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A PROGRAM EVALUATION OF A SPECIAL EDUCATION DAY SCHOOL FOR
STUDENTS WITH EMOTIONAL AND BEHAVIORAL DISABILITIES

by

Lucinda Klein-Lombardo

A Dissertation

Presented to the Faculty of

the Graduate College of the University of Nebraska

In Partial

Fulfillment of Requirements of the Degree

Doctor of Education

Major: Educational Administration

Under the Supervision of Kay A. Keiser, Ed.D., chair

Omaha, NE

May 2012

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Abstract

A PROGRAM EVALUATION OF A SPECIAL EDUCATION DAY SCHOOL FOR STUDENTS WITH EMOTIONAL AND BEHAVIORAL DISABILITIES

Lucinda Klein-Lombardo, M.S., Ed.D.

University of Nebraska 2012

Advisor: Dr. Kay A. Keiser

The purpose of this study was the program evaluation of a special education day school compared to a set of best practice standards for school programs for students with emotional and behavioral disorders. This evaluation will enable the organization to make decisions about which aspects of the program to continue, strengthen, or discontinue.

In this study, Malcom Provus' Discrepancy Evaluation Model (DEM) was used. The population included students enrolled in the program for the 2008-2009, 2009-2010, and 2010-2011 school years. Data was gathered from the teachers, coordinators, and youth workers who worked directly with these students. The study was organized into four domains: (1) academic, (2) social skills, (3) mental health, and (4) sustainability. Archival data including attendance records, assessment scores, social skills and level advancement records, mental health information of the students, and information on students' transitions back to public school was used. The analysis of this program evaluation included descriptive statistics and inferential statistics regarding pretest and protest scores on the Peabody Individual Achievement Test (PIAT).

The results of this program evaluation indicate that in the academic domain there was a very significant difference in the pretest and posttest scores of the students on the

PIAT. In the social skills domain, some students showed improvement in social skills while others showed little or no gains. In the mental health domain, individual mental health needs of the students were clearly a priority and there was no “one size fits all” aspect. In the sustainability domain, most students maintained their transition back to a less restrictive environment (public school).

The information gathered from this student suggests that the organization should continue to enhance their program by using evidence-based practices in the academic and social skills domains. In the mental health domain, the individual differences of the students should continue to drive the decisions made about that aspect of the program. In the sustainability domain, collaboration between parents, schools, and other agencies should continue and expand to meet the needs of this very challenging population of students.

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So many people have contributed to this process and helped carve a path of success for me. By providing encouragement, expressing confidence, sharing their expertise and giving of their personal time, they have helped me in this journey. It is with sincere gratitude that I express the following acknowledgements.

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My sincere gratitude goes to Dr. Kay Keiser, my dissertation supervisor, whose wisdom and patience allowed me to persist and overcome and made this process truly meaningful for me. Also, thanks to my dissertation committee members Dr. Peter Smith, Dr. Richard Christie and Dr. Julie Delkamiller. In addition, Dr. Laura Schulte (Retired), a former faculty member provided impetus and initiated my journey.

My daughters Caitlin and Alison probably can't remember a time when I wasn't studying, taking a class, or writing a paper. Even though my attention was sometimes on my college courses, they were always my first priority. Finally, my husband, Russ was a tireless advocate and partner. To my husband and daughters, I offer my deepest love and appreciation for their constant inspiration.

To all of these people and countless others too numerous to mention, I extend my heartfelt gratitude.

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Chapter 1

Introduction

Students with emotional or behavioral disorders have some of the worst educational outcomes of all student groups (Bullis & Cheney, 1999). These students often struggle with the academic and social demands of the school setting, are removed from the classroom, and fail academically which increases the risk of early school leaving. They are among the most likely to drop out of school, have lower success rates in transition programs, have academic underachievement, higher grade retention, lower graduation rates, and higher rates of suspension/expulsion (Suh & Suh, 2007 ; Cheney & Bullis, 2004).

Behavioral difficulties in childhood are associated with a variety of difficulties that carry on into adulthood (Visser, Cole, & Daniels, 2002). Children and adolescents with emotional and behavioral disorders (EBD) are much more likely to have problems maintaining employment, forming and maintaining personal relationships, and are at increased risk of criminal activities as adults (Stevenson & Goodman, 2001). When combined with school failure, children who are aggressive and anti-social face poor adult outcomes in terms of social adjustment and mental health (Hallahan, Kauffman, & Pullen, 2009). Many children and youth with behavioral disorders grow up to be adults who have real difficulties leading independent, productive lives. This is especially true for those who have conduct disorders (Walker, 2004). The conduct disordered (hyperaggressive) child's adulthood is frequently characterized by socially intolerable behavior, social incompetence, and incarceration (Walker, 2004; Stevenson & Goodman, 2001).

Usually, students with behavioral disorders are not good at making friends. If they do develop friendships, it is often with peers who also have negative behavior (Farmer, 2000). Often students with behavioral disorders lead lives of terrible desperation and their affect is one of extreme unhappiness. In the school setting, their dysfunctional behavior indicates they are not getting something they need. Their poor decision making brings them to the attention of school officials and juvenile courts. Because schools are charged with maintaining safe learning environments and students with poor judgment and poor decision making skills threaten that environment, school officials often choose more restrictive school placements that offer the best safety and protection.

When repeated office referrals fail to stop their disruptive behavior, students with behavior disorders are assigned to in-school suspension programs (Kritsonis & Cloud, 2006; Morrison, Anthony, Storino & Dillon, 2001). Persistent problems then result in the student being suspended from school (Arcia, 2006; Dupper & Bosch, 1996). Frequent removal from school contributes to poor attendance; a major risk factor linked to low test scores and school failure (Roby, 2004).

Many students with EBD live lives of desperation, depression, and rejection. Students who are withdrawn or depressed do not develop the close and satisfying relationships needed for normal child and adolescent development. Many students with EBD display abusive, destructive, unpredictable, hostile, and aggressive behavior even towards others who are attempting to be friendly (Farmer, 2000).

Students with a diagnosis of EBD are frequently destined for a life of crime and abuse. Because of poor judgment and internal control, students with EBD often provoke

aggressive and even violent counter reactions in individuals they may be attempting to victimize (Cullinan, 2004). Consequently, students with EBD are often placed in more restrictive treatment programs for their own protection as well as the protection of those they may victimize. In general, students identified with EBD are often described as being their own worst enemies because they persistently repeat self-destructive patterns of behavior and disrespect towards persons in authority including teachers and principals. This pattern of persistent disrespect and open defiance towards adults contributes, more than any other variable, with early exclusion from regular school classrooms. When combined with school failure, children who are aggressive and anti-social face poor adult outcomes in terms of social adjustment and mental health (Hallahan, et al., 2009).

During the 1990's there was increased recognition that the mental health needs of youths involved in the juvenile justice system were not being met. This realization was undoubtedly associated with an increase in youth violence and the obvious link between externalizing behaviors and violence. In fact, in the United States violent acts committed by youths accounted for 40% of all deaths among teenagers (Snyder, 2000). Deaths where firearms were involved were the second leading cause of death among youth of all races and the leading cause for African American male youth (Snyder, 2000). By 2000, there was a reduction in serious violent acts by youths. However, other less serious but harmful aggression continues to get the attention of educators because of their incidence in school settings. The most dangerous of these behaviors are physical fights and carrying weapons to school. This information has resulted in increased attention by educators to the origins and occurrence of externalizing disorders among students.

Milder forms of student problem behavior at school are sometimes considered a “red flag” for future behavior that could threaten school safety. Since these problem behaviors tend to accelerate over time, these behaviors are likely to become extremely troublesome to others and may ultimately result in the students being “pushed out of school.” (Walker, Forness, Kauffman, Epstein, Gresham, & Nelson, 1998). The 1997 reauthorization of IDEA stipulated that a student with an identified disability could not be expelled from school for behaviors caused by the disability. Rather than being expelled, these students are often reassigned to a special school.

The association between problems in academics and behavioral difficulties is clear. Some describe the possibility that academic problems may lead to behavior problems for some students and behavior problems may lead to academic problems for others. Though there is no clear causal link between academic and behavior problems, learning problems do seem to be linked through co-morbidity with other factors, such as attention, hyperactivity, attendance, disciplinary problems, and family background (Farmer, 2000).

During the 1980’s and 1990’s, one of the biggest issues in special education was where students with disabilities should be taught. There are several studies that have documented a connection between the severity of EBD and the degree of restrictiveness of the school placement. Youths residing in residential settings exhibited more severe behavior problems, had greater risk factors in various areas of their lives, and had more contact with agencies than peers served in special education in public school settings (Silver, Duchnowski, Kutash, & Friedman, 1992).

History of Research Site

Like so many organizations of its kind, the research site was formed because of a specific need. A flood in 1881 left many residents weakened and financially vulnerable. Because of the disaster, people were left helpless with little or no means to care for their children, destitute elderly persons, and orphans. By late 1882, the situation had become severe.

A local reverend related his experiences with the countless poverty-stricken families in the city and appealed to the citizens for goods and financial assistance to help the “poor and friendless.” In December 1882, a man came to the reverend’s church chapel and requested that the reverend take his three daughters into his home as his wife died the previous day and he could not care for them. As word spread, a few others dropped off children to be cared for. In March 1883, a group of supporters gathered to draw up articles of incorporation and chose the name for the research site. In 1894, the name was changed and nearly a century later, in 1986, there was an addition added to the name of the research site.

Beginning in the late 1950’s and through the 1960’s, there began to be changes in the types and numbers of children referred for care. This necessitated a change in the programs, facilities and staff required to meet the needs. By 1965, the majority of referrals for services were from various juvenile courts in the southwestern area of the state. By 1972, there was a major transformation to the programs and services. Rather than relying strictly on private donations, the organization began utilizing payment for services programs with state and other governmental agencies. In 1977, an addition to one of the residential cottages was completed and opened as a controlled care detention

facility. Due to changes in the law regarding locked settings for juveniles, this facility was revamped and became a non-locked emergency shelter for children.

In 1986, the special education day school (Academic Center) was opened in response to the educational needs of students in the residential programs at the research site. In 1990, the research site became a Psychiatric Medical Institute for Children (PMIC). PMIC organizations accept and treat children who meet the specific criteria for this level of care in the state.

Currently, the Academic Center serves two populations of students in Grades 1-12 who require segregated special education services for emotional and behavioral disorders: (1) students who live in the PMIC program at the research site, and (2) students who live at home or in foster homes and are referred to the Academic Center from their home schools. The center serves students who require a self-contained classroom and individual support. Emphasis is placed on developing the students' academic, behavioral, and social skills to a degree where it is possible for the student to return to public school. The program maintains a student to adult ratio of approximately three to one. The program is highly structured and provides students with immediate opportunities to problem solve and receive feedback. The program components include, a core academic curriculum, specialized reading, math and written language intervention (Title I), a token economy, hourly behavior monitoring, medication management, daily social skills instruction, opportunities for individualized instruction as needed, and individual sessions with staff coordinators. Mental health services are individualized and include individual therapy, milieu therapy, and family therapy. Transitions back to public school are on an individual basis and involve extensive communication and problem solving with the

receiving public school staff, parents, and student. Transitions take place gradually (adding one or two classes at a time) and are usually finalized within a period of approximately two years.

Evaluation Framework

The 21st century has brought huge challenges to our society and our schools. Most of these challenges are not new and over time, they have become more complex. Public and nonprofit sectors alike confront profound social problems like reducing functional illiteracy, supporting families, and reducing drug abuse, child abuse and teenage pregnancy. Increased concern over these problems has mobilized a greater effort to resolve them. Local, state, and national groups have advanced programs aimed at the foundational causes of these complex problems. Over time, some programs deemed to be ineffective have been replaced by new programs with the purpose of finding better solutions. Tight budgets and shrinking resources have added to the struggle of maintaining those programs which have produced the most promising results. Even some successful programs are in danger as leaders and policy makers grapple with how to stretch limited funds to cover so many diverse needs. To make informed decisions, leaders need good information about the efficacy of each program. Which programs are working well? Which are working poorly? Are some parts of the programs working better than others? What adaptations would make the programs more effective? Answers to these questions are found using program evaluation.

Statement of the Problem

The purpose of this study is to compare aspects of the Academic Center program in the following domains: academic, social skills, mental health, and sustainability to

seven standards. The results of the study will aid leaders in making decision about improving, maintaining, or terminating the program or some aspect of it.

Research Questions

1. How successfully is the Academic Center meeting the standards in the academic domain?
2. How successfully is the Academic Center meeting the standards in the social skills domain?
3. How successfully is the Academic Center meeting the standards in the mental health domain?
4. How successfully is the Academic Center meeting the standard in the sustainability domain?

