Consultation in Public School Settings

Florence D. DiGennaro Reed and Sarah R. Jenkins

Federal legislation mandates a free and appropriate public education for students with disabilities within a least restrictive environment (e.g., P.L. 99–142; P.L. 99–457) and provides assurance that individuals with severe challenging behavior will have access to appropriate educational services (P.L. 105–117). While these educational reforms have the potential to advance the equity and quality of services offered to students with disabilities, they also place increased demands on educators to meet the needs of an increasingly diverse group of students with unique needs (Putnam, Handler, Rey, & McCarty, 2005). As a result of these and other mandates, consultation within public school settings has become a stand-alone service available to educators by a team of professionals (Luiselli & Diament, 2002; Martens & DiGennaro, 2008).

Although there are several philosophical approaches to consultation, those based on the principles of behavior analysis (i.e., behavioral consultation) are the most common (e.g., Medway, 1982; Sheridan, Welch, & Orme, 1996) and have been shown to produce positive outcomes in both case studies and experimental investigations (Fuchs, Fuchs, & Bahr, 1990; Gutkin, 1986; Medway, 1982; Sheridan et al., 1996).

Research suggests that the number of students referred for special education has decreased due to school-wide behavioral consultation (Fuchs et al., 1990; Graden, Casey, & Bonstrom, 1985; Gutkin, Henning-Stout, & Piersel, 1988; Rosenfield, 1992). Teachers also report that school consultation is highly effective and improves performance for a majority of students (e.g., MacLeod, Jones, Somers, & Havey, 2001). As such, school-based behavioral consultation has become an important service and is a valuable resource to educators and students in crisis. The purpose of this chapter is to describe behavioral consultation in public schools and the various roles comprising this service. In addition, the chapter will provide details about the range of activities commonly addressed during consultation and decisions concerning the transition of a student in crisis to a more restrictive service-delivery model.

What Is Consultation?

School consultation is an indirect process by which an expert provides support and assistance to an educator to improve student learning and engagement (Erchul & Martens, 2010; Putnam et al., 2005). In this model, the expert has little or no direct contact with the student, hence, an indirect service-delivery process; instead, the expert collaborates with the educator who is expected to be an active participant. Responsibilities of

F.D. DiGennaro Reed (✉) • S.R. Jenkins
Department of Applied Behavioral Science, University of Kansas, 4001 Dole Human Development Center, 1000 Sunnyside Avenue, Lawrence, KS 66045-7555, USA
e-mail: fdreed@ku.edu

educators include participating in face-to-face interviews, providing relevant information about the conditions under which problem behavior occurs, collecting data, and implementing agreed-upon treatment plans (Kratochwill & Bergan, 1990; Luiselli, 2002; Martens, Erchul, & Witt, 1992). For the purposes of this chapter, we will rely on the definition offered by Erchul and Martens (2010) who defined consultation as:

> a process for providing psychological and educational services in which a specialist (consultant) works cooperatively with a staff member (consultee) to improve the learning and adjustment of a student (client) or groups of students. During face-to-face interactions, the consultant helps the consultee through systematic problem solving, social influence, and professional support. In turn, the consultee helps the client(s) through selecting and implementing effective school-based interventions. In all cases, school consultation serves a remedial function and has the potential to serve a preventive function (pp. 12–13).

Consultation is designed around a systematic problem-solving process implemented through a series of face-to-face interviews (Erchul & Martens, 2010; Putnam et al., 2005) and consultation activities in order to identify and assess an academic or behavioral problem as well as to evaluate the effectiveness of an assessment-driven intervention. D'Zurilla and Goldfried (1971) originally conceptualized the four-stage process of behavioral consultation, which has since been described and expanded by Kratochwill and Bergan (1990) and Erchul and Martens (2010). The four-stage process includes several interviews requiring shared consultant-consultee responsibility (Martens & DiGennaro, 2008). The goal of the problem identification interview (PII) is to identify a particular target behavior that will be addressed through consultation, estimate how often and when it occurs, and determine baseline data collection that will take place before the next interview. During the second interview—termed the problem analysis interview (PAI)—the consultant and consultee use the gathered baseline data to identify behavior change goals, discuss the putative function of problem behavior based on hypothesized antecedents and consequences, and design an intervention to address

the target behavior. The problem evaluation interview (PEI) is arranged after the plan has been implemented for a period of time so that the consultant and consultee can determine whether the plan should be terminated, continued, or modified.

