support	11
positive behavioral supports kansas	9
http://kmhpbs.org	6
http://kmhpbs.org/awareness/login	6
Total	2,884

Kansas Mental Health Positive Behavior Support

Section 7: Effectiveness of Facility-wide Positive Behavior Support Training

Introduction to a Three-Tiered Model for Preventing Problem Behavior

Across the United States, treatment centers, juvenile correctional facilities, and other organizations serving children and youth with problem behavior have been modifying an approach called School-wide Positive Behavior Support (SWPBS) to these alternative settings. The SWPBS model includes a three-tiered prevention model taken from the field of public health and applied to educational settings to prevent serious problem behavior.

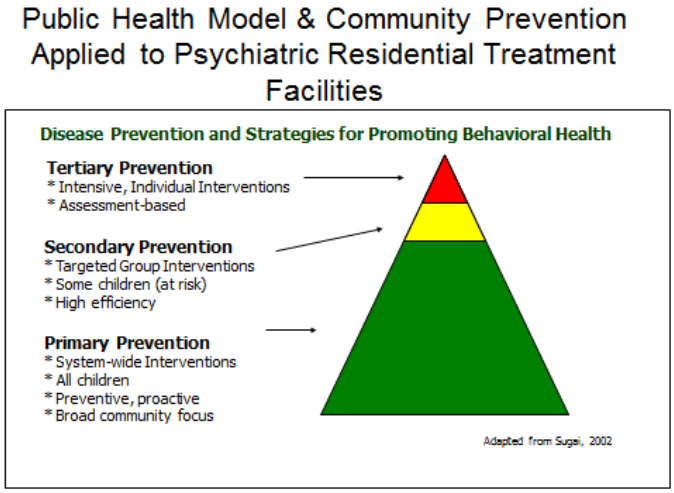
Introduction to a Three-Tiered Model for Preventing Problem Behavior

Facility-wide positive behavior support (PBS) includes team-based and consensus driven problem-solving at each of the three prevention tiers. A triangle is frequently used to show how prevention-based strategies become increasingly intensive at each tier, universal, secondary, and tertiary levels.

"…for us to go from twenty-two kids down to five kids in a year and a half and the only thing that had changed was introduction of PBS I think that's pretty awesome."

- Interview with mental health professional in an alternative education program

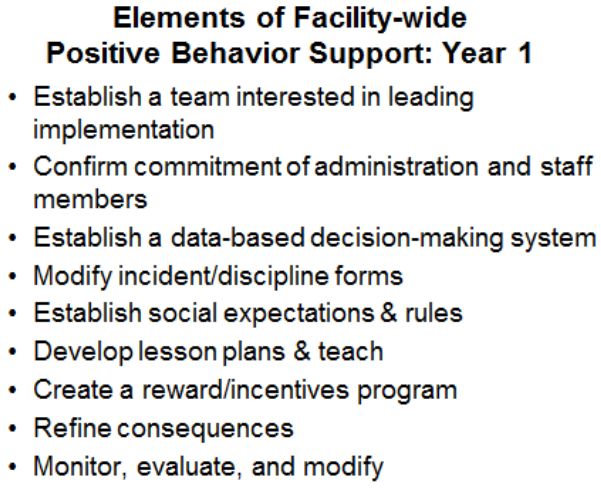
Figure 1. A Three-Tiered Model for the Prevention of Problem Behavior.



In facility-wide positive behavior support, the first tier is primary prevention and involves actively teaching all children and youth within a PRTF a set of social skills and reinforcing them across all educational and residential settings, while all adults respond to the occurrence of problem behavior in a consistent manner. Data systems are modified to increase efficiency for team-based decision making.

The second tier, referred to as secondary prevention, provides facility teams strategies and tools for early identification of children and youth who are at-risk for an escalation of problem behavior over time. Early intervention strategies are implemented at the secondary level to prevent crises from occurring. Tier three, or tertiary prevention strategies, includes individualized and intensive positive behavior support plans for each child in the facility. Planning teams for each facility meet with all staff using consensus-based strategies to design interventions at each prevention level and use data, systems and practices to implement PBS.

Figure 2. Key Elements of Facility-wide Positive Behavior Support.



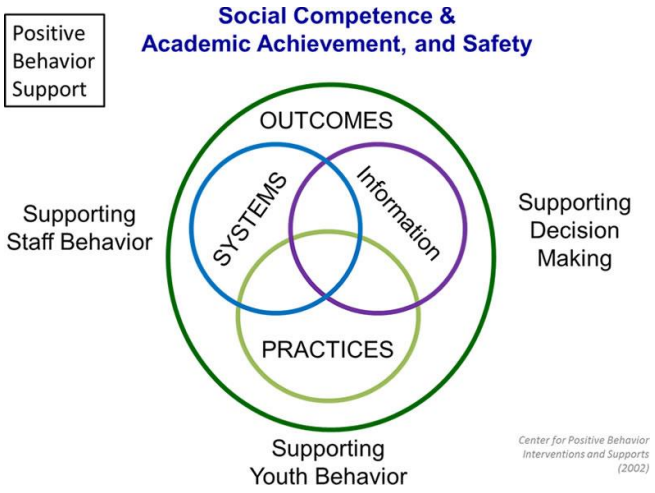
"I just think once they…see the results…that will be boost enough. That was it for me. We were working hard. We were at a crisis and wearing ourself out, job burnout…and staff burnout. It's…like work smarter and not harder."

- Interview with mental health/PRTF participant

Using Data, Systems and Practices to Implement Positive Behavior Support

Figure 3 shows how teams are working together to prevent problem behavior by teaching social competence, increasing safety and promoting academic and vocational achievement. The KMHPBS training helps facilities avoid the *"Train and Hope"* model that relies mainly on individual workshops to share information. Teams meet regularly using data to identify and implement practices for teaching children and youth important social skills. Systems for supporting staff increase the likelihood that practices will be implemented effectively.

Figure 3. Positive Behavior Support and Systems Change: Avoiding the "One-Shot Workshop" Approach.



Positive social and emotional outcomes are achieved by using data gathered within a facility to identify the most important social skills practices that are then taught and systematically reinforced. Children are given the opportunity to practice positive social skills across settings. These practices are put in place with the facility planning team working closely with staff and children. Staff members need opportunities to meet, gain consensus, and build interventions together. Reinforcement for staff members is equally as important since our adults model the social skills we want our children and youth to learn.

Planning teams within PRTF facilities that chose to participate in this team-based training were guided through a self-assessment and action-planning process for embedding positive behavior support. Teams are learning how to:

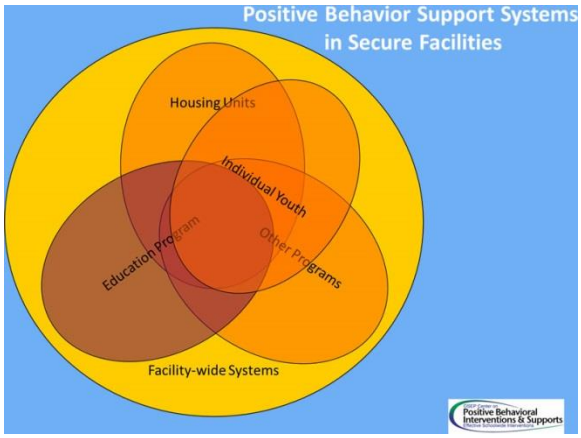
- Work together with all staff to assess the already existing strengths within the facility;
- Identify individuals with experience in wraparound and/or person-centered planning and positive behavior support who can guide ongoing training and staff support;
- Build action plans that will focus on creating positive host environments that will make it easier to assist children and youth in transitioning back into their home community, family, and school settings.

"that's the culture that we've…built here so newer staff come into this culture and they're learning it from day one and they're watching other staff do it. They've learned that one, the kids are happier, and two, their job is a whole lot more fun when you're coming in and building relationships with the kid instead of having to deal…with behaviors all day long."
- Interview with PRTF staff member.

As you can see in Figure 4, an important part of PRTF facility-wide PBS is to assess and intervene across all settings including the educational, residential, and facility-wide settings in which children and youth live and learn. Data collected by the team help show what settings are the most important areas in which to intervene.