Definition of Terms

The following terms will be used consistently throughout the study:

Academic Time After School (ATAS): after school time in which a student works under the supervision of a teacher to complete academic tasks not completed during the regular school day.

Attention-Deficit/Hyperactivity Disorder (ADHD): a condition characterized by severe problems of inattention, hyperactivity and/or impulsivity, often found in people with learning disabilities (American Psychiatric Association, 2000)

Antidepressant Medications: intended to reduce depression symptoms. Examples are: fluoxetine (Prozac), citalopram (Celexa), and escitalopram oxalate (Lexapro).

Anxiety Based Disorders: a group of mental disturbances characterized by anxiety as a central or core symptom. Although anxiety is a commonplace experience, not everyone who experiences it has an anxiety disorder. Anxiety is associated with a wide range of physical illnesses, medication side effects, and other psychiatric disorders. (American Psychiatric Association, 2000).

Autism Spectrum Disorder: a complex developmental disability that causes problems with social interaction and communication. Symptoms usually start before age three and can cause delays or problems in many different skills that develop from infancy to adulthood (American Psychiatric Association, 2000).

Basic Reading Inventory (BRI): an individually administered informal reading assessment which identifies a student's strengths and weaknesses. This inventory identifies a student's independent, instructional, and frustration levels.

Behavioral Time After School (BTAS): after school time in which a student completes a teaching intervention under the supervision of a teacher or paraprofessional about a specific behavioral concern (e.g., physical aggression, verbal abuse, etc.).

Bipolar Disorder: a mood or affective disorder characterized by periods of mania alternating with periods of depression usually interspersed with relatively long intervals of normal mood (American Psychiatric Association, 2000).

Borderline Personality Traits: individuals with this diagnosis experience problems in their relationships with others. Relationships with others are intense and unstable. They swing wildly from love to hate and back again. People with borderline personality traits frantically try to avoid real or imagined abandonment. (American Psychiatric Association, 2000).

Child and Adolescent Functional Assessment Scale (CAFAS): used by mental health clinicians to assess the degree of impairment in children and adolescents with emotional, behavioral, or substance use symptoms/disorders (Hodges, 2004).

Council of Accreditation (COA): an international, independent, not-for profit, child and family serving and behavior healthcare accrediting organization. It was founded in 1977 by the Child Welfare League of America and Family Service America (now the Alliance for Children and Families). An organization is evaluated against best-practice standards, which are developed using a consensus model with input from a wide range of service providers, funders, experts, policymakers, and consumers.

Co-morbid: having two or more conditions or diseases at one time.

Conduct Disorder (CD): any of a number of types of repetitive and persistent antisocial behavior exhibited in childhood or adolescence (American Psychiatric Association, 2000).

Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV-TR): published by the American Psychiatric Association, it provides a common language and standard criteria for the classification of mental disorders. It is a multi-axial classification system consisting of five axes referring to different domains of information that assists the clinician in treatment planning. Axis I refers to the principal disorder, Axis II refers to personality disorder, Axis III refers to medical issues, Axis IV refers to psychosocial stressors, and Axis V is the global assessment of functioning (GAF) (Luborsky, McLellan, Diguier, Woody, & Seligman, 1997). The fourth edition text revision was published in 2000.

Emotional and Behavioral Disorders (EBD): a condition exhibiting the following characteristics over a long period of time and to a marked extent, which adversely affects educational performance; an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory relationships with peers and teachers; inappropriate types of behavior or feelings under normal. Many different terms have been used to designate children who have extreme social-interpersonal and/or intrapersonal problems, including emotionally handicapped, emotionally disturbed, behaviorally disordered, emotionally impaired, behaviorally impaired, socially/emotionally handicapped, emotionally conflicted, and seriously behaviorally disabled. For the purposes of this study, the term emotional and behavioral disordered (EBD) will be used.

Externalizing Behaviors: acting-out behavior; aggressive or disruptive behavior that is observable as behavior directed toward others.

Family Therapy: type of psychological counseling done to help family members improve communication and resolve conflicts.

Forty Developmental Assets: grounded in extensive research in youth development, resiliency, and prevention, the developmental assets are a framework by the Search Institute representing the relationships, opportunities, and personal qualities that children and adolescents need to avoid risk and thrive.

Full Continuum of Alternative Placements: a range of placement options varying in separateness from general education and degree of specialness including general education, general education with consultation, itinerant teacher, resource

teacher, self-contained special class, special day school, homebound or hospital instruction, and residential school.

Global Assessment of Functioning (GAF): The GAF Scale is the fifth axis of a multi-axial diagnostic classification system. The GAF Scale is a rating scale of overall psychological functioning on a scale of 0-100 (Luborsky, et al., 1997). A rating of 100 is described as “superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities, no symptoms.” A rating of 60 is described as “moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). In contrast, a rating of 30 is described as “behavior is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriate, suicidal preoccupation) or inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends). The clinician considers psychological, social, and occupational or school functioning in a hypothetical continuum of mental health illness. The clinician can consider the full range of codes including intermediate codes when appropriate, e.g., 45, 68, 72.

IDEA: Individuals With Disabilities Education Act was enacted in 1990 and re-authorized in 1997 and 2004; it replaced PL 94-142, enacted in 1975. This federal law requires that to receive funds under the act, every school system in the nation must provide a free, appropriate public education for every child between the ages of three and twenty-one, regardless of how or how seriously he or she may be disabled.

Impulse Control Disorder: A psychological disorder characterized by the repeated inability to refrain from performing a particular action that is harmful either to oneself or others (American Psychiatric Association, 2000).

Inclusion: teaching students with disabilities in the same environment as their age peers who don't have disabilities.

Individual Educational Program (IEP): IDEA requires an IEP to be drawn up by the educational team for each exceptional child; the IEP must include a statement of present educational performance, instructional goals, educational services to be provided, and criteria and procedures for determining that the instructional objectives are being met.

Individual Therapy: or personal counseling intended to aid a client in problems of living.

Internalizing Behaviors: acting-in behavior; anxiety, fearfulness, withdrawal, and other indications of an individual's mood or internal state.

Iowa Assessments: standardized assessments formerly known as the Iowa Tests of Basic Skills (ITBS) and Iowa Tests of Educational Development (ITED) (Hieronymous, Hoover, Oberley, Cantor, Frisbie, Dunbar, Lewis, & Lingquist, 1990).

Learned Helplessness: an act of giving up trying as a result of consistent failure to be rewarded in life.

Milieu Therapy: a form of inpatient therapy involving prescriptive activities and social interactions according to a patient's emotional and interpersonal needs.

Mood Disorders: also known as Affective Disorders, any of several psychological disorders characterized by abnormalities of emotional state including

major depressive disorder, dysthymia, and bipolar disorder (American Psychiatric Association, 2000).

Obsessive Compulsive Disorder: Obsessive-compulsive disorder is an anxiety disorder in which people have thoughts, feelings, ideas, sensations (obsessions), or behaviors that make them feel driven to do something (compulsions) (American Psychiatric Association, 2000).

Oppositional Defiant Disorder (ODD): a disruptive behavior pattern of childhood and adolescence characterized by defiant, disobedient, and hostile behavior especially toward adults in positions of authority (American Psychiatric Association, 2000).

Peabody Individual Achievement Test-Revised-Normative Update (PIAT-R/NU): an individual measure of academic achievement appropriate for use with mildly disabled individuals.

Pica: an eating disorder that is characterized by an appetite for non-nutritionally substantive things, such as dirt or plastic (American Psychiatric Association, 2000).

Post Traumatic Stress Disorder: a type of anxiety disorder that can occur after an individual has seen or experienced a traumatic event that involved the threat of injury or death. (American Psychiatric Association, 2000).

Program Evaluation: pertinent information used by those who hold a stake in whatever is being evaluated, helping them to make educated, informed decisions (Fitzpatrick, Sanders, & Worthen, 2011).

Psychiatric Medical Institute for Children (PMIC): a specialized residential treatment program for eligible children and adolescents.

Psychosis: a loss of contact with reality, usually including false ideas about what is taking place or who one is (delusions) and seeing or hearing things that are not there (hallucinations). (American Psychiatric Association, 2000).

Reactive Attachment Disorder: a problem with social interaction that occurs when a child's basic physical and emotional needs are neglected, particularly when the child is an infant (American Psychiatric Association, 2000).

Segregated School Program or Special Education Day School: an all-day special placement for exceptional learners who need this level of specialization or dedication to their needs. This type of placement is usually organized for a specific category of exceptional students and may contain special equipment or special procedures for their care and education. These students return to their homes during non-school hours.

Stimulant Medications: the most widely used drugs in the treatment of students with disabilities. Their intended effects are to make students more ready to learn rather than to make the students learn. They inhibit hyperactivity, distractibility, and inattention. Examples are: methylphenidate hydrochloride (Ritalin) and magnesium pemoline (Cylert).

Therapeutic Crisis Intervention (TCI): developed at Cornell University, a crisis prevention model for residential child care organizations that assists in preventing crisis from occurring, de-escalating potential crisis, effectively managing acute crisis, reducing potential and actual injury to children and staff, learning constructive ways to handle stressful situations and developing a learning circle within the organization.

Assumptions

The research site is accredited by Council on Accreditation (COA). COA is an international, independent, not-for-profit, child and family service and behavioral healthcare accrediting organization. To be accredited, an organization is evaluated against best-practice standards. While the Academic Center is not one of the accredited programs at research site, as a support service of the residential treatment program, some of the treatments and procedures are reviewed including crisis management and medication management. It is assumed that the best-practice standards for accreditation are aligned with best-practice standards for a segregated special education program for students with emotional and behavior disorders.

Limitations

There are two limitations to this study. One limitation is that the researcher is the Director of the program and consequently does not bring the outside perspective of an external evaluator. In addition the study is limited to only one school location. The study is also limited by issues of confidentiality.

Delimitations

This study involves one small special education day school operated at one site in Midwest America. The small number of individuals and the nature of student needs does not lead to broad generalization of findings. In addition, students who attend the Academic Center are identified as eligible individuals for special education in the area of behavior disorders and are considered seriously disordered.

Significance of the Study

Although the Academic Center has existed for many years, no formal program evaluation has been conducted. The data collected in this study will be used to create a process used by the research site in making decisions about maintaining, improving, or terminating the program.

This study will add some much needed research regarding students with serious emotional and behavior disorders. In addition, organizations are searching for guidance when developing programs for students with complex issues. This framework can be the foundation organizations are searching for when undertaking program development. This framework will help organizations looking to expand the continuum of services for special education students. In light of the current economic climate, schools and other organizations needing to decide where to put their resources can utilize this process to evaluate the effectiveness of programs. This study will provide information to practitioners about the needs of students with EBD while they are in a treatment setting as well as what they need when they return to the public school setting.

Outline of the Study

A review of the selected literature is presented in Chapter Two. The review of literature provides information about the four domains: academic, social skills, mental health, and sustainability. In Chapter Three, the researcher will discuss the rationale for using Malcom Provus' Discrepancy Evaluation Model as the study design. The researcher will also identify the population of the study, selection of survey measurement tools, collection of data, and the analysis procedures.

Chapter 2

Review of Literature

Historical Foundations

History tells us that children with emotional and behavioral disorders (EBD) have been present in every society and era. In the past, these children were not given any special treatment. On the contrary, they were frequently left to their own devices. They were subjected to severe punishment, abuse, seclusion, rejection and ridicule in whatever environment they happened to find themselves (Kanner, 1962; Kauffman, 1976). The purpose of segregated placements or alternative placements was to deal with these children in an effective and humane manner. Some of early (19th century) segregated placements were psychiatric hospitals. “Moral Treatment” of individuals in general psychiatric hospitals included physical, occupational, recreational, psychological, and educational therapies (Brigham, 1994; Mayo, 1839). In these settings both adults and youths were treated.

Because school is such an important part of children’s lives, it played a role in the evolution of child psychiatry (Bettelheim, 1950). In the 1930’s, there was special attention, in the form of special units for children and adolescents in psychiatric hospitals (Kanner, 1957). The Menninger Clinic’s Southard School started in 1926 as school for young children who were functioning at a “retarded level.” Children with psychiatric disorders were included later. While “moral treatment” was the model for those with psychiatric issues, those who were juvenile delinquents, homeless or “bad” were placed in “houses of refuge” or “reform schools” (Rothman, 1971). As a general rule, if an individual was placed in a psychiatric hospital, they were deemed to be “sick” and

deserving of therapeutic care; whereas, those in “reform schools” were “bad” and deserving of punishment.