Because of the effectiveness of this model and federal mandates emphasizing prevention and early identification of school-related problems through the use of behavioral consultation (c.f. Individuals with Disabilities Education Improvement Act of 2004; IDEIA), public schools have adopted consultation in various formats over the past three decades. The way in which consultation is offered differs across states and even districts within the same state. For example, schools may hire an *internal* consultant as an employee to provide consultation to educators on an as-needed basis. School-based consultation may also be provided by an *external* consultant who has a contract with the district. In this model, consultants may function as independent practitioners under their own license, certification, or other credential and arrange the contract directly with the school. Alternatively, consultants might work as part of a team hired by a not-for-profit or for-profit organization who holds the contract with the school district.

Schools may also offer prereferral intervention services (McDougal, Clonan, & Martens, 2000) where a teacher can seek consultative assistance from a team of consultants or specialists often comprised of numerous disciplines (e.g., school psychologist, behavior analyst, speech therapist, reading specialist all of whom are school employees), to address a behavioral or academic concern in the classroom. Note that the terminology used for the prereferral intervention team varies widely, for example, school-based intervention and child study teams. Some schools or districts implement school-wide positive behavior support (SWPBS), a systemic and preventive approach derived from behavioral theory, whose goal is to eliminate problem behavior in favor of socially appropriate behaviors (Carr et al., 2002). In SWPBS, a continuum of support is available for educators within a three-tiered system (http://www.pbis.org/). Efforts toward
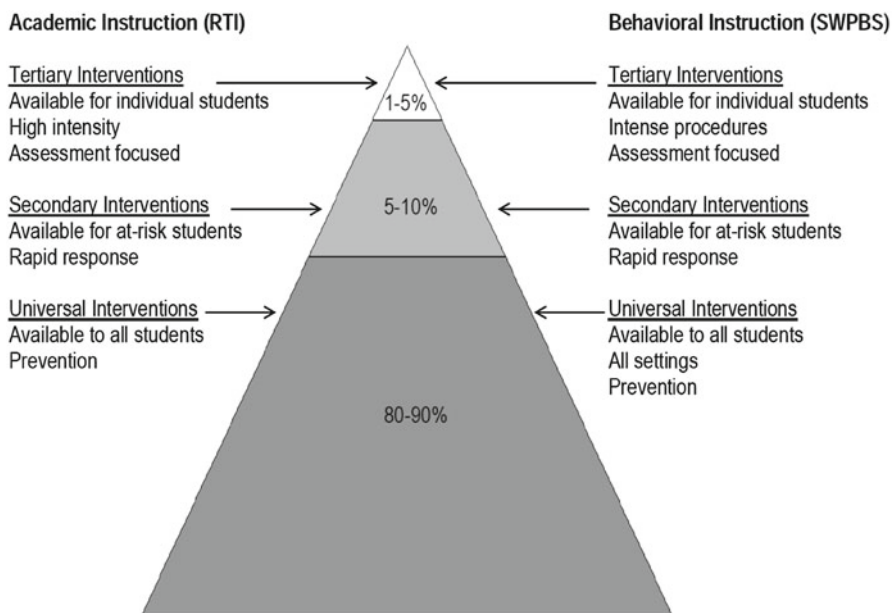
Fig. 18.1 RTI and SWPBS model. A pictorial display of the similarities and differences between RTI and SWPBS within school settings. The percentage of students who are served by each tier is represented within the pyramid. A general description of each tier for each type of intervention is also provided (Adapted from Positive Behavioral Interventions and Supports, retrieved August 22, 2012, from http://www.pbis.org/school/rti.aspx)

primary prevention include making available a school-wide behavior management system using positive reinforcement procedures. Secondary prevention includes more specialized systems for at-risk students or students who continue to emit problem behavior despite the school-wide reinforcement system. In tertiary prevention, individualized and specialized systems are available for high-risk students (Fig. 18.1).

