Introduction to b.e.s.t.

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INTRODUCTION

Mental and behavioral health is critical for learning. Children must have a sense of wellbeing to access new learning challenges and changing social/community expectations. For school-aged children, success at school is a critical protection that mediates other life risks.[1]

WHY DO CHILDREN ACT THE WAY THEY DO?

In the Beginning, most children start from the same place. The effects of biology, environmental conditions, learned experiences and specific context variables make the differences we see. Approximately half of preschool children who display challenging behavior prior to kindergarten maintain inappropriate behavior patterns well into elementary school years.[2]

A negative relationship between challenging behaviors and achievement difficulties may develop through a series of reciprocal process that involves parents, children and teachers within the context of the home, school and peer group.[3] **Children who have not learned** the critical social, environmental and behavioral competencies required for school success, or exhibit these critical competencies at such a low rate, do not access positive consequences that encourage social emotional and behavioral growth.

Some children may need to be taught how to belong, or need help learning skills that allow them to manage stress at school. All learning must be recognized as equal and integrated and when children are preoccupied with emotional distress or social confusion, they cannot fully participate in academic learning.

The referral peak for children with academic problems occurs between grades 2 and 3;[4] in contrast, the referral peak for children with behavior problems occurs in grade 9, about seven years later.[5]

WHY DO CHILDREN ACT THIS WAY AT SCHOOL?

School life for many children is inherently difficult. There is a continuous struggle, not just for biological survival, but for some personal recognition, a sense of self and personal identity. **Clinically significant, challenging behaviors** exhibited reflect "repeated patterns of behavior

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[1] Gearity, A. (2014). Educational model for mental health: Serving children in school. A professional paper.

[2] Campbell, S.B. & Ewing, L.J. (1999). Follow-up of hard-to-manage preschoolers: Adjustment at age 9 and predictors of continuing symptoms. *Journal of Child Psychology and Psychiatry, 31*, 871-889.

[3] Conduct Problems Prevention Research Group. (1992). A developmental and clinical model for the prevention of conduct disorder: The FAST Track program. *Developmental and Psychopathology,* 4, 509-527.

[4] Lloyd, J. W., Kauffman, J. M., Landrum, T. J., & Roe, D. L. (1991). Why do teachers refer pupils for special education? An analysis of referral records. Exceptionality, 2(3), 115-126.

[5] Walker, H. M., Nishioka, V. M., Zeller, R., Severson, H. H., & Feil, E. G. (2000). Causal factors and potential solutions for the persistent under-identification of students having emotional or behavioral disorders in the context of schooling. Assessment for Effective Intervention, 26, 29-40.

that interfere with or is at risk of interfering with optimal learning or engagement in pro-social interactions with peers and adults."[6]

At the beginning of second grade, children with lower developmental trajectories face nearly insurmountable obstacles to catching up. If that trajectory is not altered by the end of third grade, these behaviors most often are considered chronic problems that interfere with successful school experiences, academic functioning, positive relationships with peers and teachers and often predict exclusion from the classroom.[7]

CAUSE AND CURE ARE NOT THE SAME THING

Although, prevention is the first response to challenging behavior and needs, there is no easy answer or quick fix. Acceptable behavior is the result of appropriate exposure to necessary learning conditions. To normalize or replace behaviors, measurement is used, not feelings.

IDENTIFYING AND SPECIFYING BEHAVIORS

Most practitioners use a typological approach in analyzing behavior, based on observable behaviors and emotions with constructs used to describe the behavior. **Constructs are broad descriptive terms** such as "good" or "bad" "disruptive" or "attention seeking." **Constructs are emotionally charged and operationally meaningless.** Behavior must be described in objective terms that are precise so that anyone can recognize and observe the behavior.

Classification systems like the **b.e.s.t.** provide a schema for organizing traits or behavior based on observed emotions and behaviors but must also address the function or purpose of behavior.

Event Horizons

Children exposed to risk factors manifest the effect in a variety of ways,[8] some children are on a trajectory to later difficulties[9] and others may present moderate to severe behavioral challenges because of exposure to trauma or risk behaviors in the first five years of life.[10]

Factors of Risk

Life for many children is inherently difficult. There is a continuous struggle, not just for biological survival, but for some personal recognition, a sense of self and personal identity.

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[6] Smith, B. J., & Fox, L. (2003). *Systems of service delivery: A synthesis of evidence relevant to young children at risk of or who have challenging behavior*. Tampa, FL: University of South Florida, Center for Evidence-Based Practice, Young Children with Challenging Behavior.