Over time, hospitals and residential placements continued to provide some “educational therapy” to the children they served. The assumption behind this practice was that some children could not be managed and taught in their communities, but living in a structured environment for a time with trained personnel could restore the needed attitude and behaviors to allow reintegration (Bettelheim, 1950).

In 1953, the first day school for students with severe emotional disturbance was opened (Fenichel, 1966). The primary purpose of this type of school was to allow the student to live at home, but receive an education in a more structured setting.

In the 1970’s mainstreaming affected the placements of students with disabilities in all categories. In the 1990’s the “inclusion” movement identified the neighborhood schools as the appropriate educational placement for essentially all children, regardless of disability (Stainback & Stainback, 1996). Both mainstreaming and inclusion seemed to threaten the maintenance of the continuum of alternative placements. The continuum of alternative placements requires the establishment of service programs that contain a variety of alternative settings as options.

Currently, nearly half a million children in the United States receive special education services under the category of Behavioral Disorders (DSM-IV-TR, 2000; U.S. Department of Education, 2007). Teaching students with attention-deficit/hyperactivity disorder (Barkley, 1990), conduct disorder (Colvin, 2004; Patterson, Reid, & Dishion, 1992; Walker, et al., 1998), oppositional defiant disorder (Farmer, 2000; Walker, Ramsey & Gresham, 2004), bipolar disorders (Cullinan, 2004; Gresham & Kern, 2004), and co

morbid conditions requires that a student's presenting behavioral and emotional problems be dealt with before in-classroom instructional control and task completion can be accomplished (Furlong, Morrison, & Fisher, 2005; Walker, 1995; Walker, et al., 2004).

Fifty percent of elementary-age students who exhibit high levels of antisocial behaviors (e.g., disobedience, fighting) and have an early diagnosis of behavior disorders, including attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder, continue their misbehavior into adolescence and as many as 75% of these adolescents will require more restrictive placement in therapeutic day treatment schools or residential psychiatric programs (Eddy, Reid, & Curry, 2002).

In the United States, children with behavioral disorders are referred to as having emotional and behavioral disorders (EBD) if they exhibit one or more of the following behaviors over an extended period of time and to a marked degree: (a) an impairment in educational performance that cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers or teachers; (c) inappropriate behaviors or feelings under normal circumstances; (d) a general mood of unhappiness or depression; and (e) a tendency to develop physical symptoms or fears associated with personal or school problems (Individuals with Disabilities Education Improvement Act, IDEA, 2004).

Most children and youth with emotional or behavioral disorders have multiple and complex needs. For most of them, life is chaotic in many ways. In addition to their problems in school, they often have family problems and difficulties in their community including substance abuse, problems maintaining employment, a lack of positive peer and adult relationships, and illegal activities. Because of this, children or youths with

emotional or behavioral disorders might need other services in addition to special education. Their needs may include psychotherapy or counseling, family-related services, and job related training. While schools play an important role in the lives of these children and youths, no single service agency can meet all the needs (Farmer & Farmer, 1999; Kauffman & Landrum, 2009). It is now considered best practice to coordinate the needed services into an integrated effort. For the purposes of this study, the standards used in the program evaluation will be organized into four domains: academic, social skills, mental health, and sustainability (Hallahan, Kauffman, & Pullen, 2009).

Academic Domain

Besides having low grades and other negative academic outcomes, students with emotional or behavioral disorders typically have higher dropout rates and lower graduation rates than other students groups. These students are often placed in highly restrictive settings. In addition to frequent encounters with the juvenile justice system, these students are disproportionately from poor and ethnic-minority families (Coutinho, Oswald, Best, & Forness, 2002; Oswald, Coutinho, Best, & Singh, 1999). The dismal statistics about students with emotional or behavioral disorders have made the successful education of these students an important and challenging task (Landrum, Tankersley, & Kauffman, 2003). It is critical to remediate the overrepresentation of ethnic minorities in programs for students with emotional or behavioral disorders. However, it is equally important to find effective intervention strategies for the diverse students in our schools. (Ishii-Jordan, 2000; Landrum & Kauffman, 2003).

The assertion that children and youths with EBD have above average IQs is a myth. Research clearly shows that few of these students score above the bright-normal range and the average student with EBD has an IQ in the dull-normal range (around 90) (Kauffman & Landrum 2009). Some may presume that emotional or behavioral difficulties might prevent children from scoring as high as they are capable of scoring. However, lower-than-normal IQs for these students suggest lower ability to perform tasks that other students perform successfully. Impairment in other areas of functioning (e.g., academic achievement and social skills) is also characteristic of lower IQ scores.

Often students with emotional or behavioral disorders are underachievers as assessed by standardized tests (Kauffman & Landrum, 2009). Most students with emotional or behavioral disorders do not achieve at the level expected for their mental ages and rarely are these students academically advanced. Most students with severe disorders lack basic reading and math skills. For the minority of students who have basic reading and math skills, few are able to apply the skills to their everyday lives.

Even though these students have very complex needs, some researchers have proposed that inclusion is the most appropriate placement for all students with disabilities. The underlying premise of full inclusion is that the regular classroom in the neighborhood school is always the least restrictive environment (LRE) for all students with disabilities. On the flip side, the underlying premise of the full continuum of alternative placements is that the least restrictive environment for learning will vary from student to student (Crockett & Kauffman, 1999.) Those opposing full inclusion argue that a full continuum of alternative placements ranging from regular classrooms to resource classes, special self-contained classes, and special day or residential schools and

hospitals is necessary if every student with a disability is to receive an appropriate education (Bateman & Chard, 1995). According to Hallenbeck, Kauffman, & Lloyd (1993) the full continuum of alternative placements is essential to implement “least restrictive environment.”

The association between problems in academics and behavioral difficulties is clear. Some describe the possibility that academic problems may lead to behavior problems for some students and behavior problems may lead to academic problems for others. Though there is no clear causal link between academic and behavior problems, learning problems do seem to be linked through co morbidity with other factors, such as attention, hyperactivity, attendance, disciplinary problems, and family background (Farmer, 2000).

Even though students with EBD come with a variety of labels and diagnoses, placement decision should not be based on the diagnostic label of a child, but instead the child’s specific needs. Within the public school, there are a number of possible service delivery models: (1) full-time general education, (2) general education with resource classroom support, and (3) the self-contained special education classroom. Research over the past 40 years has indicated that often the general education classrooms where EBD students are taught do not employ the strategies and supports that have been shown to work (Hayling, Cook, Gresham, State, & Kern, 2008). Therefore, for many EBD students in the public schools, there is a *wait-to-fail* model. School personnel react to problem behaviors (office referrals, suspensions, and even expulsions) instead of implementing a proactive supportive approach intended to prevent problems. Federal initiatives and national efforts (No Child Left Behind and IDEA) have led professionals

to conclude that more students with disabilities should receive education in the general education classrooms. However, when looking at EBD students, the trend toward inclusion raises certain issues. Some researchers maintain that in the general education environment, EBD students have experienced many difficulties (Guetzloe, 1999). Others assert that the very specific needs of EBD students are often better served in a separate setting (Kauffman, Bantz, & McCullough, 2002).

During the 1980's and 1990's, one of the biggest issues in special education was where students with disabilities should be taught. There are several studies that have documented a connection between the severity of EBD and the degree of restrictiveness of the school placement. Youths residing in residential settings exhibited more severe behavior problems, had greater risk factors in various areas of their lives, and had more contact with agencies than peers served in special education in public school settings (Silver, et al., 1992).

Even with IDEA (Individuals with Disabilities Education Improvement Act, 2004), the impairment criterion has been criticized for being overly subjective and vague (Wiley, Siperstein, Broutree, Forness, & Brigham, 2008). Studies have shown that schools do not necessarily serve a homogenous group of students in the category of EBD. Indeed, some studies indicate that there is a variation in interpretation of *impaired educational performance* to mean low achievement relative to the average achievement of students in their school, not to a more universal standard of "low achievement" (Wiley, et al., 2008).

Social Skills Domain

The lack of social skills is one of the unifying characteristics of students with EBD. Students may engage in inappropriate behavior because they do not have the necessary skills to survive within the school environment. For these students, disruptive behavior is often the result of a discrepancy between the demands of the school environment and social competencies of the individual students (Schinke & Gilchrist, 1984).

Students with emotional or behavioral disorders desperately need specific instruction in social skills. How to manage one's feelings and how to get along with other people are fundamental features of the curriculum for students with emotional or behavioral disorders. Prior to being identified for special education, most students with EBD have been in regular classrooms where they could observe and learn from appropriate peer models. However, these students usually fail to imitate these models. They don't benefit merely from being with other students who display appropriate behaviors. Incidental social learning is insufficient to address their difficulties (Colvin, 2004; Hallenbeck & Kauffman, 1995; Kauffman & Pullen, 1996; Rhode, Jensen, & Reavis, 1992; Walker, et al., 2004). For students with EBD to learn from peer models of appropriate behavior, most will require explicit, focused instruction about whom and what to imitate (Kauffman, 1999; Walker, 1995).

Social skills instruction for students with EBD is as crucial as any academic skill. (Hallahan, et al., 2009). Some students need to learn the skills that individuals use to function in normal social tasks, like starting and maintaining conversations, giving and receiving compliments, engaging in play with peers, and making a request (Gresham,

2002). Also, how people manage their feelings and behavior and how they interact with other people are essential components of the curriculum for students with EBD. These skills must be learned and then practiced in natural settings to maximum generalization after treatment. Students with EBD learn to replace their avoidance and hostility with these normal responses when given specific instruction and practice in real situations.

Social skills interventions are based on the premise that (1) the individual lacks the skills to engage in positive behaviors that result in reinforcement, (2) others may avoid interacting with an individual who exhibits negative or antisocial behaviors, or (3) individuals may be unable to reinforce others thus reducing the rate of mutual reinforcement (Hallahan, et al., 2009). Predominantly, social skills interventions rely on a combination of instruction, modeling, and/or role play.

Students with EBD are referred from inclusive educational settings to more restrictive settings including day treatment and residential treatment as a result of their antisocial and maladaptive behavior (Moffitt & Caspi, 1995). Usually, the reasons for referral to more restrictive day or residential programs fall into three categories. These reasons are not due to the students' diagnosis or severity of psychopathology, but rather due to their behavior. The three categories are: (a) the student is dysfunctional within the family, (b) the student is dysfunctional with the school environment, and/or (c) the student is dysfunctional within the community environment.

When the student's behaviors are disruptive to home life and the parents are not able to provide needed structure to manage the disruptive behavior, a therapeutic setting that provides a "home-like" atmosphere may be needed. There are times that the family itself is so dysfunctional that the students would not have a stable environment while

trying services that are community-based services are used. When this is the case, a more restrictive placement may be needed.

Within the school environment, students may be unavailable for learning and display behaviors so violent or disruptive that others are not able to learn. In these cases, school authorities may consider a placement in a special school outside of the system. If the student's behavior is characterized by not going to school or going to school but leaving, a different type of program is called for. Frequently, the driving force behind a more restrictive school placement is the principal especially if there are repeated violent or disruptive episodes with teachers or peers. Children and adolescents do not go to residential treatment programs because they have "conduct disorder" or because they are mentally ill. They are placed because their behaviors are unacceptable in one or more of the three primary environments (home, school, community) necessary to their future development.

An effective social skills program should be an actual course at least twice weekly (Bullis & Benz, 1998). These classes should be long-term in order to affect the social behavior of adolescents significantly. Classes should include content related to work, school, and living settings. If the instruction is connected to these "real" environments and the behavior requirements needed in each, students are more likely to see the relevance of these classes. Relevance leads to a greater likelihood that skills will be practiced, acquired and generalized. Social skills should never really end. When necessary, students might need to reenter classes or participate in more specialized social skills classes, when needed.

Learning to manage stress is an essential survival skill. An individual's perception plays a major role in signaling a reaction of fight or flight. Students with EBD frequently misinterpret social cues. It is commonplace with these students to overreact to minor situations. There are four conditions that challenge the self-control of students (Henley, Ramsey, & Algozzine, 2002). These are: coping with anxiety, controlling the floodgates of the past, adapting to new situations, and relaxing. Students with EBD frequently resort to maladaptive attempts to relax such as using alcohol and drugs. These students benefit from learning adaptive relaxation techniques. Since relaxation is an emotional and biochemical state, students learn to relax by recognizing body signs that they are relaxed (Henley, et al., 2002). These body signs include a slower pulse rate, warm skin temperature, and paced and easy breathing.