PRTF staff members who are already implementing facility-wide positive behavior support have indicated that there are a number of benefits in addition to decreases in problem behavior including better communication across residential and educational settings, more consistent implementation across staff members, and the empowerment of children/youth in the problem solving process.

Figure 4. Interventions are Implemented Across All Parts of the Facility and with Individual Children.



A total of five PRTFs participated in the KMHPBS training (four agencies; one of which has two facilities in different parts of the state. Five professionals (one from each facility) originally enrolled in tertiary level training system. Two PRTF professionals completed the six-month course and completed a case study that will address transition planning to support children moving back into the family home. The two professionals are creating tools, systems, and processes that will be used to support other children transitioning home from the PRTF in the future. *The data for these professionals taking the six month intensive training course will be reported as part of the KIPBS cohort data. Since launch of the six month training was delayed due to problems finalizing the KIPBS contract, these data are still being collected. Final analyses will be available soon for reporting purposes.*

Figure 5. Professionals Participating in a PRTF Team Training.

Figure 6. Example of Social Skills "Matrix" Taught in One Kansas PRTF.

PR-Stars Program

Safety	Trust	Accountable	Respectful	Supportive
Keep hands and feet to self	Follow directions	Let go and move on	Acknowledge others	Take care of self and others
Be where you are supposed to be	Be Honest	Receive feedback openly	Pay attention to others	Reinforce expectations
Follow rules and directions	Be on time	Own your own stuff	Use appropriate language	Give Positive feedback
Maintain Personal space	Take care of your things	Agree to move forward	Say please and thank you	Be open to help others
Report problems to staff	Communicate needs and feelings	Be open to differences	Be Present	Hold others accountable

Teams implementing facility-wide positive behavior support spend the first year conducting the self-assessment and then using these data to establish:

- Universal teaching of social expectations for all children;
- Creating reinforcer systems that reward children for engaging in positive social behavior;
- Improving consistency of responses to the occurrence of problem behavior;
- Modifying the data collection systems to improve data-based decision making using; and incident reports, length of stay, use of restraints, and other related data.

Across the nation, most teams beginning systems-wide positive behavior support spend the first year improving data systems and preparing the launch of universal social skills instruction. Teams establish a "matrix" (see Figure 6) in collaboration with staff and youth that outlines what behaviors are expected by children in each of the different settings within the facility. Staff members systematically teach these social skills, often using the mascot for the facility or a local school system. One mental health professional working in an alternative education center describes the way in which they teach social skills:

> *"It's from ceiling to floor…thing on our…wall of this Prime transformer guy… Prime stands for…Pride…and Respect, Integrity…Making good choices, and Empathy. So…we've got these posters in every location--in the hallway, in the bathroom, in the classroom…in the school bus, in school cafeteria…what does Prime look like in this…location because it might look different…in the bathroom as the cafeteria."*

Figure 7. Matrix from an Alternative Education Program.

"They [students] know what that means and I think that's so awesome that they…They can grasp it and they and they…want to be part of it…they own it…we want them to be proud of the school and…take care of each other…and our building and stuff and they just bought… into it hundred percent so fast. I never would've dreamed it was so fast."

Figure 8. Another Example of PRTF Social Expectations.

Universal Interventions– Behavior Matrix/Behavior education

Respect	Responsibility	Safety
• Acknowledge others • Pay attention to others •Use appropriate language •Say please and thank you	•Follow directions •Be honest •Take care of your things •Be on time •Ask for help when needed •Communicate needs and feelings •Be actively involved in an appropriate way •Dress appropriately for activity	•Keep hands and feet to self •Be where you are supposed to be •Follow rules •Maintain personal space •Report problems to staff

The other major activity involved in primary prevention involves improving data systems so that planning teams can actively use the data gathered to improve positive behavior support implementation, decrease the number of incident reports and the use of restraints, and increase collaboration with

families in order to provide transition planning for children moving back into their home and community.

Table 1. PRTF evaluation data using the Campus Evaluation Tool (CET).

Campus Wide Evaluation Sub-scores	Expectations Defined	Behavioral Expectations Taught	On-going System of Rewarding Behavioral Expectations	System for Responding to Behavioral Violations	Monitoring and Decision-Making	Management	Administrative Support
PRTF 1	**25%**	**60%**	**100%**	**38%**	**50%**	**63%**	**50%**
PRTF 4	**75%**	**60%**	**83%**	**38%**	**50%**	**63%**	**100%**
PRTF 5	**0%**	**50%**	**80%**	**75%**	**100%**	**69%**	**100%**

Evaluating the Effectiveness of the PRTF Facility-wide Implementation efforts

PRTFs were evaluated using the Campus-wide Evaluation Tool (CET). The CET was based on a SWPBS tool with established psychometric properties. Modifications were used in order to evaluate residential and day treatment settings. The adapted version of the CET was piloted in one of the PRTFs and then administered in three of the five facilities. Scheduling problems resulted in delays in completing the CET in the two remaining PRTFs prior to December 31, 2013.

The CET takes approximately five hours to complete. A trained evaluator interviews administrators and a range of staff from program managers to direct support youth care workers. Youth within the facility are also interviewed. The onsite visit includes observations conducted at the facility to evaluate the extent to which positive behavior support is implemented. Record reviews are completed (e.g. policy and procedure manuals, staff handbooks, youth/resident handbooks, examples of incident reports, and evidence of social skills training or other strategies used with youth and staff). Example of items on the CET that are evaluated include *Does the team have an action plan with specific goals that is less than a year old?* and *Can at least 70% of 15 or more youth state 67% of the campus social expectations?* The CET is scored by assigning values of 0, 1, or 2 to each item (depending on the level of implementation). Then percentage scores are assessed on the subscale items seen in Table 1 above. The total score is determined by the percentage of subsections scoring 80% or higher.

The CET in Table 1 provides a summary where facilities were with respect to positive behavior support implementation in the first year one of the project. Most organizations have a relatively lower score on the CET during the first year as the team is working on implementing interventions to increase the use of positive behavior support in the facility. The data in Table 1 are considered a baseline since most of the PRTFs are using this year to create interventions that take time to be implemented. Next year's data will show the progress made by the PRTFs on positive behavior support implementation. In addition, data are usually modified and reported by the end of the first year. Therefore, PRTFs will be implementing

modified data systems for monitoring problem behavior at the beginning of the next implementation year.

A Team Implementation Self-assessment Checklist was developed for use in the PRTF trainings. This tool aligns with the CET so that teams can continually assess progress in implementing positive behavior support. There are a total of 22 items included in the PRTF Team Implementation Checklist (TIC). For each item, coaches for each team enter a "0" if the action had not yet started, "1" for actions that were in process but not completed, and "2" for items that had been completed. Examples of items on the TIC include: *Team has regular meeting schedule, effective operating procedures* and *Faculty-wide behavioral expectations taught directly & formally.*

Figure 10. Self-assessment Scores on the TIC Across Four PRTF Teams.