IDEIA also permits the use of Responsiveness-to-Intervention (RTI) practices within educational settings, and many schools have since adopted this model. Special education state department directors report that efforts are being made to train RTI and emphasize progress monitoring and data-based decision making in 90 % of states (Hoover, Baca, Wexler-Love, & Saenz, 2008). Like SWPBS, RTI includes three levels of prevention (http://www.rti4success.org) but focuses on instructional practices rather than problem behavior prevention, although the National Dissemination Center for Children with Disabilities indicates RTI can be used for both academic and behavioral problems. Primary

prevention efforts include adopting quality instruction for all classrooms in all grade levels. If a student experiences difficulty with the core content, secondary prevention including an evidence-based intervention is implemented. Tertiary prevention is offered to students who do not respond to previous efforts and includes individualized instruction and intervention (Fig. 18.1). Students who continue to struggle even after intense, individualized intervention are referred for a comprehensive evaluation and determination of eligibility for special education services. Interested readers may wish to refer to a blueprint specifying acceptable and best practices available at no charge on the internet (see Fuchs & Fuchs, 2005).

Roles Within School Consultation

As previously described, three primary roles exist within a consultative model including consultant, consultee, and client. A successful consultative relationship depends upon the actions each indi-

vidual takes toward meeting a set of shared and unique responsibilities. In the past, the consultant–consultee relationship was described as collaborative and nonhierarchical, suggesting that neither person had more power than the other. It was also considered a voluntary relationship, one in which the consultee was able to decline consultant assistance (Erchul, 1999). However, recent changes in legislative regulations outlined in IDEIA 2004 altered the consultative process dramatically. Because the regulation requires scientifically supported interventions for clients needing additional support and instruction (Yell & Drasgow, 2007), consultation is no longer considered a voluntary activity and educators have less flexibility to reject or decline assistance. Additionally, inclusion of RTI within IDEAI increased school-based educators' reliance on experts (consultants) to analyze outcomes of clients and provide an appropriate intervention when outcomes do not meet the legislative standards (Erchul, 2011).

Consultant

The consultant is hired by virtue of having particular expertise and/or specialization in the target problem area or referral issue (Martens & DiGennaro, 2008). Responsibility rests with the consultant to follow federal educational regulations and to spearhead the consultation process beginning with school entry and contract negotiations through ensuring that the goals of consultation are realized via intervention evaluation (Kratochwill & Bergan, 1990). To meet the target goals for change, it is necessary for the consultant to support and maintain the consultative relationship with the consultee. To this end, the consultant works directly with the consultee, rather than the client, and is responsible for generating *consultee* behavior change (Erchul & Martens, 2010) via training and support (Martens & DiGennaro, 2008; Wickstrom, Jones, LaFleur, & Witt, 1998). Changes in consultee behavior (e.g., intervention plan implementation, responding to problem behavior in a different manner) bring about changes in client behavior (e.g., less problem behavior).

To maximize effectiveness, a consultant should have coursework, training, and supervision in consultation, applied behavior analysis, functional behavior assessment, school-based interventions, and single-case research designs (Kratochwill & Bergan, 1978; Shriver & Watson, 1999). Consultants may be master's level or doctoral level certified school psychologists or board certified behavior analysts. In addition, licensed clinical or educational psychologists may serve as consultants. It is important to note that individuals with doctoral level training and experience within both school and behavioral consultation generally have the appropriate amount of experience and expertise to effectively use the problem-solving model and to evaluate outcomes (Putnam et al., 2005). Luiselli (2002) also pointed out that consultants should have exemplary interpersonal and time management skills to achieve success.

Consultee

Consultees have direct contact with the client and are charged with the responsibility of implementing designed interventions during consultation (Martens & DiGennaro, 2008). The consultee is typically a teacher or other educator who is responsible for the behavioral and academic progress of students. The consultee plays an important role in the consultative relationship by interacting with and providing important information to the consultant during the problem-solving process, collecting data, implementing the agreed-upon intervention, interacting directly with the client, and communicating with the consultant on all relevant matters. As an indirect service-delivery model, the consultant produces behavior change in the client through the consultee.

Client

The client is an individual who faces an obstacle that is not being sufficiently remedied or addressed and, in many cases, is a student (Erchul & Martens, 2010). Within the roles of consultation,

the client is charged with making the behavioral changes (e.g., increases in appropriate behavior and/or decreases in problem behavior) that serve as an end goal of consultation. Depending on the client's skills, she/he may help to define and assess the goals, which is an important step within the consultation process (Kratochwill & Bergan, 1990).

Professional Activities Within the Consultation Model

Functional Behavior Assessment and Analysis

The problem-solving process includes interview questions in the PII and PAI that evoke discussion about the environmental variables surrounding problem behavior. This philosophical approach to problem behavior remediation focuses on the events that occur before and after problem behavior, rather than on causes internal to the child (e.g., pathology, frustration, anger, self-esteem), and is consistent with a behavior analytic approach (Asmus, Vollmer, & Borrero, 2002). A behavioral consultant will conduct a functional behavior assessment (FBA) to identify the purpose that problem behavior serves for a client (or the function of problem behavior) by assessing the conditions under which clients emit problem behavior and the consequences that follow it.