Because students with EBD may be unable to tell the difference between a real threat and their normal feelings of anxiety, they may strike out physically or verbally. Gathering information on how a student with EBD perceives a specific event assists the teacher in understanding how to intervene. Active listening techniques make it possible to identify those factors that lead to a fight or flight reaction. Over time, students can learn to identify their "thinking errors" that lead to overreactions. All students need to be able to adjust to new situations or unfamiliar people. Appropriate social skills for new situations include asking questions, verbalizing apprehension, and using caution (Henley & Long, 1999).

An important aspect of any program for students with emotional and behavioral disorders is behavioral control (Colvin, 2004). It is very unlikely that academic and social learning will occur without effective strategies for controlling disruptive behavior.

Studies indicate excellent academic instruction will reduce many behavior problems and teach important academic skills (Falk & Wehby, 2001; Kauffman, et al., 2002; Stein & Davis, 2000; Sutherland & Wehby, 2001). However, even the best instruction won't deter all disruptive behaviors. Effective control strategies are essential as well as involving students in self-control techniques as much as possible. In addition to self-control, teachers must offer effective instruction in academic and social skills that will assist their students in living, learning, and working with others (Farmer, Quinn, Hussey, & Holahan, et al., 2001; Walker, et al., 2004). Additionally, it is essential that teachers allow students to make choices whenever possible. (Jolivet, Stichter, & McCormick, 2002; Kauffman, et al., 2002).

Mental Health Domain

Students with emotional and behavioral disorders frequently have mental health diagnoses that can present a wide variety of behaviors causing concern in the school setting. The behaviors and/or mental health disorders of these students are frequently classified in two broad dimensions: externalizing and internalizing (Cicchetti & Toth, 1991).

Externalizing and internalizing classifications are not mutually exclusive. Individuals often show behaviors of both. For example, they may show internalizing behaviors like distractibility, poor concentration, and short attention span and also display externalizing behaviors like annoying others and fighting. Comorbidity or the co-occurrence of two or more conditions in the same individual is not uncommon (Cullinan, 2004). Specific information about externalizing behavior and internalizing behavior is presented later in this paper.

An even more complex concern is students with major psychiatric disorders (e.g., schizophrenia, bipolar disorder) who may have a wide variety of behavior and academic problems. Some individuals may need hospitalization and intensive treatment, while others may be able to remain at home and attend school. Although the trend today is away from placement in institutions or special schools, those students with severe disorders may require more restrictive placements, specialized treatments, and procedures.

During the 1990's there was increased recognition that the mental health needs of youths involved in the juvenile justice system were not being met. This realization was undoubtedly associated with an increase in youth violence and the obvious link between externalizing behaviors and violence. In fact, in the United States violent acts committed by youths accounted for 40% of all deaths among teenagers (Snyder, 2000). Deaths where firearms were involved were the second leading cause of death among youth of all races and the leading cause for African American male youth (Snyder, 2000). By 2000, there was a reduction in the serious violent acts by youths. However, other less serious but harmful aggression continues to get the attention of educators because of their incidence in school settings. The most dangerous of these behaviors are physical fights and carrying weapons to school. This information has resulted in increased attention by educators to the origins and occurrence of externalizing disorders among students.

Milder forms of student problem behavior at school are sometimes considered a "red flag" for future behavior that could threaten school safety. Since these problem behaviors tend to accelerate over time, these behaviors are likely to become extremely troublesome to others and may ultimately result in the students being "pushed out of

school.” (Walker, et al., 2004). The 1997 reauthorization of IDEA stipulated that a student with an identified disability could not be expelled from school for behaviors caused by the disability. Rather than expulsion, these students are often reassigned to a special school.

Externalizing Behaviors. Attention-deficit/Hyperactivity Disorder (ADHD), Opposition Defiant Disorder (ODD), and Conduct Disorder (CD) are the most common externalized disorders, characterized by acting out towards others. The most frequent basis for referral of children and adolescents for psychiatric and psychological problems and criminal behaviors are associated with conduct disorder (Doll, 1996; Kazdin, 1997). There are a range of antisocial behaviors that begin in childhood and continue into the adult years that are associated with conduct disorder (Moffitt, Caspi, Rutter & Silva, 2002). Not surprisingly, students who exhibit these disruptive behaviors are problematic in the traditional classroom environment and display poor academic performance. Antisocial behavior has been related to truancy and high dropout rates (Rumberger, 1987).

Students with Attention-Deficit/Hyperactivity Disorder (ADHD). The term attention-deficit/hyperactivity disorder describes a behavioral disorder of childhood. The definition of ADHD has evolved over time and through four revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. ADHD, at one time presented as two subtypes of a broad-based concept, attention-deficit with and without out hyperactivity, is now combined into one disorder with three characteristics – hyperactivity, impulsivity, and distractibility.

Between 3 to 7% of the school-age population have ADHD (Barkley, 2006). ADHD occurs more frequently in boys than girls, with estimates as high as 5 to 1 in community-based samples (Barkley, 1990). Though the exact cause is unknown, ADHD is presumed to be neurological. ADHD is purposeless, chronic, pervasive, driven behavior and affected children are described as *unavailable* for learning, whether the learning is academic, social, or emotional.

While most people think inattention is the key characteristic of ADHD, there is a growing consensus that the three characteristics – hyperactivity, impulsivity, and inattention are actually the result of problems in behavioral inhibition (Barkley, 1990). Behavior inhibition is the ability to stop an intended response, to stop an ongoing response, to guard an ongoing response from interruption, and to refrain from responding immediately. Behavioral inhibition allows executive functions, the ability to self-regulate, to occur.

The child with ADHD, lacking the ability to self-regulate, is likely to be viewed as disruptive or perhaps *bad* by his peers and by adults. The distractible ADHD child has a short attention span and seems to *not pay attention*. In reality, the distractible ADHD child is *paying attention to everything* – not filtering the essential information from the unimportant. While the young ADHD child may display purposeless motor behavior, the ADHD adolescent may be able to control visible motor behavior. Instead of the constant fidgeting and movement of the young ADHD child, the ADHD adolescent may move less, but be focused on his own racing thoughts.

Students with Oppositional Defiant Disorder (ODD). Students with ODD act out in specifically defiant ways, like disobeying the requests of adults or blaming others

for their poor decisions. Frequently, these children are angry and have difficulty making friends or gaining any positive attention from adults (American Psychiatric Association, 2000). Because of their acting out, they are in a position to have problems in school.

To be diagnosed with ODD, children must exhibit at least four of the following behaviors for at least six months: often loses temper, often argues with adults, often actively defies or refuses to comply with adults' request or rules, often deliberately annoys people, often blames others for his or her mistakes or misbehavior, is often irritable or easily annoyed by others, is often angry and resentful, and is often spiteful or vindictive (Kauffman, et al., 2002). Although all children will go through periods of defiance in the natural course of development, the persistent nature of the opposition differentiates students with ODD. Many children experiment with being defiant. Many of these children eventually abandon their defiant behaviors for more adaptive ways of getting their needs met (Kauffman, et al., 2002). On the other hand, children with ODD continue to use maladaptive behaviors with adults and peers even though they may experience rejection.

One of the most difficult aspects of working with students with ODD is the fact that many of the behavior management strategies that teachers employ with other students do not work for these students. For example, positive reinforcement, in the form of verbal praise in front of a student's peers, can actually have the opposite effect on the student with ODD. The primary motivation for the student with ODD is public opposition, therefore the teacher who uses public, verbal praise will likely experience positive reinforcement failure.

Students with Conduct Disorder (CD). Students with a diagnosis of CD may present a variety of behaviors and symptoms including a repetitive and persistent pattern in which the rights of others or societal norms or rules are violated, as manifested by the presence of aggression to people and animals, bullying, threatening, or intimidating others, initiating physical fights, using a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun), being physically cruel to people or animals, or has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery), or has forced someone into sexual activity.

Furthermore, according to the American Psychiatric Association children with CD often are engaged in the destruction of property, such as deliberately engaged in fire setting with the intention of causing serious damage, or has deliberately destroyed others' property, are deceitful, avoid obligations, cons others, and has stolen items of nontrivial value without confronting a victim by shoplifting. Serious violation of rules such as staying out at night despite parental prohibitions (beginning before age 13 years), running away from home overnight (at least twice while living in parental or parental surrogate home or once without returning for a lengthy period), or is often truant from school (beginning before age 13 years). Within the school setting, psychiatric labels are sometimes used, but commonly, children, and adolescents displaying serious and troubling behavior problems, including antisocial behaviors, even though determined to be eligible for special education services seldom receive the mental health, pro-social, and behavior replacement intervention they will need to succeed in school (Colvin, 2004; Patterson, et al., 1992; Walker, et al., 2004).

Internalized Disorders. Internalized behaviors sometimes called *acting in* behaviors commonly occur in individuals diagnosed with mood disorders, one of which is bipolar disorder, or anxiety-related disorders (Gresham & Kern, 2004). Students with externalizing behavior tend to immediately get the full attention of school officials, while students with internalizing behavior, who may be able to sit still in the classroom nonetheless, require intense mental health intervention which they seldom receive in school.

Mood-related disorders. Mood disorders are divided into Depressive Disorders (unipolar depression), Bipolar Disorders and two disorders based on etiology – Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder. For the purposes of this study, only Depressive Disorders and Bipolar Disorders will be discussed further.

The Depressive Disorders are distinguished from the Bipolar Disorders by the fact that there is no history of ever having had a Manic, Mixed, or Hypomanic Episode. Bipolar Disorders involve the presence or history of Manic, Mixed, or Hypomanic Episodes, usually accompanied by the presence or history of Major Depressive Episodes.

The essential feature of a Major Depressive Disorder is a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities (American Psychiatric Association, 2000). In children and adolescents, the mood may be more irritable than sad. The individual must also experience some other symptoms from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. Depression in children and adolescents does not

represent a personal weakness nor is it the result of ineffective parenting (Cash, 2003). It is more than just *feeling down* or having a *bad day* or having normal reactions to life events (e.g., breakup of a relationship). Children and adolescents with depression may present as defiant or oppositional and withdrawn from friends or activities (Crundwell & Killu, 2007). Depression in childhood and adolescence has been associated with serious impairments in academic, cognitive, and interpersonal functioning with the school setting (Hammen & Rudolph, 2003; Nolen-Hoeksema, Girgus, & Seligman, 1992). Studies have reported significant negative correlations between ratings of academic competence and depression (Slotkin, Forehand, Fauber, McCombs, & Long, 1988). Furthermore, on the Children's Depression Inventory, adolescents with high depression scores are less likely to graduate from high school (Kandel, Raveis, & Davies, 1986).

Comorbidity of depression with other disorders often results in teachers being confused about the child's condition and consequently missing signs of depression. Depression in children and adolescents is often comorbid with anxiety disorders (Kendall, Brady, & Verduin, 2001), attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder (Fleming & Offord, 1990).

Suicide attempts are much more common in children and adolescents diagnosed with a mood-related disorder (Poland & Lieberman, 2002). The U.S. Public Health Service reports that suicide is the third leading cause of death for adolescents and youth adults (ages 15-24) and the fourth leading cause of death for children ages 10-14. Suicide rates for children ages 5-14 have doubled over the past 20 years.

According to the DSM-IV-TR, Bipolar Disorder is actually divided into Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise

Specified. For the purposes of this study, only Bipolar I Disorder and Bipolar II Disorder will be discussed further.

The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of at least one Manic Episode or Mixed Episode. The elevated mood of a Manic Episode can be described as euphoric, unusually cheerful, good or high. Lability of mood (e.g., the alternation between euphoria and irritability) is frequently seen. Inflated self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions. A Mixed Episode is characterized by rapidly alternating moods (sadness, irritability, euphoria).

The essential feature of Bipolar II Disorder is the occurrence of one or more Major Depressive Episodes accompanied by one or more Hypomanic Episodes. Hypomanic Episodes are distinguished from Manic Episodes in that besides the elevated, expansive, or irritable mood, there must be other symptoms drawn from a list that includes decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities that have a high potential for painful consequences. These activities include unrestrained buying sprees and sexual indiscretions.

Mood Disorders present a significant challenge in the classroom; resulting symptoms can impact memory, recall, motivation, problem solving, task completion, physical and motor skills, and social interactions (Hammen & Rudolph, 2003; Nolen-Hoeksema, et al., 1992).