[7] Walker, H.M., Ramsey, E. & Gresham, F.M. (1995). *Antisocial behavior in school: Strategies and best practices*. Pacific Grove, CA: Brooks/Cole.

[8] Coie, J. D., Watt, N. F., West, S. G., Hawkins, J. D., Asarnow, J. R., Markman, H. J., et al. (1993). The science of prevention: A conceptual framework and some directions for a national research program. American Psychologist, 48, 1013−1022.

[9] Loeber, R., & Farrington, D. P. (2001). Serious and violent juvenile offenders: Risk factors and successful interventions. Thousand Oaks, CA: Sage.

[10] Reid, J. B., Patterson, G. R., & Snyder, J. J. (Eds.). (2002). Antisocial behavior in children and adolescents: A developmental analysis and the Oregon Model for Intervention Washington, DC: American Psychological Association.

Caplan[11] suggested that a crisis often creates a time at which children are uniquely predisposed to change.

Practically, What Does That Mean?

Although there are many factors that could explain a child's behavioral difficulties in school, children learn to behave or misbehave in ways that satisfy a need or results in a desired outcome. Stress makes some children preoccupied and unable to learn new knowledge.

Children who are struggling need a reliable and predictable structure to be able to contain worries and shift to learning new skills.

A continuum of supports for school aged children is needed: ***universal strategies*** to promote the social and emotional well-being and development of all students; ***selected, brief strategies*** to support students at risk of or with mild behavioral health challenges; and ***intensive, ongoing strategies*** to support those with significant needs, including a streamlined referral process with community **mental health providers**.

UNIVERSAL SCREENING FOR BEHAVIORAL, EMOTIONAL AND SOCIAL NEEDS

THE b.e.s.t.

The *President's Commission on Excellence in Special Education*[12] and the *No Child Left Behind Act of 2001*[13]. The National Research Council[14] "…recommend adopting a *universal screening and multitier intervention strategy* in general education" to "test the plausibility and productivity of universal behavior management interventions, *early behavior screening*, and techniques to work with children at risk for behavior problems".

An ideal screening instrument requires several features. First, it should be inexpensive, brief, easy to administer, score, and interpret, and ideally linked to intervention.[15] Second, it distinguishes children who have or will develop difficulties from those who will not with precision.[16] A universal screener should:

- Identify children who are manifesting appropriate developmental behavioral, emotional health and social skills.

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[11] Caplan, G., M.D. (1964). *Principles of preventive psychiatry.* New York: Basic Books, Inc.

[12] United States Department of Education Office and Special Education and Rehabilitative Services. (2002). *A new era: Revitalizing special education for children and their families.* Washington, DC: Author.

[13] United States Department of Education, (2001). *No child left behind.* Retrieved August 21, 2001, from http://www.ed.gov/inits/nclb/titlepage.html

[14] Donovan, M.S., & Cross, C.T. (2002). *Minority students in special and gifted education. Washington, DC: National Academy Press.*

[15] Schatschneider, C., Petscher, Y., Williams, K. M. (2008). How to evaluate a screening process: The vocabulary of screening and what educators need to know. In L. Justice, & C. Vukelich (Eds.), Achieving excellence in preschool literacy instruction (pp. 304-316). New York: Guilford Press.

[16] Glover, T. A., & Albers, C. A. (2007). Considerations for evaluating universal screening assessments. Journal of School Psychology, 45, 117-135.

- Identify children who may be experiencing transient behavioral, emotional health and social difficulties.
- Identify children who may exhibit fixed and reoccurring behavioral, emotional and social difficulties.
- Provide information to inform decision-making.
    - Specify areas of behavioral, emotional and social support that a child needs.
    - Provide a pathway to ensure access to equitable, high quality resources.
    - Monitor the progress made based on the intervention(s) implemented.

No single rating scale, criterion or formal process exists which can simply and unilaterally inform decisions for professionals. **Although 100% screening accuracy is desirable, there is inherent measurement error and difficulties in measuring developing skills in children.**[17] Therefore, a screening team, realizing behavior may differ across situations, must converge data from multiple sources using a variety of methods to make informed decisions.

Universal behavioral, emotional and social screening with b.e.s.t. should be considered the cornerstone of informed decision making and the foundation for informed action, conducted with every child within a population (e.g. classroom, grade, district, etc.) to assess the overall health of a defined and specific population, to identify those at risk for behavioral/emotional/social concerns and to predict those children who may have future difficulties.