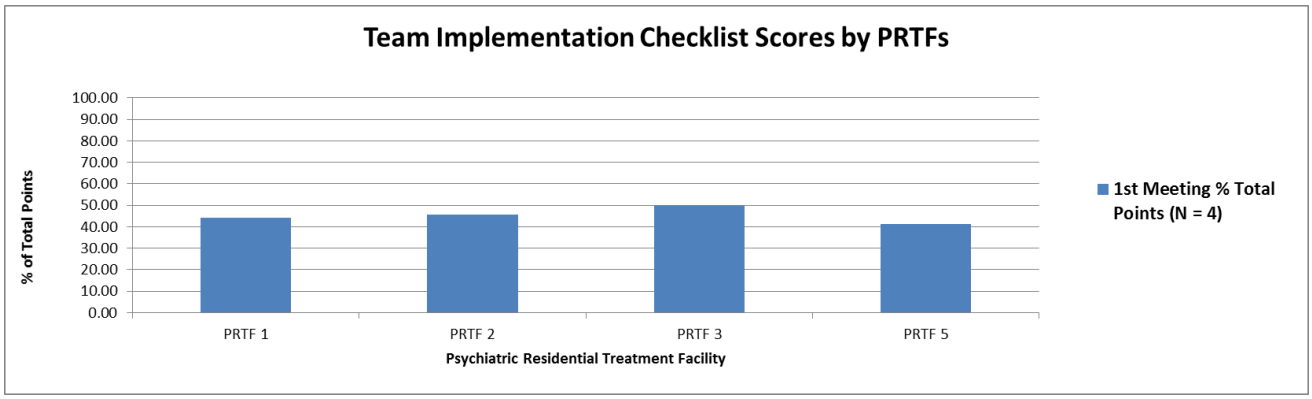
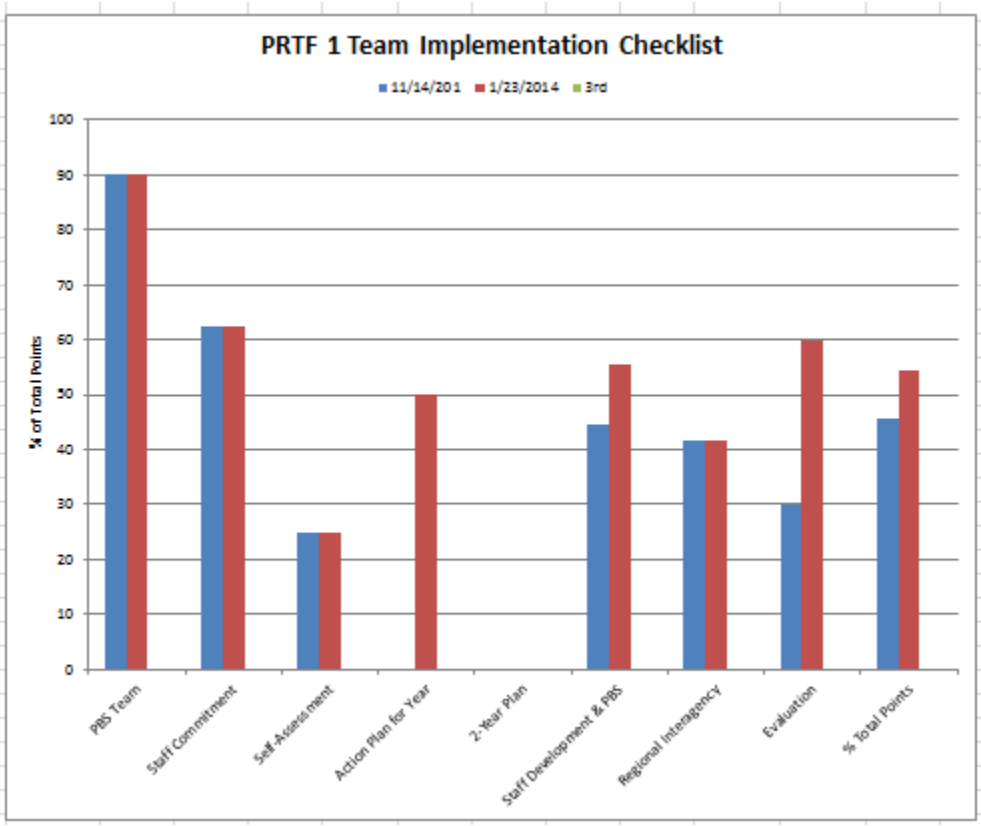


Figure 10 summarizes progress reported by teams on the TIC. The "y" axis shows the overall average percent completed overall on the TIC. The "x" axis indicates the different PRTFs completing the TIC. Figure 10 shows the TIC data used by the individual PRTF during team meetings. The y axis shows the overall average percent completed on each subscale item of the TIC as well as the overall average percent score. The x axis lists the subscale items for each part of the TIC. One PRTF chose not to complete the TIC during the project.

The graph in Figure 11 shows that the PRTF team members make decisions using the TIC data. For instance, you can see in Figure 11 that the team completed the one year action plan for the facility during the second meeting on January 22, 2014. PRTF team members can also see that they still need to start working on a two-year plan for establishing positive behavior support over time.

Figure 11. Example of Results for the TIC Completed by a PRTF.



Progress Establishing Data Systems For Team-based Problem Solving

Each PRTF has its own systems for collecting data on problem behavior and often these organizations have invested in programs that allow for a wide array of documentation. The goal of the facility-wide positive behavior support process is to ensure that the data that are collected are easy to access for team-based meetings and provide the type of information that allows the facility to implement interventions to directly address problems.

Figure 12. Key Types of Data for Team-based Problem-solving: The Big Five.

At the primary prevention level, the types of data gathered are meant to provide an overall view of problem behaviors occurring with the PRTF. Figure 12 shows the type of data that are needed at this larger-facility-wide level:

1. How often do problems occur?
2. Where are behaviors reported?
3. What types of problems are reported?
4. Are there times of day that most difficult?
5. Which children are engaging in the problem behaviors?

Average behavioral incidents occurring per day per month within the facility may lead the team to evaluate the types of children that were served during that period and to investigate the reasons why problems might be higher during certain times of the year. For instance, the team may find that staff members need additional training to effectively prevent problem behavior when there are higher numbers of children in the PRTF engaging in problem behavior maintained by attention. Staff may have more problems working with these children, especially during quiet times in the evening routine. The team will use this information to provide inservice training to staff members to help provide proactive strategies for preventing attention-seeking behavior in the evenings.

Once the PRTF has established a data system, teams learn to use the information in Figure 12 to design interventions that directly address problems occurring within the facility. Teams use the data gathered to decide what types of social skills instruction would be most important for the facility. For instance, if the type of problem behavior observed most frequently is aggression towards other children, the PRTF staff

members will increase social skills instruction and provide additional opportunities to practice new skills to address this issue.

During the first year of training, it is important for PRTFs to carefully assess the data systems that are already in place. Administrators work with the PRTF team to find ways to provide the data to staff that are described in Figure 10. While those efforts are occurring, the team works with all staff members to increase consistency across the facility. Staff members work together to create a plan for documenting the data observed and reporting it using new or modified data collection systems. For this reason, data systems for PRTFs are usually launched in year two of the implementation process. PRTFs participating in the project were given the opportunity to learn about how other alternative settings are using a software program for tracking data called the SWIS software program. The next section describes the SWIS training in more detail.

Software Program for Data-based Decision Making: SWIS

A total of eight staff from PRTFs received training in a software program originally designed for schools but used by a number of alternative treatment programs nationally. This program called the School-wide Information System (www.swis.org) provides a way in which to collect data on frequency of incident reports. Professionals attending this two and a half day certification training learned how to use, teach, and manage the software program for teams to use for decision making. The PRTFs used this training to assess the current data systems and consider how to proceed with changes to improve data based decision making within the PRTF.

Why Consistency is Important

- ***"...if there's not a consistency across the board with staff, then there's no way there can be a consistency with a child."***

  - Interview with Mental Health/PRFT Participant

- ***"When you're talking about residential treatment, you're talking about three shifts worth of people. So, when you're talking about consistency, if my 2 days off, and this has happened, Johnny X is a wonderful child on first shift from 7:00 to 3:00, because I work on the first shift from 7:00 to 3:00 and Johnny is in my group for first shit, from 7:00 to 3:00. However, on second shift, his entire world is different because he has a different staff and a different staff creates a different climate – that's a different culture in a residential facility. So you may have 2 or 3 different cultures going on in one building where kids have to acclimate to different things."***

  - Interview with Mental Health/PRTF Participant

Kansas Mental Health Positive Behavior Support

Appendices

The following appendix items are included in this report

I. *Map of KMHPBS Training Activities*

II. *CMHC Participation Table*

III. *Matrix of Intensive Level Course Outline*

IV. *45 Item PBS-PCP Checklist*

V. *Campus-wide Evaluation Tool*

The following can be found online at www.kmhpbs.org.