Anxiety-related disorders. Students with anxiety-related disorders often display a disproportionate response to certain environmental events. These disorders include

separation anxiety, selective mutism, obsessive-compulsive disorder and posttraumatic stress disorder. Anxious and withdrawn adolescents in particular experience a great deal of distress in the school environment (Masia, Klein, Storch, & Corda, 2001)

Sustainability Domain

Students with severe EBD often receive educational services in a segregated school or a special day school. These settings are designed to address the very specific needs of this population of students. Some general characteristics of these programs are: low student/teacher ratio, high degree of structure, individual and/or small group instruction, opportunities to work through emotional and/or behavioral issues immediately, and adults who are given specialized training to work with students who exhibit both internalizing and externalizing behaviors. Frequently, a major goal for students in these highly restrictive environments, is to eventually transition back to a less restrictive placement in a public school.

Several elements of transition or re-entry into public schools have been identified: age-appropriate placement in local public schools, integrated delivery of service, social integration, transition planning, home-school partnership, and systematic program evaluation. In addition to these elements, another important aspect of transition or sustainability is self-determination. The importance of self-determination is highlighted by the research on motivation. This research consistently shows that students were more motivated to perform tasks when they have participated in choosing (Kohn, 1993).

Educators in both the segregated schools and in the public schools do not take these transitions lightly. Placing an ill-prepared student into a public school environment may result in repeating the cycle of school failures. A student who has displayed anti-

social behaviors in the past may not be “welcomed” back by the school officials, parents, or students. These scenarios not only produce lowered self-esteem and frustration for the student, but can increase tension between the segregated school and public school.

The sustainability domain is defined as a commitment to sustained intervention. For the purposes of study, the researcher will examine “sustainability” in terms of successful transition from a restrictive school setting to public school setting. Very little research exists related to this specific transition. Therefore, research regarding adolescent students making these transitions was reviewed: from foster care to home, from residential treatment to home, from incarceration to home, and from high school to the adult world.

A frequent concern regarding specialized behavioral programs is that skills acquired in the “special” setting do not generalize in the natural environment. Since adolescent’s most commonly feared situations occur at school, integrating interventions used in the “special” setting into the public school setting provide optimal opportunity for meaningful change and stability.

Because many emotional or behavioral disorders are developmental disabilities and will not be eliminated completely or “cured,” there is a need for a strong commitment by educators to provide the targeted and sustained interventions necessary to help these students be successful over time. Some research suggests that many adolescents and young adults with severe conduct disorders will require interventions throughout their life span (Wolf, Braukmann, & Ramp, 1987).

Best practice indicates that it is essential to have careful transition planning and collaboration between the segregated school and the public school. When such a

collaboration is nurtured over time, a feeling of trust and confidence develops between the two organizations; the educators in the public school believe that the segregated school will transition students when they are ready and provide the needed supports, and the educators in the segregated school believe the students will be treated in a fair manner when they transition to public school.

Risk and Resilience

Although there is scant research that explores the challenges of students transitioning from a restrictive environment to a less restrictive environment, some conclusions can be inferred from related studies of students with EBD transitioning from school to adulthood. In these studies, certain risk and resilience factors have been identified. A defining notion has been established that resilience concerns successfully coping with or overcoming risk and adversity or developing competence when faced with stress or hardship (Garmezy, Mastern, & Tellegen, 1984). Repeatedly, researchers have found that a significant number of children who have lived in the most adverse circumstances grow up to become productive and competent adults. Therefore, resilience research has emerged from studies of developmental risk. Resilience research asks the questions: Are there characteristics, mechanisms, and processes that enable some high-risk students to achieve personal and educational success when facing poor odds? The results of this research have reassured educators that deliberately promoting resilience may help counterbalance the risk factors facing many students with EBD (Doll & Lyon, 1998).

Risk factors of the youth in this research include: repeated school failures, mental illness, poor social skills, poverty, drug use, gang activity, criminal behavior, low parent

education, family dysfunction, ineffective parenting, child mistreatment, poor physical health of child or parent, parent mental illness or incapacity, and large family size (Doll & Lyon, 1998). Resilience is usually accompanied by “protective factors.” Some examples of “protective factors” are: a caring support system, a decrease or elimination of self-defeating behaviors, reasonable goals, and experiencing success toward reaching those goals. It is clear that the web of risk and protective factors in a student’s life is complex and is affected by many life circumstances.

Successful transition or sustainability often does not progress in clear, steady stages. One of the hallmarks of students with EBD is the variability of their behaviors. It can be baffling to see a student who has been doing well suddenly behave poorly for no apparent reason. Therefore, a crucial part of transitions is the capacity to provide support and structure to students even during these hard times. Staff members and programs willing and able to “go the extra mile” can make a difference in a student’s life (Bullis & Benz, 1998).

Chapter 3

Methodology

The purpose of this study is to examine program aspects of the Academic Center program and compare them to seven standards in the following domains: academic, social skills, mental health, and sustainability. These standards are considered best practice standards in the field of education for students with emotional and behavioral disorders. The research findings will enable the organization to be efficient, effective and fiscally responsible in allocating resources to improve, maintain, or terminate the program or some aspect of it. This may be used as a guide by other similar segregated school programs to strengthen their programs.

Design

The basis of this study is program evaluation theory. This design is the sequence of logical steps that assists the researcher in accessing the empirical data, connecting it to the research questions, and then forming the study conclusions (Yin, 1984). Program evaluation originated in response to both social experimentation on a large scale and government interventions. It is the identification, clarification, and application of defensible criteria to determine an evaluation object's value (worth or merit), quality, utility, effectiveness, or significance in relation to those criteria (Fitzpatrick, et al., 2011). Program evaluation has been utilized to inform leaders in making decisions and improvements regarding future planning.

Specifically, Malcom Provus's Discrepancy Evaluation Model (DEM) theory is a form of program evaluation based on the following processes:

1. Agreeing upon standards (another term used in place of "objectives")

2. Determining whether a discrepancy exists between the performance of some aspect of a program and the standards set for performance.
3. Using information about discrepancies to decide whether to improve, maintain, or terminate the program or some aspect of it (Fitzpatrick, et al., 2011).

Evaluation consists of comparing *Performance (P)* with a *Standard (S)*. This comparison results in *Discrepancy (D)* information. The *D* is used to judge the value or worth about the object of the evaluation (Steinmetz, 1976). Discrepancy evaluation is a practical approach to a wide range of evaluation needs. It can be used to view the daily activities of an individual teacher or for educational program evaluation. One of the main features of the model is its emphasis on self-evaluation and systematic program improvement.

Provus's DEM is a problem solving approach which allows the leaders to evaluate a program during any of four developmental stages, to which he added, a fifth optional stage. The stages are: definition, installation, process (interim products), and product. The fifth optional stage is cost-benefit analysis.

In the *definition* stage, the program is designed and the majority of the work is spent defining goals, processes or activities, and assigning resources and activities. During *installation*, the intent is to make sure the program has been installed as it had been designed. At the *process* stage, evaluation focuses on gathering data on the progress of the participants to determine whether their behaviors changed as expected. During the *product* stage evaluation determines whether the objectives of the program have been achieved.

For this study, the program has been in place for a number of years. Therefore the *product* stage of evaluation was used to ascertain if the objectives have been met. As stated above, DEM requires an agreed upon set of objectives or standards against which the researcher can evaluate the targeted program.

The model's central focus was on use of discrepancies to help leaders determine the extent to which program development is proceeding toward attainment of stated standards. The standards for this study will be: (1) systematic, data-based intervention, (2) continuous assessment and monitoring of progress, (3) provision for practice of new skills, (4) treatment matched to the problem, (5) multi-component treatment, (6) programming for transfer and maintenance, and (7) commitment to sustained intervention (Peacock Hill Working Group, 1991; Walker, Forness, et al., 1998; Kauffman & Landrum, 2009). Table 1 shows the organization of these seven standards into four domains: academic, social skills, mental health and sustainability. These four domains are the organizational foundation for this study.

Qualitative and quantitative information was used and measured using descriptive and inferential data. Descriptive and inferential data was gathered from retrospective information in four domain areas: academic, social skills, mental health, and sustainability. Appraisal data assisted the director and other leaders in understanding the strengths and weaknesses of the Academic Center in meeting the needs of the students served. Shared understanding from the research will provide a knowledge base that can guide the director and other leaders as they make decisions about the future of the program.

Table 1

Domains and Sources of Data

Standard	Descriptive	Inferential
1. Systematic, data-based interventions 2. Continuous assessment and progress monitoring (Academic Domain)	PIAT, level system, daily behavior sheets (daily, weekly, hex term, trimester data), Iowa Assessments, Child and Adolescent Functional Assessment Scale (CAFAS), Global Assessment of Functioning (GAF), 40 Developmental Assets, weekly team meetings, IEP progress 6 times per year	PIAT pre & post-test (standard scores [t-test])
3. Provision for practice of new skills 6. Programming for transfer & maintenance (Social Skills Domain)	Level system packets – demonstration of skills, field trips, community activities, speakers, visitors to campus, community events, teaching interventions in Behavioral Time After School	Numbers of social skills signed off, numbers of students participating in events, daily behavior sheets
4. Treatment matched to the problem 5. Multi-component treatment (Mental Health Domain)	Teaching interventions, behavior contracts, goal setting, social skills instructions daily, reading, math & written language intervention, medication, coordinators' sessions, individual psychotherapy, family therapy sessions, meditation/relaxation, coping skills instruction, staffings with home schools, low student-teacher ratio, high-degree of structure, IEPs, treatment plans, individual or small group instruction	Individual IEP goals, treatment plan goals, behavior contracts, medications, coordinators' sessions, psychotherapy, specialized therapy, small group or individual instruction
7. Commitment to sustained intervention (Sustainability Domain)	Gradual transition to less restrictive environment (1 or 2 classes at a time), complete transition may take 1-3 years to complete depending upon the student. Continuous interaction with public school personnel regarding transitioning students, aftercare services, independent living services	Documentation of students' gradual transition to public school

While many individuals have made contributions to the development of the objectives-oriented evaluation approach since its origins in the 1930s, the person most

often credited with influencing the widespread use of this process is Ralph W. Tyler, for whom the Tylerian Evaluation Approach has been named (Smith & Tyler, 1942).

Building on the Tylerian approach, several other approaches using goals or objectives as the main focus have been refined by Metfessel and Michael (1967) and Provus (1971).

Provus saw evaluation as “a continuous information-management process designed to serve as the watchdog of program management and the handmaiden of administration in the management of program development through sound decision making” (Provus, 1973). In Provus’s Discrepancy Model, the focus is on the use of discrepancies to help leaders determine the extent to which a program is proceeding toward the stated objectives. If a discrepancy is found, Provus recommends that a cooperative problem-solving process be utilized asking, (1) Why is there a discrepancy? (2) What corrective actions are possible? and (3) Which corrective action is best? Provus’s model was designed to facilitate program development in a large public school and then statewide evaluation by a federal bureau, but the model is appropriate to evaluate smaller programs like the Academic Center because it relies on agreed upon standards, determining discrepancy, and using information about discrepancies to make important decisions about the program.

Research Questions

1. How successfully is the Academic Center meeting the standards in the academic domain?
2. How successfully is the Academic Center meeting the standards in the social skills domain?
3. How successfully is the Academic Center meeting the standards in the mental

- health domain?
4. How successfully is the Academic Center meeting the standard in the sustainability domain?

Subjects

Students participating are from the Academic Center in grades 1-12 during three school years, 2008-2009, 2009-2010, and 2010-2011. Ninety-eight percent of the students qualify for free or reduced lunch. One hundred fifty-five students will take part in this study ($N = 155$): for 2008-2009 ($n = 58$); for 2009-2010 ($n = 44$); for 2010-2011 ($n = 53$). Eighty-three percent of the students are male ($n = 128$), and 17% are female ($n = 27$). All students in the study are from ages seven to eighteen. Of the total number of participants ($N = 155$), 81% are White, not Hispanic ($n = 126$), 9% are Hispanic ($n = 14$), 6% are Black, not Hispanic ($n = 9$), and 4% were Native American ($n = 6$). All of the participants ($N = 155$) were enrolled in the Academic Center.

Staff participating are all employees of the research site and work in the Academic Center with students in grades 1-12 during the three school years; 2008-2009, 2009-2010, and 2010-2011. Twenty-three staff members will participate in this study ($N = 23$). Over the course of the three school years of the study, the percentages of males and females varied slightly, but the average was approximately 50% male and 50% female. Of the total number of staff participants ($N = 23$), 50% are youth workers (paraprofessionals) ($n = 12$), 35% are teachers ($n = 8$), 9% are coordinators ($n = 2$), and 4% was the director ($n = 1$). Of the total number of staff participants ($N = 23$), 52% have Bachelor's degrees ($n = 12$), 26% have Associates degrees ($n = 6$), 17% have Masters degrees ($n = 4$), and 4% have two Masters degrees ($n = 1$). Of the youth workers

(paraprofessionals) ($n = 12$), there is an average of three years of experience. Of the teachers ($n = 8$), there is an average of eleven years of experience. Of the coordinators ($n = 2$), there is an average of 14 years of experience. The director ($n = 1$) has thirty-five years of experience.