FBA includes a continuum of assessment techniques including indirect assessment (e.g., rating scales or informant reports; e.g., Durand & Crimmins, 1988), direct assessment (i.e., observing clients in the natural environment and recording the environmental events surrounding problem behavior; e.g., Bijou, Peterson, & Ault, 1968; English & Anderson, 2006), and functional analysis (i.e., an experimental approach; Iwata, Dorsey, Slifer, Bauman, & Richman, 1994; Martens, Witt, Daly, & Vollmer; 1999). Readers are encouraged to see Chaps. 8 (assessment of problem behavior) and 9 (functional analysis) in this handbook for precise descriptions of these techniques. The 1997 amendments to the

Individuals with Disabilities Education Act mandated FBA in public schools under particular circumstances; however, the regulations lack the specificity to require a behavior-based and empirically supported approach to FBA (Asmus et al., 2002; Ingram, Lewis-Palmer, & Sugai, 2005). As a result, assessment is often restricted to indirect techniques in public school settings, which fall short of best practices (March & Horner, 2002; McIntosh, Brown, & Borgmeier, 2008).

Academic Assessment

Consultants may also be involved with assessment of academic skills for students experiencing performance problems in the classroom curriculum. Standardized, norm-referenced testing, such as cognitive and ability testing, is typically restricted to school psychologists who have the required training and certification to conduct assessments of this type. However, consultants may be involved with *direct academic assessment* by (1) sitting on a prereferral intervention team whose members determine assessment is necessary, (2) completing one as part of the consultation process, or (3) implementing RTI and conducting academic assessment for progress monitoring purposes (Luiselli, Reed, & Martens, 2010).

Direct academic assessment refers to practices that assess performance of students within the instructional curriculum. That is, the assessment itself has overlap with the curriculum materials used in the classroom. There are several types of direct academic assessment including curriculum-based assessment (e.g., Blankenship, 1985; Shapiro, 1990), curriculum-based evaluation (Howell & Nolet, 1999), and curriculum-based measurement (Deno & Mirkin, 1977). Although there are differences in scope and use (e.g., progress monitoring versus assessment to guide intervention), the shared purpose of all types of direct academic assessment is to "focus on the evaluation of student academic performance to examine student skills" and "to examine the instructional environment in which the student is being taught" (Shapiro, 2004, p. 19). Shapiro

(2004) recommends a four-step process informed by the empirical literature that includes assessment of the environment where instruction takes place, assessment of placement within the curriculum, modifications to instruction, and ongoing monitoring of progress. Students who experience difficulty with the instructional curriculum may engage in problem behavior to avoid or escape challenging tasks. As a result, direct academic assessment may be necessary if the FBA identifies the function of problem behavior as negative reinforcement in the form of escape from—or avoidance of—instruction.

We encourage readers to incorporate assessment procedures for academic difficulties in order to better understand the reasons a student is exhibiting low performance. In some instances, academic difficulties are due to a skill deficit (i.e., a *can't do* problem; Lentz, 1988). Skill deficits occur for several reasons including (a) not enough exposure to the curriculum, (b) a student requiring more help than is presently available, (c) lack of student mastery of the curriculum goals, or (d) the academic task exceeds the student's skill level (Daly, Witt, Martens, & Dool, 1997). Academic difficulties may also result from a performance deficit (i.e., a *won't do* problem) in which the student lacks interest and/or fails to interact with curricular materials because reinforcement contingencies do not support doing so (Lentz, 1988). Identifying the type of deficit is important because it directly informs the appropriate next steps in developing an intervention. Interventions addressing skill deficits aim to teach new skills and/or behavior, whereas performance deficit interventions create new contingencies within the environment in order to increase active participation in the curriculum (Daly et al., 1997).