VI. *Example of Systems Change Project*

VII. *Team-Based Self-Assessment and Planning Tool*

VIII. *Assessment of Staff Development Needs Tool*

IX. *Annual Planning Tool*

X. *2 Year Planning Tool*

XI. *Assessment of Technology Needs*

XII. *Community Mapping Tool*

XIII. *Evaluation Data from Awareness Level Onsite Events*

XIV. *Links to PBS Online Modules*

XV. *PBS Talking Points Brochure*

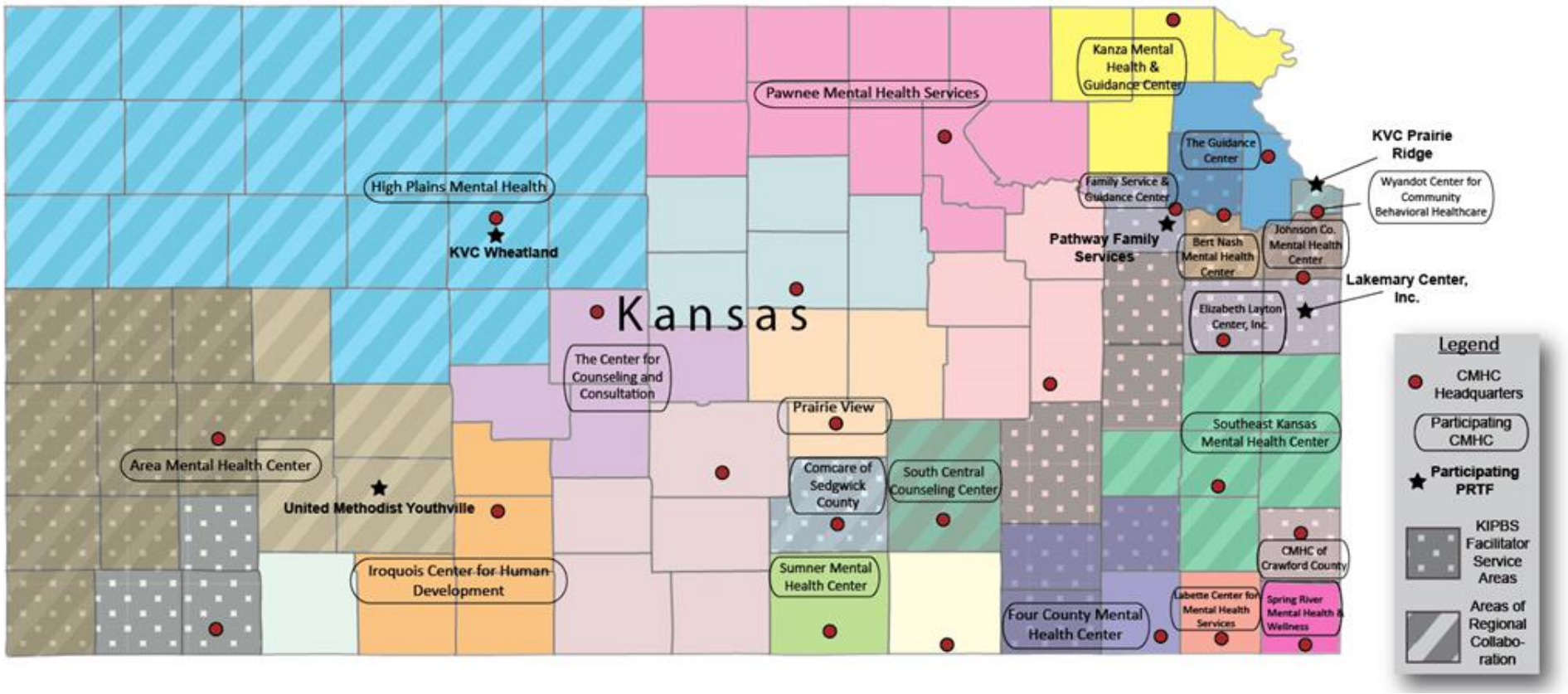
XVI. *KMHPBS Case Study Selection Tool*

XVII. *KMHPBS Case Study Referral Process Overview*

XVIII. *Updated Pre-Post Survey of PBS Knowledge*

XIX. *KMHPBS Project Overview Glossies*

Appendix Item I. Map of KMHPBS Training Activities



Appendix Item II: Table showing CMHC participation levels. Column 2 represents the layers of the project in which the corresponding CMHC was subcontracted to participate and the minimum number of staff each agreed to train as part of their subcontract.

CMHC	Level of Participation
Area Mental Health Center	Awareness (30); Intermediate; Regional; Intensive (2)
Bert Nash Community Mental Health Center	Awareness (15); Intermediate; Regional; Intensive (2)
Center for Counseling and Consultation	Awareness (30); Intermediate; Intensive
Comcare of Sedgwick Co.	Awareness (30); Intermediate; Regional; Intensive (2)
Crawford County Community Mental Health	Awareness (25); Intermediate; Intensive
Elizabeth Layton Center	Awareness (10); Intermediate; Intensive
Johnson County MHC	Awareness (30); Intermediate; Regional; Intensive (2)
Family Service and Guidance Center	Awareness (30); Intermediate; Intensive
Four County Mental Health	Awareness (9); Intermediate; Intensive
High Plains Mental Health	Awareness (30); Intermediate; Regional; Intensive (2)
Iroquois Center for Human Development, Inc	Awareness (6); Intermediate; Intensive
Kanza MH & Guidance Center	Awareness (25); Intermediate; Intensive
Labette Center for MH Services	Awareness (10); Intermediate; Intensive
Pawnee Mental Health Services	Awareness (6); Intermediate; Intensive
Prairie View, Inc.	Awareness (30); Intermediate; Intensive
South Central MH Counseling Center	Awareness (30); Intermediate; Regional; Intensive (2)
Southeast Kansas MHC	Awareness (15); Intermediate; Regional; Intensive (2)
Spring River Mental Health & Wellness	Awareness (13); Intermediate; Intensive
Sumner Mental Health Center	Awareness (23); Intermediate; Intensive
The Guidance Center	Awareness (30); Intermediate; Regional; Intensive (2)
Wyandot Center- PACES, Inc.	Awareness (30); Intermediate; Regional; Intensive (2)

Appendix Item III. Matrix of Onsite and Online Intensive level Courses

KMHPBS Cohort MH					
Module	Content	Location	Dates	Instructors/Regional Trainers	Format
0-1	Pre-service on Adobe Connect & Blackboard/Intro to PBS	Kickoff (Wichita)	4/26/13 (KMHPBS)	All	Month 1--onsite—large group format
2 + 3	Introduction to ABA/PCP	Online	Week of May 13th Monday 11-1, Wednesday 9-11, Friday 1-3 (Choose one)	KU Staff	Month 2-online
2 + 3	Introduction to ABA /PCP	Onsite	May 31st	All	Month 2-onsite class
4 + 5	Measurement & Design/FBA	Online	Week of June 10th Monday 11-1, Wednesday 9-11, Friday 1-3 (Choose one)	KU Staff	Month 3-online
4 + 5	Measurement & Design /FBA	Onsite	June 28th	All	Month 3-onsite class Mid-term Exam Available *Midterm Exam due July 12th
6 + 7	Designing PBS Plans/Multi-component Interventions	Online	Week of July 15th Monday 11-1, Wednesday 9-11, Friday 1-3 (Choose one)	KU Staff	Month 4-online
6 + 7	Designing PBS Plans/Multi-component Interventions	Onsite	August 2nd	All	Month 4-onsite class Mid-term Exam Returned
8 + 9	Emotional & Behavioral Health/System Change	Online	Week of August 12th Monday 11-1, Wednesday 9-11, Friday 1-3 (Choose one)	KU Staff	Month 5-online
8 + 9	Emotional & Behavioral Health/System Change	Onsite	August 30th	All	Month 5-onsite class Final Exam Available
Additional (Optional)	Case Studies	Onsite	Week of September 9th	All	Month 6-onsite (3hrs) *Final Exam due Sept. 13th
10	KIPBS Facilitator Guidelines	Final Celebration	9/27/13 (KMHPBS)	All	Month 6—onsite--large group format Final Exam Returned
Case Studies	Mock Case Study Begins		Month 2 (May 2013)		
Case Studies	Mock Case Study Due		Month 6 (Sept. 2013)		
Case Studies	Live Case Study Begins		Month 5 (Aug. 2013)		
Case Studies	Continued Case Study Classes (Optional if needed)	Onsite	October & November		
Case Studies	Complete Live Case Study		By Nov. 29th 2013		

Appendix Item IV. 45 Item PC-PBS Checklist

KIPBS
Kansas Institute for Positive Behavior Support

Person-Centered Positive Behavior Support Plan (PC-PBS) Report Scoring Criteria & Checklist (2-9-12)