Additionally, other staff members are involved in the lives of the students either during or outside the school day. These individuals include: a psychiatrist, a pediatrician, an optometrist, a dentist, nurses, therapists, juvenile court officers, clinical case managers, residential supervisors, residential youth workers, and a residential director.

Data Collection & Analysis

Data were collected in two ways. First, the participants were given a pre-test using the Peabody Individual Achievement Test N/U (PIAT) within thirty days of enrollment in the Academic Center. Each child was given a posttest using the PIAT either at the end of the school year or within one week of discharge from the program, whichever came first. Second, the researcher used data from the research site staff and faculty.

The PIAT uses a multiple-choice format and is designed to assess students with disabilities. It is an achievement test that is administered individually to each student. Using a flip book and record sheet, test administration takes less than one hour. The results identify strengths and weaknesses in six subtest areas. The PIAT is a criterion based test which is also normed. The normative update is based on a national sampling of over three thousand people.

The research questions were analyzed using information gathered in several ways. Data were used from PIAT pre and post-test information. School records' information

included information from reading tests, standardized tests, IEP progress monitoring, documentation from after school teaching interventions, transcripts of high school credits earned, behavior sheets, and social skills packets, therapy, and skills groups. Finally, information about student transitions back to public schools was utilized.

Summary

The methodology used in this study includes survey research comprised of a series of questions concerning the four domains: academic, social skills, mental health, and sustainability. In addition, information was gathered from pre-test and post-test data from the Peabody Individual Achievement Test (PIAT.) The methodology is based on principles included in Malcom Provus's Discrepancy Evaluation Model.

Chapter 4

Results and Discussion

Prior to reporting on the results of each of the research questions for this study, it is necessary to explain how the data were gathered. All data were gathered from Children's Square Academic Center records for school years 2008-2009, 2009-2010, and 2010-2011.

Research question 1 was analyzed using inferential data from the Peabody Individual Achievement Test (PIAT) pre-tests and post-tests. The PIAT was chosen because it was developed as an achievement test for students with disabilities. The PIAT contains the following subtests: general information, reading recognition, reading comprehension, mathematics, spelling, and written expression. When given the full battery, students also earned a test total score. Standard scores of the test total were used for this study. On the PIAT, standard scores of 85-115 are considered average.

At the Academic Center, the pre-test was administered within the first thirty days after a student is admitted. The post-test was administered as close as possible to the student's discharge date. In addition to inferential data, research question 1 was analyzed using descriptive data from Academic Center school records.

Research questions 2, 3, and 4 were analyzed using descriptive data from Academic Center school records.

Research Questions

A program evaluation of the Academic Center for students with emotional and behavior disorders at Children's Square U.S.A. Academic Center was completed using archival data. Section one of chapter four will address each research question posed in this study.

Research Question 1

How successfully is the Academic Center meeting the standards in the academic domain?

As seen in Table 2, posttest PIAT scores ($M = 93.01$, $SD = 12.59$) were statistically significantly higher than pretest scores ($M = 88.12$, $SD = 13.17$), $t(154) = 21.21$, $p < .001$, $d = 0.38$.

The PIAT test was also used to determine which students would receive supplemental instruction in Title I Reading. Of the 155 students in this study, 73 students received this additional academic support

At the Academic Center, academic progress was monitored on a daily, weekly, mid-term, and end-of term basis. For daily monitoring, each student carried a daily behavior sheet that documented progress on IEP goals and general school social skills. Each student's behavior looked a little different because of the individual nature of his/her goals. Staff members rated each student each period in each goal area. Copies of daily behavior sheets were sent home for a parent signature and the original was kept at school. For weekly monitoring, staff members met each week to discuss the students' individual academic progress and progress in interpersonal relationships. Mid-term progress reports were mailed to the parents and the student's home school three times per year. End-of-term progress reports were mailed to the parents and the student's home school three times per year. Mid-term and end-of-year reports contained grades and progress on IEP goals.

Beginning PIAT Scores Compared to Ending PIAT Scores

Source	Pretest		Posttest		<i>t</i>	<i>p</i>	<i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
PIAT	88.12	13.17	93.01	12.59	21.21	< .001	0.38

One of the aspects of the Academic Center program is to hold students accountable for the quality of their academic work. Students must earn a minimum of 85% on all assignments, projects, and tests. If a student's grade is below 85%, the student works with the teacher to re-do the assignment. If only minor adjustments are

needed for the student to reach 85%, the student may re-do the work during the school day. If re-teaching is needed, the student is required to stay after school for Academic Time After School (A-TAS) to re-do the work. A student also has the option of re-doing work to earn a grade higher than 85%. If a student is absent from school, A-TAS is also used to make sure the student becomes current on the assignments. A student may stay after school for A-TAS for multiple days, if needed, to catch up on all assignments.

Each winter, students in grades 2, 3, 4, 5, 6, 7, 8, 9, & 11 took Iowa Assessments. The results of these assessments were shared with the student, parent, and home school. Teachers used the results of these assessments in planning instruction for the next year. Prior to taking the Iowa Assessments, each student met with the teacher to set goals to achieve on the assessments.

When a secondary student was enrolled in the Academic Center, the student's transcript was reviewed. In the IEP process, the student's program of study was developed and transition needs were addressed. In instances where the secondary student was enrolled in a course that was not offered at the Academic Center, the staff accessed computer resources so that the student could complete the course and earn the credit.

One student came to the Academic Center during the first semester of her junior year and had been enrolled in Spanish III in her home school. Foreign languages are not offered at the Academic Center, so she completed a computer class in Spanish III earned high school credit for the course.

One perplexing issue at the Academic Center was concerning students with poor school attendance. Obviously, residential students are required to attend school. However, community students frequently have developed a long-standing habit of school

avoidance. In some cases, the habit was enabled by the parent who would call and report the student was sick, when the student was refusing school. The staff at the Academic Center worked with parents to help them understand their role in school attendance. There was some progress with some parents in breaking these patterns and refuse to call the student in sick when the student refused to come to school. Other parents, however, stated they would continue to call the student in sick to avoid a confrontation with the student. Students under the age of 16 who had poor school attendance were reported to the county attorney for truancy. Some of these cases went to mediation. At times, the mediation agreement was helpful in “forcing” the parent to make sure the student attended school.

The more challenging attendance issues were with students who were 16 and older. In Iowa, students must attend school up through age 16, so cases of poor attendance of older students were not handled by the county attorney’s office. If the student turned 16 during the school year, the student was required to complete that school year. In some situations, the parents verbalized the expectation that the students would quit school at 16. In other cases, the parents did not follow through with consequences and placed the entire responsibility for all school matters on the student. One strategy that worked with some students was revoking the student’s driver’s license. In Iowa, if a student was not attending school regularly, the school could write a letter to the Department of Transportation requesting that the student’s license be revoked until the attendance issue was resolved. Unfortunately, this strategy was unsuccessful with some students who continued to drive without their licenses.

Research Question 2

How successfully is the Academic Center meeting the standards in the social skills domain?

The program at the Academic Center used a three-tiered level system. At enrollment, a student began on Level I and could advance to Level II and then Level III by meeting certain expectations including demonstrating targeted social skills, reaching a certain percentage of goals over multiple weeks, service learning, and making a speech in front of other students.

Students at the Academic Center received daily social skills instruction. This instruction was approximately 35 to 45 minutes per day. In addition to this instruction, students were given opportunities to demonstrate targeted social skills in real settings. Each student had a social skills packet with a list of the targeted social skills (see Tables 3-7). When the student demonstrated the social skill in a real setting, the staff member signed and dated the packet. When a student completed the social skills packet, he/she applied to advance to the next level. In order to complete level advancement, the student made an oral presentation in front of the class focusing on the reasons he/she should advance to the next level. Once the requirements were met, the student advanced and the parents were informed of the student's level advancement. Level advancement also meant an increase in responsibilities and privileges. Students had 100 opportunities to

Table 3

List of Social Skills

All Levels

1. Completing All School Work and Assigned Tasks
2. Staying on Task During Class Period
3. Respecting Personal Space and Property
4. Following Directions
5. Using Appropriate Language and Conversation

Level 1

1. Accepting “No” Answers
2. Using “I Feel” Statements
3. Engaging in a Conversation
4. Using Table Etiquette
5. Greeting Others

Level 2

1. Accepting Compliments
2. Seeking Positive Attention
3. Showing Respect
4. Resisting Peer Pressure
5. Disagreeing Appropriately

Level 3

1. Modeling Expectations for Peers
2. Confronting Peers Using Body Basics
3. Reporting Peers’ Behavior Appropriately
4. Ignoring the Distractions of Others
5. Showing Sensitivity to Others

Table 4

Example of Steps in Social Skill Acquisition

Level 1: Using “I Feel” Statements

1. State “I feel _____ when I/my _____; I need _____.
2. Be non-blaming. Do not use YOU statements.
3. Stick to the present situation.
4. Keep a calm voice and show appropriate body language.
5. Express your point of view.
6. Allow the other person to express his/her point of view.
7. Don’t interrupt.

Table 5

Example of Steps in Social Skill Acquisition

Level 2: Accepting Compliments

1. Look at the person who is complimenting you.
2. Use a pleasant tone of voice.
3. Thank the person sincerely for the compliment. Say “Thanks for noticing” or “I appreciate that.”
4. Avoid looking away, mumbling, or denying the compliment.

Table 6

Example of Steps in Social Skill Acquisition

Level 3: Showing Sensitivity to Others

1. Express interest and concern for others, especially when they are having troubles.
2. Recognize that disabled people deserve the same respect as anyone else.
3. Apologize or make amends for hurting someone's feelings or causing harm.
4. Recognize that people of different races, religions, and backgrounds deserve to be treated the same way as you would expect to be treated.

Table 7

Example of Social Skills Sign-off Sheet / Level 1: Using "I Feel" Statements

1. State “I feel _____ when I/my _____; I need _____.”
2. Be non-blaming. Do not use YOU statements.
3. Stick to the present situation.
4. Keep a calm voice and show appropriate body language.
5. Express your point of view.
6. Allow the other person to express his/her point of view. Don’t interrupt.

Date	Description	Staff Signature
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

demonstrate targeted social skills – ten opportunities for ten different social skills.

Students in this study earned between 29 and 100 signatures on their targeted social skills in a school year.

Students were expected to demonstrate social skills in the school every day. In addition, students used their social skills when they participated in community activities

such as attending baseball games, eating in restaurants, etc. On a regular basis, guest speakers were invited to make presentations in the classrooms. When students met guests, they were expected to use their social skills and were given opportunities to do so.

Each student carried a daily behavior sheet on which the staff members documented the student's social skills (see Appendix B – D). Students were rated each period on their targeted social skills. Students earned points for positive behavior. Earning a certain percentage of points for multiple weeks was one of the requirements for level advancement. When a student earned the required percentage of points for the week, he/she earned a “yes” week. Students in this study earned between 8 and 36 “yes” weeks in a school year.

Some students made steady improvement in the social skills domain. Of study participants, 27 students advanced from one level to the next within six weeks, the earliest advancement possible. Fifty-nine students advanced a level within seven to 24 weeks. Forty-four students advanced a level within 25 to 36 weeks. Twenty-five students did not advance from one level to the next during the school year.

Some students seemed to reach a “plateau.” They demonstrated social skills and earned “yes” weeks for a while, but then seemed to lose their motivation. For these students, staff members used contingency contracting to increase the likelihood the students would continue to work toward the goals. In some cases, this intervention was effective. One student earned “yes” weeks and earned 62 signatures in a four week period. When his progress stopped, his teacher wrote a contingency contract that required him to earn two more “yes” weeks and 20 more signatures and he would earn a

movie pass to a local theater. He met the requirements of the contract and earned his reward.

In some cases, staff members found it difficult to find something to motivate certain students. One student was not making progress on any of the expectations for social skills. He would occasionally demonstrate the appropriate social skills, but his positive behaviors were very inconsistent. One staff member decided to spend more time with the student to form a closer relationship. During that time, the staff member learned the student liked comic books. With this information in hand, a contingency contract was written that included comic books and more time spent with that particular staff member as the reward. This proved to be effective for this student.