Organizing and Quantifying Behavioral, Emotional and Social Needs

There are two major contrasting conceptualizations of behavioral, emotional and social needs. The traditional qualitative or clinical model holds that a disorder is either present or absent, i.e., all or nearly all the symptoms must be present in order to classify a concern. In contrast, the quantitative or empirical model views disorders as a group of symptoms with a number of symptoms present and ranked on a scale being a measure of the severity of the disorder. All children have a place on the dimension[18] and most, of course, fall at the low end of the scale.[19]

Empirical systems are often the method of choice for classification systems, since behavior can be measured comparatively and individuals are thought to occupy some place on the defined dimension. The **b.e.s.t.** provides a systematic and useful way of organizing and quantifying observations of behavior and helps to differentiate and reinforce appropriate positive behavioral development for typically-developing children, identifies interventions for those with elevated risk status and directs intensive focused intervention for those with targeted needs.

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[17] Jenkins, J. R., Hudson, R. F., & Johnson, E. S. (2007). Screening for service delivery in an RTI framework: Candidate measures. School Psychology Review, 36, 582–599.

[18] Cullinan, D., Epstein, M. H. & McLinden, D. (1986). Status and change in state administrative definitions of behavior disorder. *School Psychology Review*, 15, 383-392.

[19] Quay, H. C. & Peterson, D. R. (1983). *Interim manual for the revised behavior problem checklist* (1st Edition). Unpublished Manuscript. University of Miami.

The Classroom Teacher's Role: Standard of Comparability

Problem behaviors manifested by normal children do not generally differ in kind from those shown by children with behavioral, emotional and social problems, but are different in frequency, occurrence, degree of severity, duration and clustering.[20]

Classroom teachers play a central role in the identification of childhood problems. Their observations and judgements can be the single most effective index of the child's growth and development; sharpened by professional training by day-to-day experience with normal developmental behavior of other children. Teachers observe and interact with children on a daily basis, in a variety of circumstances, over a period of time and as a result can analyze typical performance of what a child can and cannot do in comparison to other children of the same age.[21]

The classroom teacher represents the primary agent for carrying out the social function of the schools and also serves as the primary referral agent for psychological assessment and special intervention.[22] A teacher's observation of a child's behavior is an important source of information when decisions are made about children's needs.[23] Although one must acknowledge that a rating of a child is a blend of actual behavior and the rater's perception, the teacher rating has face validity derived from the central strategic importance they occupy in the classroom.[24]

Determining Levels of Intervention

The analysis of behavior as a manifestation of personality is complex. All children experience and demonstrate normal problems of everyday living while some children have fixed and occurring symptoms of behavioral, emotional and social difficulties. We need to approach prevention and intervention as a means of educational habilitation or psychological aid, customizing interventions to address individual differences, regardless of the degree of those differences.

b.e.s.t. Universal Screening identifies healthy students, targets high risk, and helps stop, reduce, and change at risk trajectories by habilitation, reconstructing and intervening with a principled and measured confirmation of change.

There must be a clear and unambiguous relationship between the data collected and the intervention that is recommended.[25] Linking data with real time problem solving logically facilitates better outcomes.

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[20] Id.

[21] Bower, E. M. & Lambert, N. M. (1961). *Teacher's manual for in-school screening of emotionally handicapped children.* Princeton Educational Testing Services.

[22] Algozzine, B. (1983). Issues in the education of emotionally disturbed children. *Journal of Behavioral Disorders,* 6, 223-235.

[23] McGinnis, E., Kiraly, J., Jr., & Smith, C. R. (1984). The types of data used in identifying public school students as behaviorally disordered. *Behavioral Disorders,* 9, 239-246.

[24] Wood, F.H., Smith, C.R., & Grimes, J. (1985). *Iowa assessment model in behavioral disorders: A training manual.* Des Moines: Iowa Department of Public Instruction.

[25] Severson, H. H., Walker, H. M., Hope-Doolittle, J., Kratochwill, T. R., & Gresham, F. M. (2006). Proactive, early screening to detect behaviorally at-risk students: Issues, approaches, emerging innovations, and professional practices. *Journal of School Psychology*, 45(2007), 193-223.

b.e.s.t.: THE RIGHT INFORMATION AT THE RIGHT TIME

Teachers work in prescriptive environments while certain practices are favored. **b.e.s.t.** puts people together with the right information at the right time to help them think critically, make important decisions wisely about what children may need.

The relative standing of a child on b.e.s.t. indicates the amount of support they are likely to need to achieve a different status while end of the year outcomes provide a basis for evaluating the support, intervention or the effect of replacement behaviors taught and learned.

We need to help children learn how to keep learning. "Any and all learning can make you feel better."

Appendix A

Essential Components of a Behavioral Health Framework