Intervention Design

Determining the function or purpose of problem behavior helps the consultant design appropriate intervention procedures (Iwata, Pace, Kalsher, Edwards Cowdery, & Cataldo, 1990). An assessment-driven and function-based intervention must incorporate findings of the FBA and,

as appropriate, a direct academic assessment. In addition, identifying the purpose of problem behavior may aid in selecting the least intrusive intervention (Vollmer & Northup, 1996), which requires fewer resources and can be implemented quickly by teachers who are more likely to implement them across a longer span of time (Erchul & Martens, 2010). Recent clinical advances now consider a treatment analysis—an evaluation of the effects of a consultee-implemented intervention on client behavior or performance—an important component of comprehensive assessment. Although requiring resources up front, a treatment analysis will help preserve time in the long term by increasing the likelihood that an effective intervention will be recommended and adopted. To make the most efficient use of resources, a brief experimental analysis (BEA) of potential interventions can be conducted to quickly evaluate the effects of treatment before long-term implementation (Martens, Eckert, Bradley, & Ardoin, 1999).

Brief Experimental Analysis

BEA is an assessment tool used to determine which treatment or intervention is most appropriate and effective in addressing a given academic or behavioral problem (Martens et al., 1999). It is derived from the fields of school psychology and applied behavior analysis and allows consultants to base recommendations on methodologically sound assessment practices (Martens et al., 1999). BEA relies on the elements of single-case design (e.g., repeated measurement, replication of effects, and visual inspection; Martens & Gertz, 2009) to demonstrate the beneficial effects of one intervention over another. Thus, a consultant must have training and experience in behavior analytic research methods to conduct this analysis. Meta-analytic findings suggest that BEA has empirical support (Burns & Wagner, 2008). During BEA, client performance is measured during brief and rapidly alternating intervention sessions (Erchul & Martens, 2010). Clear behavior change in the desired direction during an intervention session helps the consultant make a recommendation to the consultee about which procedures should be implemented long term.

Harding, Wacker, Cooper, Millard, and Jensen-Kovalan (1994) used BEA to identify the least intrusive intervention package necessary to improve appropriate behavior for seven children in an outpatient clinic. Using a multielement design, Harding et al. (1994) rapidly alternated conditions in a hierarchy of least-to-most intrusive interventions beginning with those that were easiest to implement by parents. If improvements in on-task behavior were not observed with a less intrusive intervention (e.g., antecedent procedures), more intrusive components (e.g., reinforcement and/or mild punishment procedures) were added to the intervention package. This analytic technique allowed the researchers to individualize the interventions they designed for the clients. Three clients showed increases in on-task behavior when antecedent interventions were implemented (e.g., increased choice-making opportunities, delivery of clear instructions by caregivers). Other participants required the addition of consequence-based components, such as differential reinforcement of alternative behavior and access to preferred activities, in order to produce changes in behavior.

Intervention Components

Two categories of intervention components are typically embedded into behavioral interventions, both of which reduce the likelihood of problem behavior occurring in the future. A body of research supports the effective use of antecedent and consequence-based interventions to reduce problem behavior and teach appropriate behavior (Bregman, Zager, & Gerdtz, 2005). Both categories of intervention procedures and corresponding research examples are described below.

Antecedent Interventions

Antecedent interventions include procedures that prevent the occurrence of problem behavior and, as a result, increase the occurrence of appropriate behavior (Kern & Clemens, 2007; Reeve & Carr, 2000). The results of FBA should reveal the contexts under which problem behavior occurs as well as situations during which clients do not engage in problem behavior. This information allows consultants to identify slight modifications

to the environment which can produce dramatic reductions in problem behavior. Although FBA has not always been necessary to inform effective antecedent strategies (O'Reilly et al., 2012), we recommend its use to better understand why a particular strategy is effective. Common antecedent intervention practices are modifying the delivery (Matheson & Shriver, 2005), pace (Darch & Gersten, 1985), or difficulty of instruction (Kern, Gallagher, Starosta, Hickman, & George, 2006); establishing clear expectations (Johnson, Stoner, & Green, 1996); providing access to an enriched environment (Wilder, Zonneveld, Harris, Marcus, & Reagan, 2007), revising or developing routines (Bohn, Roehrig, & Pressley, 2004; O'Reilly, Sigafoos, Lancioni, Edrisinha, & Andrews, 2005), and many others (e.g., providing choices; Cannella, O'Reilly, & Lancioni, 2005).