Some students achieved level advancement, then began to regress in their social skills. One student advanced to Level II and was very motivated to make progress. However, she was informed by her clinical case manager that due to family issues she would not be returning to her parents' home, but would be going into a foster home once she completed the residential treatment program. This sent the student into downward spiral of depression, poor choices, and negative behavior. This continued for three weeks until she met her foster family, worked through some issues in family therapy, and worked in individual therapy with her clinical case manager. Her outlook began to change and got back on a more positive path.

All students were not motivated by additional, more attractive privileges or contingency contracting. Some students made very little progress on the social skills packets (signatures for demonstrating the social skill in a real setting) and remained on the same level for the entire school year.

One aspect of the Academic Center program is Behavioral Time After School (B-TAS). If a student displayed the following: (1) physical aggression, (2) verbal abuse, or (3) leaving his/her assigned area, B-TAS was given. During B-TAS, the student did an assignment with a staff member that focused on the offending behavior. For some students, B-TAS was effective. The time spent with staff provided extra instruction and practice in social skills. Some students, however, were after school for B-TAS on a consistent basis.

Research Question 3

How successfully is the Academic Center meeting the standards in the mental health domain?

The Child and Adolescent Functional Assessment Scale (CAFAS) was a tool used by mental health clinicians to assess the degree of impairment in children and adolescents with emotional, behavioral, or substance use symptoms/disorders. The CAFAS helped the clinician decide the level of mental health care needed and whether that care should include inpatient or outpatient treatment. The Global Assessment of Functioning (GAF) was used by clinicians to examine areas of psychological, social, and occupational or school functioning. The GAF is the fifth axis in the multiaxial classification system in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (Luborsy, et al, 1997). The GAF is a dynamic score that changes as the student received treatment or experienced life stressors. Mental health professionals use the DSM-IV system to diagnose what specific mental illnesses exist. Table 8 lists the types of mental illnesses diagnosed in the students in this study.

A student in inpatient or residential treatment received milieu therapy. Milieu therapy is a form of inpatient therapy involving prescriptive activities and social interactions according to a patient's emotional and interpersonal needs. These prescriptive activities and social interactions took place in the course of daily activity. They took place during meals, while preparing for school, during leisure time, while doing chores, etc.

When a student was admitted to residential treatment, he/she was assigned a clinical case manager. The function of the clinical case manager was to supervise the overall treatment of the student. The clinical case manager along with the medical director, the student's parents, and other members of the clinical team decided on a treatment plan for the student. Part of the treatment planning process was to write specific treatment goals. Treatment goals focus on areas such as: recognizing triggers to anger, developing options to physical aggression, participating in therapy sessions, being compliant with medications, etc. During the treatment planning process, decisions were made about the types of treatment the student would receive. The clinical case manager or medical director provided therapy or the student received therapy from another clinician.

Some students required specialized therapy. Some examples were grief therapy, family therapy, and therapy for sexual issues. Grief therapy might be necessary when a student had experienced the death of loved one. Grief therapy might also be used for

Table 8

Psychiatric Disorders of Students (students may have more than one diagnosis)

Diagnosis	Number of students

ADHD	110
Mood Disorder	112
Anxiety Based Disorder	41
Post Traumatic Stress Disorder	66
Autism Spectrum Disorder	5
Oppositional Defiant Disorder	85
Obsessive Compulsive Disorder	13
Psychosis	28
Other diagnoses: Pica, Impulse Control Disorder, Reactive Attachment Disorder, Borderline Personality Traits	

students whose parents were incarcerated for an extended time, whose parents' parental rights had been terminated, or whose parents had abandoned them.

Frequently, students with mental health needs came from dysfunctional families or families who were in significant crisis. Even when families were reasonably functional, having a family member with mental illness was very difficult. In these cases,

family therapy was used to address parent/child relationships and interactions. A student who had perpetrated sexual assault or had been the victim of sexual assault might need specialized therapy. This type of therapy was provided by a clinician specializing in sexual concerns. A student diagnosed with drug and/or alcohol abuse issues was provided specialized treatment for those concerns. Of the 155 students in the study, 62 students were in family therapy, 36 were in grief therapy, 23 were in therapy for sexual issues, and 12 students were in treatment for drug and/or alcohol issues.

Students with emotional and behavioral disorders might have medical concerns as well. While there may not have been a causal relationship between mental illness and medical concerns, medical concerns were addressed and ruled out as problematic to the student's overall wellbeing. Students admitted to residential treatment began with a complete medical exam, vision exam, and a dental exam. A student might have had a chronic medical condition that required on-going treatment. Some examples of chronic medical conditions were diabetes, allergies, and asthma. Depending upon a student's individual needs, he/she was treated by a dermatologist, gynecologist, orthopedist, neurologist, urologist, gastroenterologist, etc. as parts of his/her overall treatment.

To focus on the mental health domain, a student's needs were addressed individually. A student was assigned to a teacher and a homeroom. The teacher was responsible for convening IEP meetings as required by special education law. When IEP goals were written, besides educational goals, other goals were developed to assist with mental health issues. Some examples were: using coping skills during stressful situations, verbalizing emotions, self-advocacy, using a problem solving method when in conflict, and using meditation and relaxation techniques during stressful situations.

Within the school day, the student was provided individual and/or small group instruction as appropriate for each student and each content area.

Another tool used to address mental health concerns was a contingency contract. With a contingency contract, the student would comply with a required behavior and would earn a pre-determined reward. Conversely, failure to abide by the requirements resulted in a pre-determined consequence. An example of a contingency contract was: The student will refrain from physical aggression (hitting, kicking, shoving) for five days. Reward: 20 minutes of time in the gym with a staff member. Consequence: student will not be allowed to leave the building for a community activity.

Students at the Academic Center were often prescribed medications for their mental health needs. Some prescriptions called for the student to receive medications at school. While the staff at the research site did not diagnose or prescribe medications, they administered medications as directed by the medical director or other physician. Children and youth might be prescribed medications for depression, anxiety, mood disorders, and psychosis. Others were prescribed stimulants or non-stimulants to help with ADHD symptoms.

As well as being assigned to a teacher's homeroom, a student at the Academic Center was assigned to a coordinator. Coordinators were responsible for helping the student and parents with school needs such as attending meetings, problem solving conflicts, and monitoring academic progress. In addition to school services, coordinators assisted the student and parents with accessing other resources and services such as counseling, financial assistance, etc.

The students have complex mental health needs. One of the students was a victim of sexual abuse as a young child. Later he began to display inappropriate sexual behaviors towards other male students. Besides milieu therapy and individual therapy, he went to therapy two times per week for sexual issues. Another student was abandoned by both parents at an early age. She was in individual therapy and also in grief therapy. One student had a long history of physical and sexual abuse. He was in individual therapy, therapy for sexual issues, and also in treatment for substance abuse. One of the young students had been severely neglected as a baby. His parent's rights were terminated and he was placed in a foster home. Later, he was adopted. Because of his diagnosis of reactive attachment disorder he went to specialized therapy as well as milieu therapy and family therapy with his adopted parents.

The mental health needs of some of the community students were a concern to the Academic Center staff. In some cases, the students were not currently under the care of a psychiatrist, were placed on a waiting list, or had appointments several months in the future. In these cases, the staff were sometimes able to assist the family with a referral to a psychiatrist or a psychiatric nurse practitioner. Another problem was students who did not attend their regular therapy appointments. Sometimes, students did not like the therapist or did not want to talk about their mental health issues with the therapist. Instead of working through the problem or finding another therapist, some parents simply stopped taking the student to therapy. The staff members at the Academic Center frequently talked with parents about the importance of therapy for the student. Unfortunately, some parents resumed therapy only after a crisis, so the student's mental health care took place on a reactive basis rather than a preventative one.

Research Question #4

How successfully is the Academic Center meeting the standards in the sustainability domain?

The ultimate goal for each student is to be able to return to his/her home school and be successful. New skills learned by the student must be generalized to the home school setting. In order to facilitate this, the student is transitioned back to the home school on a gradual basis. The transition back to the home school is a very individual process. The student, the parents, the home school and Academic Center staff are all involved in developing the transition plan. Some of the considerations for transition include academic, social, and mental health needs. Most transitions were complete in one to three years.

A student who had low academic skills was often placed in a self-contained special education class or a co-taught class for a core subject. Sometimes a general education class placement was most appropriate for a student who has average or above average academic skills. For a student who had a specific talent, gift, or interest, placement in an elective class was often a motivational factor for the student.

The social needs of the student were critical to the transition process. A student might have been returning to a school where he/she experienced many conflicts with students and adults. In this case classes and teachers were selected in order to provide the best situation for the student.

Mental health needs of the students were another important consideration in the transition process. Certain mental health diagnoses were particularly challenging, like

anxiety disorders or phobias. Understandably, those students whose mental health issues were stabilized, were more successful during transition.

There was no typical transition. Each transition was different because of the student's mental health needs, social needs, and academic needs. Some schools used a semester system and others used a trimester system. Elementary school, middle school, and high school transitions were very different because of their daily schedules and course offerings. Some transitions were hampered due to transportation conflicts and busing concerns.

Obviously, if a student did well in the transition classes and was able to add additional transition classes, this was considered successful. However, if a student maintained (had passing grades, had no major behavioral issues) in the transition classes, this was also considered a successful transition. A transition was considered a failure if the student had to be withdrawn from transition classes and returned to classes in the Academic Center.

One of the students had significant mental health issues including severe anxiety. This student's transition took place over the course of three years. His transition began in seventh grade when he was bused to public school for one core class in a self-contained special education classroom. During second semester of seventh grade, he added two additional classes (one core class, one elective). In eighth grade, he spent the first half of the day through lunch period in public school. During the second semester he struggled with the academic rigor of his classes and was behind on his assignments. Interventions were implemented to assist the student including extra after school sessions with the teachers and increased communication between the public school teachers and the

Academic Center teachers. His transition classes were not increased at that time. As a ninth grader he no longer attended his familiar middle school, instead he attended a large high school. Because of this major change and his severe anxiety, his transition time stayed the same –the first half of the day through lunch period. Additional classes were added during the later part of ninth grade until the student was completely transitioned.

Another student was able to transition very quickly. As a junior in high school, his transition began with two core, co-taught classes and an elective. This student was very capable academically and his elective was in the area of great interest for him. He did very well academically and socially. His transition continued so that he began his senior year full-time at public school.

One elementary student's transition was very unique. As a fourth grader, he transitioned to a self-contained special education classroom in a school that was not in his neighborhood. This decision was made because this school offered the needed supports in a less restrictive environment. After one year, he then transitioned from this school back to his neighborhood school.

One high school student who was very interested in auto mechanics began his transition by taking a two-hour class at the vocational school. With the help of Academic Center staff members, he found a job working with mechanics in a repair shop. He was able to earn some high school credit for maintaining his job and continued to earn the credits he needed to graduate from high school. After graduation, he plans to enroll in a local community college and earn a certificate in auto mechanics.

One of the “failed” transitions was a high school student who began the transition to public school with one core class in a self-contained special education classroom. He

was doing well in the classroom. A few weeks later he was charged with simple assault when he was involved in a physical altercation in his neighborhood. He was placed on probation and continued his partial transition. However, all the teen-agers involved in the altercation attended the same public school and their unresolved issues became a continuing source of conflict in school. He was removed from the transition classes and attended all his classes at the Academic Center. A few months later, his family moved out of state.

There were times when a student became so comfortable in the special setting that he did not want to return to public school. These students were not successful in the public school setting, but did well in the smaller, more structured setting at the Academic Center. In these cases, a great deal of care went into the transition decisions. In one such case, the student was taken to the public school for a tour, met with the school interventionist, counselor, and one of the classroom teachers, and started attending an afterschool club. As the student became more involved with the club, he was more comfortable with the idea of transitioning. His transition began the next semester.

Transitions were sometimes difficult for the parents as well. One student had made the necessary progress and the transition team convened to develop the transition plan. The student was seventeen years old and had a full-scale IQ of 65. The student had been involved in some inappropriate sexual behavior that was well known to the other students, parents, and school staff at the public school. The student's mother was opposed to any transition back to the school because she feared that her daughter would regress and would not be given a fair chance. In this situation, the transition team met multiple

times to try to develop a plan that was agreeable to all. In the end, the student was transitioned to a vocational program instead of returning to her home school.

The four domains in this study represent “best practice” for students with emotional and behavioral disorders. Since no one domain is more important than the others, they represent a balanced approach to programming for this population of students. Students were most successful when they made progress in all four domains.