Name: _____ Case Name: _____ Case #: ___ Rater: _____ Date: _____

Critical Features			
Note: The plan needs to meet all of the critical features listed below, and needs to obtain a score of 2 for items # 27, 36, 37,41, & 42 in order to be considered for passing			
CF1	**Interventions selected employ validated procedures**	**Y**	**N**
CF2	**Preferred lifestyle goals attempt to increase quality of life, not simply maintain it**	**Y**	**N**
CF3	**The plan is designed to make a meaningful positive difference in the life of the individual**	**Y**	**N**
CF4	**The plan clearly reflects the values and beliefs (philosophy, standards, & foundation) of KIPBS**	**Y**	**N**
CF5	**The plan has obtained a score of 2 on items 21, 24, 25, 29, & 30**	**Y**	**N**

Instructions - Please rate each of the following questions by circling either **0**, **1**, or **2** according to each question's criteria

IDENTIFYING INFORMATION				
1.	**Identifying info. is complete (facilitator name, consumer name, address, DOB, age, contacts, referral source)** 2 = All identifying information is provided including name of person writing the report, consumer's name, address, DOB, age, contacts, and referral source 1 = Some of the above identifying information is included but not all 0 = With the exception of the consumer's name, there is no identifying information included that is relevant to the plan	**2**	**1**	**0**
GENERAL INFORMATION				
Consumer Information – (GENERAL Information)				
2.	**A brief history of the consumer's life is provided** 2 = There is a description of the consumer's history, which includes health issues, behavioral issues, diagnoses, living situations, moves, and community involvement. If particular events do not apply, it is so stated. 1 = Some events are described, or there is a diagnosis provided, but the information is limited 0 = There is no information provided regarding the consumer's history	**2**	**1**	**0**
3.	**Important places for the consumer at school/work, home, and in the community are described** 2 = Important places for the consumer, at school/work, home and in the community are described in general 1 = Some places are listed, but the information is limited (e.g. does not address each setting listed above) 0 = There is no information provided regarding important places for the consumer	**2**	**1**	**0**
4.	**The consumer's strengths are described** 2 = Several specific consumer's positive behaviors, skills, and strengths are described 1 = Some positive behaviors, skills, or strengths are described but the information is limited 0 = There is no information provided regarding the consumer's positive behaviors, skills, or strengths	**2**	**1**	**0**
5.	**The consumer's preferred method of communication is described** 2 = The consumer's mode of communication is described as well as any possible issues related to communication and problem behavior 1 = Incomplete information is provided regarding the consumer's mode of communication 0 = There is no information provided regarding the consumer's mode of communication or strategies related to communication	**2**	**1**	**0**
6.	**Opportunities for choice in the consumer's current environment are described** 2 = There is a specific description of the consumer's opportunities to make choices in at least 3 areas throughout the day. If there are areas in which opportunities for choice are limited, these are listed. (Need to mention "choice") 1 = The description of opportunities to make choices addresses less than 3 areas. (Need to mention "choice") 0 = The issue of opportunities to make choices is not addressed (there is not mention "choice").	**2**	**1**	**0**
7.	**Current health and physiology issues are described** 2 = Current health status, including chronic and/or acute medical issues, medication, and necessary adaptive equipment, is described. If the consumer is in good health, it is so stated. 1 = Incomplete information is provided regarding current health status issues, including medication information	**2**	**1**	**0**

	0 = There is no information regarding current health status			
8.	**Current schedules and routines are described (quality, predictability)** 2 = There is a general description of the person's daily schedule and routines, which includes quality, choice, variety, and predictability, in general 1 = There is some information provided regarding regularly scheduled activities but there is no mention of how predictable they are or how enjoyable they are 0 = There is no information provided regarding the consumer's daily activity schedule	**2**	**1**	**0**
Reason For Referral				
9.	**Behavioral and/or environmental issues are identified** 2 = A detailed description of the consumer's problem behavior and the environmental context in which it occurs is provided 1 = A limited description of the consumer's problem behavior is provided, but no information is provided about the contexts or situations in which it occurs, or why it is a problem 0 = There is no information provided regarding why the person has been referred to for services	**2**	**1**	**0**
PART 1 – ASSESSMENT				
Understanding Consumer Preferred Future Lifestyle – (SPECIFIC Information)				
10.	**Planning and assessment participants are listed** 2 = Planning and assessment participants' names and their functions are listed 1 = There is a description of who participated in the planning and assessment, but it is incomplete (either not all participants are listed or their function is unknown) 0 = There is no mention about who participated in the planning and assessment	**2**	**1**	**0**
11.	**A global statement of the consumer's dreams is made** 2 = There is a global statement about what the consumer's dreams for the future are 1 = There is a statement about what the consumer's dreams for the future are, but it is not very clear 0 = There is no mention about what the consumer's dreams for the future are	**2**	**1**	**0**
12.	**Type of preferred living setting for the consumer is described** 2 = The consumer's preferred living setting is clearly identified and there is a statement regarding how this information was gathered 1 = The consumer's preferred living setting is identified but there is no information about how this was assessed 0 = The consumer's preferred living setting is not identified	**2**	**1**	**0**
13.	**With whom the consumer wants to socialize is clearly stated** 2 = Specific people the consumer wants to socialize with are clearly identified and there is a statement regarding how this information was gathered 1 = With whom the consumer wants to socialize is identified but there is no information about how this was assessed 0 = With whom the consumer wants to socialize is not identified	**2**	**1**	**0**

14.	**Social, leisure, or religious activities the consumer wants to participate in are described** 2 = Specific social, leisure, or religious activities the consumer wants to participate in are clearly identified and there is a statement regarding how this information was gathered 1 = What social, leisure, or religious activities the consumer wants to participate in are identified but there is no information about how this was assessed 0 = What social, leisure, or religious activities the consumer wants to participate in are not identified	**2**	**1**	**0**
15.	**Barriers to achieving Preferred Future Lifestyle are described** 2 = Possible barriers for the consumer to achieve his/her Preferred Future Lifestyle are identified, there is a statement regarding why it is thought that this may be a barrier and for what area this it may be a barrier 1 = Possible barriers for the consumer to achieve his/her Preferred Future Lifestyle are identified, but there is not mention as to why it is thought that this may be a barrier or for what area this it may be a barrier 0 = Possible barriers for the consumer to achieve his/her Preferred Future Lifestyle are not identified	**2**	**1**	**0**
Functional Assessment				
16.	**<u>Indirect</u> assessment data include at least 2 of the following (tools used & results are described):** **□ Caretaker interviews □ Record reviews □ Preferred Future Lifestyle information** **□ Assessment tools used to collect quality of life, setting events, & other related information** 2 = Results from at least 2 of the information gathering methods listed above are described. If specific tools are used, these are described, and their results are explained (e.g., mood scales). 1 = All the information is provided regarding results from only one of the assessment methods listed above, or results from tools used are explained but the tools themselves are not described, or results are listed but not explained. 0 = No information regarding results from any of the assessment methods listed above is provided (even if it is listed that such assessments were conducted)	**2**	**1**	**0**
17.	**Data from 3-5 student conducted direct observations are described** 2 = The student conducted three or more observations of the consumer, and the observations are described or the data are provided	**2**	**1**	**0**

	1 = The student conducted less than three observations of the consumer and the observations are described or the data are provided 0 = No observations were conducted or observations are not described and the data for such are not provided			
18.	**Problem behaviors are operationally defined; definitions are clear** 2 = For each problem behavior targeted (or behavior class) there is a clear operational definition, devoid of subjective and/or circular terms 1 = There is a definition, but it is unclear or incomplete or only some of the targeted problem behaviors are defined 0 = There is no definition provided regarding any problem behavior	**2**	**1**	**0**
19.	**Baseline data are clearly graphed (include labels, axis values, titles, and legend)** 2 = Baseline data are clearly graphed (no more than 3 behaviors in one graph), and the graph provided includes labels, axis values, titles and a legend 1 = Baseline data are clearly graphed (no more than 3 behaviors in one graph) and the graph has some but not all of its components 0 = Baseline data are not graphed or the graph is not clear (more than 3 behaviors in one graph)	**2**	**1**	**0**
20.	**Hypothesis statement is provided for each function of the problem behavior(s)** 2 = A hypothesis is described for every function of the problem behavior(s) listed (or behavior class). If multiple behaviors serve the same function, they can be listed together. If the same behavior serves different functions, there are separate hypothesis statements for each function. 1 = A hypothesis is described for some but not all of the functions and/or problem behaviors (or behavior class) 0 = There is no hypothesis statement	**2**	**1**	**0**
***21.**	**Data to support each hypothesis statement are presented** 2 = There are data provided in some format (graph, table, list, interview summary) that specifically support each hypothesis statement 1 = There are data provided, but it is unclear whether they support a specific hypothesis or not 0 = Either there are no data presented or the data that are presented do not support the hypotheses listed	**2**	**1**	**0**