Haley, Heick, and Luiselli (2010) evaluated the effects of colored cards—meant to signal the appropriate times to engage in vocal stereotypy—on the occurrence of stereotypy emitted by a second grade boy with autism in a general education classroom. During training, the student was taught to discriminate when it was appropriate or inappropriate to engage in stereotypy. In the presence of a green card bearing the statement "Sean, okay to speak out," vocal stereotypy received no programmed consequences (i.e., the student was allowed to engage in stereotypy). In the presence of a red card bearing the statement "Sean, quiet," the student received a prompt when he engaged in vocal stereotypy (i.e., the red card was held approximately 6 in. in front of Sean's face). Decreases in stereotypy were observed in the presence of the red card even when the size of the card was reduced and the text was removed. Stereotypy occurrence in the presence of the green card was similar to baseline levels. In a study by Butler and Luiselli (2007), escape-maintained problem behavior involving self-injury, aggression, and tantrum decreased to near-zero levels when an intervention package consisting of a noncontingent break and instructional fading (eliminating and gradually introducing instruction) was implemented. As the schedule of noncontingent breaks

decreased and the rate of instructional requests increased during the study, problem behavior remained low.

Consequence-Based Interventions

Consequence-based interventions refer to procedures that take place after the occurrence of behavior and involve modifying the behavior's consequences (Bregman et al., 2005). Reinforcement, extinction, and punishment are common consequence-based procedures (Lanovaz & Sladeczek, 2011). Reinforcement refers to the presentation (i.e., positive reinforcement) or removal (i.e., negative reinforcement) of a stimulus contingent on the occurrence of behavior, which increases the future probability of that behavior occurring (Catania, 2007). Differential reinforcement procedures are often incorporated into behavioral interventions and involve delivering reinforcement for some, but not all, behaviors (Catania, 2007). Several types of differential reinforcement procedures are available to consultants to use as a consequence-based intervention. Differential reinforcement of other behavior (DRO) is defined as the provision of reinforcement for behavior other than the target (problem) behavior (Thompson, Iwata, Hanley, Dozier, & Samaha, 2003). Differential reinforcement of alternative behavior (DRA) involves withholding reinforcement for target behavior and providing reinforcement contingent on the occurrence of an appropriate behavior (Petscher, Rey & Bailey, 2009). Differential reinforcement of incompatible behavior (DRI) is a type of DRA procedure where reinforcement is provided for an appropriate behavior physically incompatible with the target behavior (de Zubicaray & Clair, 1998). In a procedure involving differential reinforcement of low rates of behavior (DRL), reinforcement is provided for target behavior that occurs at a rate less than an established criterion (Dietz & Repp, 1973). Differential reinforcement of high rates of behavior (DRH) is defined as providing reinforcement for target behavior occurring at a rate higher than an established criterion (Catania, 2007). Durand and Carr (1991) used DRA and functional communication training to reduce problem behavior (tantrum, self-injury, disruption) displayed

by three boys with developmental disabilities. A functional analysis determined that problem behavior was maintained by escape from challenging tasks for all three boys and maintained by attention for one boy. To address the escape function, the boys were taught phrases to request help or convey that they did not understand the task. To address the attention function, one of the boys was taught to request attention while working on the tasks. Differential reinforcement consisted of delivering the requested reinforcer (e.g., help, attention) contingent on functional communication, such that problem behavior no longer produced the reinforcer. Problem behavior decreased for all three participants following the introduction of DRA and functional communication training. Follow-up data indicated that results were maintained over time and generalized to other classrooms for two of the three participants.

Extinction occurs when reinforcement is withheld for behaviors that previously contacted reinforcement (Catania, 2007) and is a component of differential reinforcement procedures involving the contingent delivery of reinforcement for some, but not all, responses. Presumably, when behaviors no longer produce reinforcement, their occurrence decreases (Simpson & Gagnon, 1999). Cote, Thompson, and McKerchar (2005) evaluated the effects of two antecedent interventions (a 2-min transition warning and access to a toy) and extinction alone and in various combinations on compliance and problem behavior for three typically developing toddlers during school transitions. Participants demonstrated increased compliance and lower problem behavior in conditions involving extinction. Specifically, the treatment package consisting of access to a toy and extinction produced the greatest improvements for two of three participants. A third participant responded positively to the extinction-only condition. Given that extinction does not teach appropriate alternative behaviors and is associated with a number of side effects (Bregman et al., 2005), we recommend that consultants evaluate the effects of extinction in a BEA before asking consultees to adopt this procedure for long-term use and consider packaging extinction with differential reinforcement.