IDENTIFYING INFORMATION, GENERAL INFORMATION, & PART 1 – ASSESSMENT

Total Points Earned (21 Items) = _____ **PERCENT** = [_____ / 42] X 100% = _____ %
(Total Points Earned)

PART 2 – INTERVENTIONS AND SUPPORTS

Preferred Lifestyle Interventions

22.	**Goals or skills to be achieved are described** 2 = The goals or skills to be achieved are clearly described 1 = The goals or skills to be achieved are listed but are not clearly described 0 = There is no mention about the goals or skills to be achieved	**2**	**1**	**0**
23.	**Plan outlines how achievement of goals or skills will be assessed** 2 = Exactly which data are to be collected, and how they will be collected, to assess goal achievement, is stated 1 = It is unclear which data will be collected or how they will be collected or which will be used to assess goal achievement 0 = There is no mention of data collection of any kind to assess goal achievement	**2**	**1**	**0**

Function Based Interventions

***24.**	**Possible function of problem behavior is addressed** 2 = The interventions selected include a description of how they address all the function(s) of the problem behavior(s) 1 = The interventions selected do not completely address the function(s) of the problem behavior(s) 0 = The interventions selected are unrelated to the function(s) of problem behavior(s)	**2**	**1**	**0**
***25.**	**Teaching of adaptive skills as replacement behavior is included** 2 = There is a portion of the intervention that addresses reinforcing or teaching adaptive skills to replace problem behavior 1 = The intervention plan notes that replacement behaviors should be reinforced but there is no description of how this would be done or there is no description of specific replacement behaviors to target 0 = There is no mention of target replacement behavior	**2**	**1**	**0**
26.	**Replacement behaviors are operationally defined** 2 = For each replacement behavior there is a clear operational definition that is appropriate for any caretaker to use to collect direct observation data 1 = There is a definition but it is unclear or incomplete or only some of the replacement behaviors are defined 0 = There is no definition provided regarding any replacement behavior	**2**	**1**	**0**
27.	**Each part of the hypothesis statement (setting event, antecedent, behavior, & consequence) is addressed** 2 = There are specific components of the intervention that address each portion of the hypothesis statement and include setting events, antecedents, teaching new skills, and consequences of the behavior 1 = Some of the components of the hypothesis statement are addressed but not all 0 = The intervention does not address the hypothesis statement at all	**2**	**1**	**0**
28.	**Environmental interventions address at least 3 of the following:**	**2**	**1**	**0**

	□ **Opportunities for choice** □ **Schedule predictability** □ **Instructional/ interaction approaches** □ **Prompts for appropriate behavior** □ **School or day program curriculum** 2 = The intervention addresses at least three of the above listed environmental issues 1 = The intervention addresses less than one or two of the above listed environmental issues 0 = The intervention does not address any of the above listed environmental issues			
***29.**	**Minimizing positive and/or negative reinforcement for problem behavior is included** 2 = The intervention specifically describes how to minimize positive or negative reinforcement for the problem behavior 1 = The intervention notes that reinforcement for problem behavior should be minimized but does not describe how this should be done 0 = The intervention does not include a component to minimize positive or negative reinforcement for problem behavior	**2**	**1**	**0**
***30.**	**Selecting effective reinforcers and/or maximizing positive reinforcement for appropriate behavior is included** 2 = The intervention includes specific reinforcers for appropriate behavior and describes how/when these will be used 1 = The intervention includes a positive reinforcement component but it is too general or does not describe how to implement it (e.g. Praise appropriate behavior) 0 = The intervention does not include a description of any positive reinforcers that could be used	**2**	**1**	**0**
31.	**Safety/emergency procedures for what to do if/when crisis occurs is addressed** 2 = There is a specific crisis intervention plan described and the components are appropriate given the severity of the behavior. If safety/emergency procedures are not necessary, it is so stated. 1 = There is a crisis plan noted but the description is incomplete or it is inappropriate given the severity of the behavior 0 = There is no crisis plan noted and the severity of the behavior warrants one	**2**	**1**	**0**
32.	**Training needs are identified and/or system of support is established** 2 = There is an explicit plan to address the abilities of the caretakers regarding the types of additional training they may need or other issues related to supporting the consumer 1 = Training issues are noted but there is no explicit plan for addressing them or it is unclear how the plan address the needs of the caretakers 0 = There is no mention of training or issues of support for the caretakers in the plan	**2**	**1**	**0**

General Intervention Considerations/ Contextual Fit				
33.	**Process for monitoring the intervention plan is described:** □ **Timeline for meetings** □ **What needs to be done** □ **When** □ **By whom (responsibilities)** 2 = There is a specific process described for the team to meet and for specific individuals to monitor the plan 1 = It is noted that the plan will be monitored regularly, but there are no specific details regarding how it will be done 0 = There is no indication that the plan will be monitored at all	**2**	**1**	**0**

PART 2 – INTERVENTIONS AND SUPPORTS

Total Points Earned (12 Items) = _____ **PERCENT** = [_____ / 24] X 100% = _____ %
(Total Points Earned)

PART 3 – FOLLOW-UP				
Preferred Lifestyle Interventions Follow-up				
34.	**Evaluation of achievement of goals or skills includes (at least 1):** □ **Number of goals or skills achieved** □ **Other measures of achievement of goals or skills** 2 = For each goal, there is a measure of some sort provided, regarding goal status 1 = Goal status is discussed, but there is not specific measure provided, or not all goals are addressed 0 = There is no mention of goal status	**2**	**1**	**0**
Function Based Interventions Follow-up				
35.	**Baseline and intervention data for each target behavior are graphed** 2 = All target behaviors are graphed and graph(s) depict(s) both baseline and intervention data 1 = There is a graph, but not all target behaviors are graphed, or graph does not include either baseline or intervention data 0 = There is no graph	**2**	**1**	**0**
36.	**Graphs are clear (include labels, axis values, titles, and legend)** 2 = The graph provided (no more than 3 behaviors in one graph) includes labels, axis values, titles and a legend 1 = The graph has some but not all of its components 0 = There is no graph or it the graph is not clear	**2**	**1**	**0**
37.	**Indirect or direct measures of replacement behavior are provided** 2 = Either direct or indirect measures of changes in the replacement behavior are provided 1 = Replacement behavior change is discussed, but there is no mention of actual direct or indirect measures of it 0 = There is no mention of replacement behavior change	**2**	**1**	**0**

38.	**Data provided support statement(s) regarding the effectiveness of interventions** 2 = There are data provided in some format (graph, table, list,) that specifically support the statements made regarding intervention effectiveness 1 = There are data provided, but it is unclear whether they support the statements made regarding intervention effectiveness 0 = Either there are no data presented or the data that are presented do not support the statements made regarding intervention effectiveness	**2**	**1**	**0**

Continuous Evaluation				
39.	**Process for continuing to monitor the intervention plan is described:** **□ Timeline for meetings □ What needs to be done □ When □ By whom (responsibilities)** 2 = There is a specific process described for the team to meet and for specific individuals to monitor the plan 1 = It is noted that the plan will be monitored regularly, but there are no specific details regarding how it will be done 0 = There is no indication that the plan will be monitored at all	**2**	**1**	**0**
40.	**Plan for sustainability includes:** **□ Plan for transitions or major setting events and/or □ Training plan for new staff** 2 = There is a long term plan for how the intervention will be kept going including addressing possible transitions or major life changes 1 = It is mentioned that the implementation of the intervention plan will continue but there is no indication of how possible transitions or major life changes will be addressed 0 = There is no mention of long-term plans for sustaining the intervention	**2**	**1**	**0**
PART 4 – ATTACHMENTS				
41.	**Sample fidelity checklist** 2 = Sample fidelity checklist is included and accurately portrays program procedures 1 = Sample fidelity checklist is included but is inaccurate, incomplete, or unclear 0 = Sample fidelity checklist is not included	**2**	**1**	**0**
42.	**KIPBS Intervention & Supports Plan At-A-Glance sheet (not need to be labeled "KIPBS")** 2 = At-A-Glance sheet is included and accurately portrays information and important program information (i.e. Do's and Don'ts) 1 = At-A-Glance sheet is included but is inaccurate, incomplete, unclear, or only addresses what to do when problem behavior occurs 0 = At-A-Glance sheet is not included	**2**	**1**	**0**
43.	**Contextual Fit Survey** 2 = Completed Contextual Fit surveys are included for at least 2 different team members (2 separate surveys) 1 = Completed Contextual Fit survey is included for only one team member 0 = There were no completed Contextual Fit surveys	**2**	**1**	**0**
44.	**Quality of Life Evaluation Survey** 2 = Completed Quality of Life Evaluation surveys are included for at least 2 different team members (2 separate surveys) 1 = Completed Quality of Life Evaluation survey is included for only one team member 0 = There were no completed Quality of Life Evaluation surveys	**2**	**1**	**0**
45.	**PCP Satisfaction Survey** 2 = Completed PCP Satisfaction surveys are included for at least 2 different team members (2 separate surveys) 1 = Completed PCP Satisfaction survey is included for only one team member 0 = There were no completed PCP Satisfaction surveys	**2**	**1**	**0**

PART 3 – FOLLOW-UP & PART 4 – ATTACHMENTS

Total Points Earned (12 Items) = _____ **PERCENT** = [_____ / 24] X 100% = _____ %

(Total Points Earned)

ENTIRE CASE STUDY

Total Points Earned = _____ **PERCENT** = [_____ / 90] X 100% = _____ %

(Total Points Earned)

Campus-wide Evaluation Tool (CET)

Overview

Purpose of the CET

The Campus-wide Evaluation Tool (CET) is designed to assess and evaluate the critical features of Campus-wide effective behavior support for a PRTF**.** The CET results are used to:

1. assess features that are in place,
2. determine annual goals for Campus-wide effective behavior support,
3. evaluate on-going efforts toward Campus-wide behavior support,
4. design and revise procedures as needed, and
5. compare efforts toward Campus-wide effective behavior support from year to year.

Information necessary for this assessment tool is gathered through multiple sources including review of permanent products, observations, and staff (minimum of 10) and youth (minimum of 15) interviews or surveys. There are multiple steps for gathering all of the necessary information. The first step is to identify someone at the PRTF as the contact person. This person will be asked to collect each of the available products listed below and to identify a time for the CET data collector to preview the products and set up observations and interview/survey opportunities. Once the process for collecting the necessary data is established, reviewing the data and scoring the CET averages takes two to three hours.

Products to Collect

1. _____	Discipline handbook
2. _____	PRTF improvement plan goals
3. _____	Annual Action Plan for meeting campus-wide behavior support goals
4. _____	Social skills instructional materials/ implementation time line
5. _____	Behavioral incident summaries or reports (e.g., incident reports,

Using CET Results

The results of the CET will provide PRTFs with a measure of the proportion of features that are 1) not targeted or started, 2) in the planning phase, and 3) in the implementation/ maintenance phases of development toward a systems approach to campus-wide effective behavior support. The CET is designed to provide trend lines of improvement and sustainability over time.

Campus-wide Evaluation Tool
(CET)
Implementation Guide

Facility _____ **Date** _____

District _____ **State** _____

Step 1: Make Initial Contact

A. Identify PRTF contact person & give overview of CET page with the list of products needed.
B. Ask when they may be able to have the products gathered. Approximate date: _____
C. Get names, phone #'s, email address & record below.

Name_____ Phone_____

Email_____

Products to Collect

1. _____ Discipline handbook
2. _____ PRTF improvement plan goals
3. _____ Annual Action Plan for meeting campus-wide behavior support goals
4. _____ Social skills instructional materials/ implementation time line
5. _____ Behavioral incident summaries or reports (e.g., incident reports, behavior discipline information)
6. _____ discipline referral form(s)
7. _____ Other related information

Step 2: Confirm the Date to Conduct the CET

A. Confirm meeting date with the contact person for conducting an administrator interview, taking a tour of the campus while conducting youth & staff interviews, & for reviewing the products.
Meeting date & time: _____

Step 3: Conduct the CET

A. Conduct administrator interview.
B. Tour school to conduct observations of posted school rules & randomly selected staff (minimum of 10) and youth (minimum of 15) interviews.
C. Review products & score CET.

Step 4: Summarize and Report the Results

A. Summarize surveys & complete CET scoring.
B. Update school graph.
C. Meet with team to review results.
Meeting date & time: _____

Campus-wide Evaluation Tool
(CET)
Scoring Guide

Facility _____ **Date** _____

District _____ **State** _____

Pre _____ **Post** _____ **CET data collector** _____

Feature	Evaluation Question	Data Source (circle sources used) P= product; I= interview; O= observation		Score: 0-2
A. Expectations Defined	1. Is there documentation that staff has agreed to 5 or fewer positively stated campus rules/ behavioral expectations? (0=no; 1= too many/negatively focused; 2 = yes)	Discipline handbook, Instructional materials Other _____	**P**	
	2. Are the agreed upon rules & expectations publicly posted in 8 of 10 locations? (See interview & observation form for selection of locations). (0= 0-4; 1= 5-7; 2= 8-10)	Wall posters Other _____	**O**	
B. Behavioral Expectations Taught	1. Is there a documented system for teaching behavioral expectations to youth on an annual basis? (0= no; 1 = states that teaching will occur; 2= yes)	Lesson plan books, Instructional materials Other _____	**P**	
	2. Do 90% of the staff asked state that teaching of behavioral expectations to youth has occurred this year? (0= 0-50%; 1= 51-89%; 2=90%-100%)	Interviews Other _____	**I**	
	3. Do 90% of team members asked state that the campus-wide program has been taught/reviewed with staff on an annual basis? (0= 0-50%; 1= 51-89%; 2=90%-100%)	Interviews Other _____	**I**	
	4. Can at least 70% of 15 or more youth state 67% of the campus rules? (0= 0-50%; 1= 51-69%; 2= 70-100%)	Interviews Other _____	**I**	
	5. Can 90% or more of the staff asked list 67% of the campus rules? (0= 0-50%; 1= 51-89%; 2=90%-100%)	Interviews Other _____	**I**	
C. On-going System for Rewarding Behavioral Expectations	1. Is there a documented system for rewarding youth behavior? (0= no; 1= states to acknowledge, but not how; 2= yes)	Instructional materials, Lesson Plans, Interviews Other _____	**P**	
	2. Do 50% or more youth asked indicate they have received a reward (other than verbal praise) for expected behaviors over the past two months? (0= 0-25%; 1= 26-49%; 2= 50-100%)	Interviews Other _____	**I**	
	3. Do 90% of staff asked indicate they have delivered a reward (other than verbal praise) to youth for expected behavior over the past two months? (0= 0-50%; 1= 51-89%; 2= 90-100%)	Interviews Other _____	**I**	
D. System for Responding to Behavioral Violations	1. Is there a documented system for dealing with and reporting specific behavioral violations? (0= no; 1= states to document; but not how; 2 = yes)	Discipline handbook, Instructional materials Other _____	**P**	
	2. Do 90% of staff asked agree with administration on what problems are reported to administration and what problems are handled on the spot by staff? (0= 0-50%; 1= 51-89%; 2= 90-100%)	Interviews Other _____	**I**	