Punishment procedures involve the presentation (i.e., positive punishment) or removal (i.e., negative punishment) of a stimulus contingent on the occurrence of behavior, which decreases the future probability of that behavior occurring (Catania, 2007). Gresham (1979) evaluated the effects of two punishment procedures (response cost alone and in combination with time-out) on the noncompliance of 11 children with intellectual disabilities. Response cost involved the loss of one earned token contingent on each instance of noncompliance with the teacher's request. During time-out, children were prompted to sit in a chair positioned away from other children and remained in time-out until appropriate behavior was displayed for one minute. Both procedures were effective in reducing noncompliance, suggesting that the response cost procedure was the necessary intervention component (i.e., controlling variable). Readers should note that the use of punishment is a source of much controversy in the fields of behavior analysis, psychology, and education so much so that many professional organizations have developed position statements on its use (e.g., Association for Behavior Analysis International, 2010). In addition, consequence-based punishment procedures are viewed as less acceptable than reinforcement procedures (Michaels, Brown, & Mirabella, 2005).

Consultee Training

Effective consultation requires consultants to train consultees to appropriately implement the recommended intervention with the client. In addition, consultants are responsible for providing ongoing follow-up to ensure that the intervention is being implemented well in the applied classroom context and is effectively addressing the referral concern. Failure to provide sufficient training will likely result in poor intervention implementation or treatment integrity, which refers to the degree to which interventions are implemented as planned (Gresham, 1989; Yeaton & Sechrest, 1981). Studies have shown that behavioral interventions lack effectiveness when they are implemented with low treatment integrity

(DiGennaro, Martens, & Kleinmann, 2007; DiGennaro, Martens, & McIntyre, 2005; Wilder, Atwell, & Wine, 2006). Efforts directed toward consultation will be wasted if consultants do not provide the necessary training and follow-up to ensure consultees implement the assessment-based interventions with integrity.

Consultees may struggle with implementing agreed-upon classroom interventions even if they have received initial training consistent with best practices (i.e., behavioral skills training consisting of modeling, coaching, and performance feedback until criterion performance is achieved). For example, Mortenson and Witt (1998) reviewed agreed-upon intervention procedures and the rationale for each intervention step with teachers, provided out-of-classroom training, confirmed verbal understanding of the intervention, and provided in-class training consisting of prompting and feedback until criterion performance of 100 % integrity was met by participating teachers. Three of four teachers showed reductions in treatment integrity following these training procedures when they were asked to independently implement the intervention without consultant assistance. This finding has been replicated across studies (DiGennaro et al. 2005, 2007; Noell, Duhon, Gatti, & Connell, 2002), treatment protocols (e.g., academic interventions versus behavior support plans), and classroom settings (e.g., special versus general education classrooms). As a result, consultants should be prepared to provide ongoing follow-up in the form of performance feedback and on-the-job coaching to be maximally effective (van Oorsouw, Embregts, Bosman, & Jahoda, 2009). Readers are encouraged to read the chapter about staff training for more information about empirically supported training techniques (see Chap. 5 in this handbook).

Crisis Management

Clients may display dangerous or intense problem behavior in public school settings despite having access to consultation services and the array of activities described in this chapter. In some

instances, a more restrictive placement within or outside the school will be necessary in order to ensure the student receives a free and appropriate education (Pitasky, 2002). We cannot emphasize enough the importance of consultants recognizing the boundaries of their competencies and when continued consultation in the current form poses a risk to the client, consultee, or other students. A consultant may assist with referrals to an alternative setting as part of a team of educators associated with the public school. Depending on the receiving placement, the school district will likely be responsible for paying for some or all of the services; thus, school representatives should be involved in any conversations or decisions about a change of placement. Families will also play an important role in placement decisions and should be actively encouraged to participate as a team member. A chapter in this handbook describes policy and planning considerations when a student transitions from a less to more restrictive educational setting (see Chap. 16) and provides rich and valuable information to guide readers.

Conclusion

This chapter provides a summary of relevant research regarding the various roles within public school consultation, assessment and intervention activities, consultee training, and abbreviated considerations regarding the transition of a student in crisis to a more restrictive service-delivery model. We recommend reliance on a behavioral consultation model that uses the principles of behavior analysis since this approach has been shown to produce beneficial outcomes for students. In our experience, consultation is most effective when (1) interventions are derived from the results of a functional behavior assessment, (2) the efficacy of interventions is tested in a brief experimental analysis, (3) consultees are provided behavioral skills training before intervention implementation, and (4) consultants provide ongoing follow-up and support to consultees to ensure interventions are implemented with high treatment integrity.

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