Feature	Evaluation Question	Data Source (circle sources used) P= product; I= interview; O= observation	Score: 0-2
	3. Is the documented crisis plan for responding to extreme dangerous situations readily available in 6 of 7 locations? (0= 0-3; 1= 4-5; 2= 6-7)	Walls Other _____ **O**	
	4. Do 90% of staff asked agree with administration on the procedure for handling extreme emergencies (stranger in building with a weapon)? (0= 0-50%; 1= 51-89%; 2= 90-100%)	Interviews Other _____ **I**	
E. Monitoring & Decision-Making	1. Does the discipline report form list (a) youth/grade, (b) date, (c) time, (d) referring staff, (e) problem behavior, (f) location, (g) persons involved, (h) probable motivation, & (i) administrative decision? (0=0-3 items; 1= 4-6 items; 2= 7-9 items)	discipline report form (circle items present on the report form) **P**	
	2. Can the administrator clearly define a system for collecting & summarizing discipline reports (computer software, data entry time)? (0=no; 1= referrals are collected; 2= yes)	Interview Other _____ **I**	
	3. Does the administrator report that the team provides discipline data summary reports to the staff at least three times/year? (0= no; 1= 1-2 times/yr.; 2= 3 or more times/yr)	Interview Other _____ **I**	
	4. Do 90% of team members asked report that discipline data is used for making decisions in designing, implementing, and revising campus-wide effective behavior support efforts? (0= 0-50%; 1= 51-89%; 2= 90-100%)	Interviews Other _____ **I**	
F. Management	1. Does the campus improvement plan list improving behavior support systems as one of the top 3 improvement plan goals? (0= no; 1= 4th or lower priority; 2 = 1st- 3rd priority)	Campus Improvement Plan, **P** Interview Other _____ **I**	
	2. Can 90% of staff asked report that there is a campus-wide team established to address behavior support systems in the school? (0= 0-50%; 1= 51-89%; 2= 90-100%)	Interviews Other _____ **I**	
	3. Does the administrator report that team membership includes representation of all staff? (0= no; 2= yes)	Interview Other _____ **I**	
	4. Can 90% of team members asked identify the team leader? (0= 0-50%; 1= 51-89%; 2= 90-100%)	Interviews Other _____ **I**	
	5. Is the administrator an active member of the campus-wide behavior support team? (0= no; 1= yes, but not consistently; 2 = yes)	Interview Other _____ **I**	
	6. Does the administrator report that team meetings occur at least monthly? (0=no team meeting; 1=less often than monthly; 2= at least monthly)	Interview Other _____ **I**	
	7. Does the administrator report that the team reports progress to the staff at least four times per year? (0=no; 1= less than 4 times per year; 2= yes)	Interview Other _____ **I**	
	8. Does the team have an action plan with specific goals that is less than one year old? (0=no; 2=yes)	Annual Plan, calendar Other _____ **P**	
G. District-Level Support	1. Does the campus budget contain an allocated amount of money for building and maintaining campus-wide behavioral support? (0= no; 2= yes)	Interview Other _____ **I**	
	2. Can the administrator identify an off-campus liaison in the area or state? (0= no; 2=yes)	Interview Other _____ **I**	

Summary Scores:					
	A = /4	B = /10	C = /6	D = /8	E = /8
	F = /16	G = /4	Mean = /7		

Administrator Interview Guide

Let's talk about your discipline system

1)Do you collect and summarize discipline report information? Yes No If no, skip to #4.

2)What system do you use for collecting and summarizing discipline reports? (E2)

a)What data do you collect? _____

b)Who collects and enters the data? _____

3) What do you do with the discipline report information? (E3)

a)Who looks at the data? _____

b) How often do you share it with other staff? _____

4) What type of problems do you expect staff to report to administration rather than handling in the specific setting? (D2)

5) What is the procedure for handling extreme emergencies on campus (i.e. stranger with a gun)? (D4)

Let's talk about your campus rules or motto

6) Do you have campus rules or a motto? Yes No If no, skip to # 10.

7) How many are there? _____

8) What are the rules/motto? (B4, B5)

9) What are they called? (B4, B5)

10) Do you acknowledge youth for doing well socially? Yes No If no, skip to # 12.

11) What are the social acknowledgements/ activities/ routines called (youth of the month, positive referral, letter home, stickers, high 5's)? (C2, C3)

Do you have a team that addresses campus-wide discipline? If no, skip to # 19

12) Has the team taught/reviewed the campus-wide program with staff this year? (B3) Yes No

13) Is your campus-wide team representative of your staff? (F3) Yes No

14) Are you on the team? (F5) Yes No

15) How often does the team meet? (F6) _____

16) Do you attend team meetings consistently? (F5) Yes No

17) Who is your team leader/facilitator? (F4) _____

18) Does the team provide updates to staff on activities & data summaries? (E3, F7) Yes No
If yes, how often? _____

19) Do you have an off-campus liaison in the state or district to support you on positive behavior support systems development? (G2) Yes No
If yes, who? _____

20) What are your top 3 campus improvement goals? (F1)

21) Does the campus budget contain an allocated amount of money for building and maintaining campus-wide behavioral support? (G1) Yes No

Additional Interviews

In addition to the administrator interview questions there are questions for Behavior Support Team members, staff and youth. ***Interviews can be completed during the campus tour.*** Randomly select youth and staff as you walk through the campus. Use this page as a reference for all other interview questions. Use the interview and observation form to record youth, staff, and team member responses.

Staff Interview Questions
Interview a minimum of 10 staff

1) What are the _____ (campus rules, high 5's, 3 bee's)? (B5)
(Define what the acronym means)

2) Have you taught the campus rules/behavioral expectations this year? (B2)

3) Have you given out any _____ since _____? (C3)
(rewards for appropriate behavior) (2 months ago)

4) What types of youth problems do you or would you report to administration? (D2)

5) What is the procedure for dealing with a stranger with a gun? (D4)

6) Is there a campus-wide team that addresses behavioral support in your building?

7) Are you on the team?

Team Member Interview Questions

1) Does your team use discipline data to make decisions? (E4)

2) Has your team taught/reviewed the campus-wide program with staff this year? (B3)

3) Who is the team leader/facilitator? (F4)

Youth interview Questions
Interview a minimum of 15 students

1) What are the _____ (Campus rules, high 5's, 3 bee's)? (B4)
(Define what the acronym means.)

2) Have you received a _____ since _____? (C2)
(reward for appropriate behavior) (2 months ago)

Interview and Observation Form

	Staff questions (Interview a minimum of 10 staff members)							Team member questions			Youth questions	
	What are the Campus rules? Record the # of rules known.	*Have you taught the campus rules/ behave. exp. to youth this year?*	*Have you given out any _____ since _____?* (2 mos.)	*What types of youth problems do you or would you report to administration?*	*What is the procedure for dealing with a stranger with a gun?*	*Is there a team on your campus to address campus-wide behavior support systems?*	*Are you on the team? If yes, ask team questions*	*Does your team use discipline data to make decisions?*	*Has your team taught/ reviewed campus-wide program w/staff this year?*	*Who is the team leader/ facilitator?*	*What are the (campus rules)?* Record the # of rules known	*Have you received a _____ since _____ ?*
1		Y N	Y N			Y N	Y N	Y N	Y N		1	Y N
2		Y N	Y N			Y N	Y N	Y N	Y N		2	Y N
3		Y N	Y N			Y N	Y N	Y N	Y N		3	Y N
4		Y N	Y N			Y N	Y N	Y N	Y N		4	Y N
5		Y N	Y N			Y N	Y N	Y N	Y N		5	Y N
6		Y N	Y N			Y N	Y N	Y N	Y N		6	Y N
7		Y N	Y N			Y N	Y N	Y N	Y N		7	Y N
8		Y N	Y N			Y N	Y N	Y N	Y N		8	Y N
9		Y N	Y N			Y N	Y N	Y N	Y N		9	Y N
10		Y N	Y N			Y N	Y N	Y N	Y N		10	Y N
11		Y N	Y N			Y N	Y N	Y N	Y N		11	Y N
12		Y N	Y N			Y N	Y N	Y N	Y N		12	Y N
13		Y N	Y N			Y N	Y N	Y N	Y N		13	Y N
14		Y N	Y N			Y N	Y N	Y N	Y N		14	Y N
15		Y N	Y N			Y N	Y N	Y N	Y N		15	Y N
Total							X				Total	

Location	Front hall/ office	Class 1	Class 2	Class 3	Cafeteria	Library	Other setting (gym, lab)	Cottage 1	Cottage 2	Cottage 3
Are rules & expectations posted?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Is the documented crisis plan readily available?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Adapted from School-wide Evaluation Tool. (2001). Sugai, Lewis-Palmer, Todd & Horner. University of Oregon.