Chapter 5

Conclusions and Recommendations

The purpose of this study was to compare aspects of the Academic Center program in the following domains: academic, social skills, mental health, and sustainability to seven standards. It seems clear from the program features and data gathered for this research, that the Academic Center has developed a program that encompasses the four domains of academics, social skills, mental health, and sustainability. Students, parents, teachers, and the community all benefit from a high quality, effective program. Peacock Hill Working Group (1991) agrees that there is strong evidence that a program that embraces the previously stated domains has a significant impact on the lives of students with emotional and behavioral disorders. It is especially important to keep in mind the purposes of a special school to serve the needs of public schools in the community.

Academic Domain

Often students who attended the Academic Center frequently arrived after a long succession of placements. Unfortunately, it was not uncommon for a student to have been in a treatment program, then a foster home, and then an emergency shelter before coming to the Academic Center. Often these placements were in different locations and different school districts. Consequently, locating data on these students was a challenge. Because of these challenges, this researcher chose to use pre-test/post-test data collected on site to measure the academic domain.

The results of the PIAT tests indicate the students at the Academic Center made significant academic gains. The daily, weekly, monthly, mid-term, and end-of-term monitoring seems to be a comprehensive system that keeps the students, parents, and staff informed of the students' academic progress.

There were program features of the Academic Center that supported academic growth. Students were expected to earn 85% or higher on all assignments, projects, and tests. When the student earned a score lower than 85%, re-teaching was done and the assignment was re-done. This immediate feedback and remediation seemed to be effective in keeping the students on track and aware of their progress. Academic Time After School (A-TAS) seems to provide a timely intensive opportunity for students to keep up with academic tasks. As suggested by Kauffman and others, this study showed how important it is to have a separate program to address the very specific needs of students with emotional and behavioral disorders (Kauffman, et al, 2002).

As with many “behavior” programs, the Academic Center focuses on managing student behavior so learning can take place. Unfortunately, this has sometimes led to less attention on academic rigor. Because the Academic Center is a special education program, there are many modifications and adaptations that occur in the curriculum and instruction. The daily, weekly, mid-term, and end-of-term monitoring of academics as well as the pretest and posttest data on the Peabody Individual Achievement Test (PIAT) clearly shows the Academic Center strives for academic progress as well as behavior management.

A persistent weakness of programs for students with behavior and emotional disorders is the focus on behavioral management with less focus on academic rigor. Special education students often develop learned helplessness. Furthermore, these students can be quite resistant to novel and challenging tasks. The combination of these factors sometimes leads to lowering teacher expectations for academics. This can be seen in the classroom as consistently below grade level tasks and one-to-one assistance from

staff on most tasks. It is essential that teachers keep high expectations for all students. To counteract learned helplessness, teachers must communicate with students and parents the importance of becoming independent learners and helping students achieve this through a careful task analysis. For example, having the student attempt a new task for a minimum of five minutes before asking for help or having the student read the directions out loud and then paraphrasing what the task requires.

For special education students who have behavioral and emotional disorders, a completely individualized curriculum might seem like the path of least resistance, and it probably is. However, a completely individualized program for most students does them a disservice. Students who are only involved in individualized instruction miss out on important skills such as learning to work with others, compromise, and problem solving.

The staff at the Academic Center should have high academic expectations for all students, even those who are resistant to new and challenging tasks and those who demonstrate learned helplessness. Group instruction needs to be emphasized so students learn valuable classroom skills: waiting to be acknowledged and called on by the teacher, learning to cooperate and compromise, learning to take turns, etc. Individualized instruction (student working one-on-one with a staff member) should be minimized. The majority of students need group instruction and curriculum that mirrors the general education setting to the greatest extent possible. Focus on group instruction and academic rigor is necessary.

Research suggests that students who are engaged in the instructional process misbehave less frequently. All the staff at the Academic Center should focus on making daily lessons more engaging in order to minimize behavior issues and to increase

student interest and motivation. Hand-on activities, field trips, guest speakers, and uses of technology are all examples staff members can use to engage students.

Social Skills Domain

The data in the social skills domain indicate mixed results. Clearly, some students made gains in social skills. Social skills acquisition seems to be a standard part of the daily program at the Academic Center. As Colvin, Kauffman and others indicated in their work (1999), this study found specific instruction in social skills is required. Thirty to forty-five minutes of social skills instruction daily is an appropriate amount of time for the acquisition of social skills. As indicated in the work of Bullis and Benz (1992), this study showed the importance of social skills learning in real environments. A review of students who advanced on the level system indicates that many students successfully demonstrated the targeted social skills.

Some students did not make the anticipated gains in social skills. It is important for staff members to differentiate between social skills acquisition, performance, and fluency. It is clear that many students have been taught and have learned social skills, but for some reason, do not demonstrate them. An examination of preexisting problem behaviors that are likely competing with the newly trained social skills would assist the staff of the Academic Center in developing interventions so students will demonstrate the desired social skill. If competing behaviors are more efficient (i.e., easier to perform and immediately reinforcing) and reliable (i.e., consistently lead to reinforcement), then they will be performed more frequently than their less efficient and less reliable alternative. For example, pushing into line may be more efficient for some students than waiting and asking politely to get into line. In this case pushing and asking politely are functionally equivalent behaviors (they produce the same consequences). Reliable means the

behavior produces more consistent reinforcement than the unreliable behavior. In a program such as the Academic Center, staff members should take a look at the reinforcement that students may be getting for undesirable behavior.

Another aspect of social skills training is fluency. Gresham (2002) distinguished the student with a fluency deficit as a student who knows how and wants to perform a given social skill, but does so in an awkward way. A student with a fluency deficit does not need additional social skills instruction (acquisition), but needs more practice or rehearsal. In other words, all students who are not demonstrating social skills don't require the same intervention.

Another issue in social skills training is treatment integrity. Treatment integrity is concerned with the accuracy and consistency with which treatments are implemented. Failure to ensure the integrity with which treatments are implemented poses several threats to drawing valid conclusions in educational research. There must be consistency with the frequency and intensity of social skills training.

Social skills training must continue to be frequent and intense. It must continue to be viewed as an important aspect of the program and given the same emphasis as other content area instruction. Staff members must understand the differences between social skills acquisition deficits, performance deficits, and fluency deficits. They must make adjustments in the program for each student to address these deficits. Monitoring of treatment integrity should be a high priority.

Mental Health Domain

The data in the mental health domain indicate the complexity of these students. The variety of mental health interventions provided indicate each student's treatment is

individualized. As in the work of Masia, et al (2001), this study found that students with mental illnesses especially need a great deal of individualized support in the school environment. There is no “one size fits all.”

Clearly, students who live in the residential treatment program received round-the-clock monitoring of their mental health needs. Mental health care for community students, however, varied. The Academic Center should encourage collaboration with parents so the mental health needs of the students are a priority. Collaborations with other agencies and entities could make mental health services seamless so students receive consistent care rather than provided as a reaction to a crisis.

However, community students did not always receive mental health care. Students waited many weeks for appointments with psychiatrists, ran out of their medications, did not receive their medication doses, or discontinued therapy. In many cases, parents did not call to schedule psychiatric appointments in a timely manner. Sometimes medications ran out before parents called in for a refill. Sometimes refills were not picked up due to the parent’s inability to pay for the prescription. At times, students came to school without being given their medications. Sometimes parents discontinued therapy when a student did not like his/her therapist or did not want to cooperate in therapy.

Mental health needs of all the students needs to be a priority. Academic Center staff members need to build strong relationships with parents so there is open communication. When a parent perceives they are being criticized for their actions or lack of action, very little will be accomplished. The Academic Center staff needs to approach parents as helpers in accessing mental health care. If a student doesn’t have

medication due to lack of funds, there are community resources to assist with this.

Parents must be comfortable enough with the staff at the Academic Center to ask for this assistance. If medication doses are missed, some doses of the medications can be given at school. When students don't respond in a positive way to a therapist, Academic Center staff members can assist in finding another therapist so there is continuity.

Sustainability Domain

Many students were very successful with transitions back to public school. The Academic Center staff members have established a procedure for transitioning that seems to be helpful to the student and helpful to the public schools. In this process, students are allowed a certain amount of choice regarding which classes to take, how quickly to transition, etc. In this study as well as in the work of Field & Hoffman (2007), self-determination was found to be an important aspect of a sustainable transition back to public school. Many of the students at the Academic Center have serious mental illnesses that will require life-long care. The long-term involvement of the staff members in the lives of the students was found to be essential in their progress, as was found in the work of Bullis & Benz, (1998). The transition procedures that are in place can help educate the public school staff members about the needs of this very vulnerable population. Some students did well in their later high school years as a result of maturing. Sometimes students "found their passion." Whether this passion was athletics, auto mechanics, or music, this specific interest was a motivational factor in the student's life and contributed to a successful transition.

Long-term sustainability is difficult to predict. There were many factors that influenced it, including family, friends, and home issues. Down the road, if a student succeeded, was it due to the school program or some other factor?

Students and parents were often resistant to returning to a public school. Understandably, students often did not want to return to a school setting where there were many problems. Understandably, parents often didn't want to return to the days of frequent calls from the school, disciplinary meetings, school suspensions, etc.

The staff members at the Academic Center need to continue to make transition and on-going work with the students and the schools a priority. This collaboration is in the best interest of the students. The grades and behaviors of students once they return to the public schools should be monitored at three months and again at six months in order to assess the long-term sustainability of the program.

Implications for Future Research

High quality instruction needs to be a priority for students with behavioral and emotional disorders just as it is for all students. These students are often resistant to novel and challenging tasks. They often display learned helplessness. These challenges as well as their poor choices, impulsivity, and aggression make this population of students particularly problematic in the classroom. Much research exists about instructional techniques that are beneficial to students in general. More research is called for in the area of effective instructional techniques and academic interventions for students with behavioral and emotional disorders.

Research has been conducted on social skills training. However, future research should systematically investigate different levels of frequency and intensity of social skills instruction with students with behavioral and emotional disorders. There is little research on treatment integrity in social skills instruction. Monitoring of treatment integrity should be a high priority in future social studies training research. Caldarella and

Merrell (1997) described a taxonomy of social skills: (1) peer relation skills, (2) self-management skills, (3) academic skills, (4) compliance skills, and (5) assertion skills. This taxonomy may be helpful in providing a vocabulary for typical social dimensions on which students may have strengths and weaknesses. It may also be the basis for measuring the effectiveness of social skills interventions.

Summary

The students in this study are examples of some of the most difficult students to maintain in the school setting. These students also have some of the worst educational outcomes of all student groups. Their complex needs – academic problems, mental health concerns, juvenile justice involvement, vocational issues – are a huge challenge for educators. School programs need to find a balance between the academic, social skills, mental health, and sustainability aspects to make the greatest impact, (Kauffman & Landrum, 2009). It is clear that no one entity can bear the responsibility for these needs. When multiple agencies or organizations collaborate, the professionals must possess a higher level of interpersonal skill. Organizations who collaborate with others may find some dissonance between the missions of these groups. This dissonance can cause disagreement among the participants. These disagreements can mark the end of the collaboration or can inspire a higher level of commitment to meeting the needs of the students.

The results of this evaluation illustrate that when a special school program is forward thinking, committed to the students and the community from a number of perspectives, and has proper practices and procedures in place, even the most complex

students can benefit. Special school programs built on validated practices are an important resource to the public schools and to the entire community.

References

- American Psychiatric Association, (2000). *Diagnostic and statistical manual of mental Disorders: DSM-IV-TR*. (4th ed., text revision). Washington: DC
- Arcia, E. (2006). Achievement and enrollment status of suspended students: Outcomes in a large, multicultural school district. *Education and Urban Society*, 38(3), 359-369.
- Barkley, R.A. (1990). *Attention Deficit Hyperactivity Disorder: a Handbook for Diagnosis and Treatment*. New York: The Guilford Press.
- Barkley, R.A. (2006). Etiologies. In R.A. Barkley (Ed.), *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (3rd ed., pp. 219-247). New York: The Guilford Press.
- Bateman, B. D., & Chard, D. J. (1995). Legal demands and constraints on placement decisions. In T. A. Astuto (Ed.), *Issues in educational placement: Students with emotional and behavioral disorders*. (pp. 285-316). Hillsdale, NJ England: Lawrence Erlbaum Associates, Inc. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1995-97583-012&site=ehost-live>
- Bettelheim, B., (1950). *Love is not enough; the treatment of emotionally disturbed children*. Glencoe, IL: Free Press.
- Brigham, A. (1994). The moral treatment of insanity in 1847. *The American Journal of Psychiatry*, 151(6), 10-15.
- Bullis, M., & Benz, M. (1998). Three service delivery components of community-based transition programs. *Reaching Today's Youth*. 2(4), 64-68.
- Bullis, M., & Cheney, D. (1999). Vocational and transition interventions for adolescents

- and young adults with emotional or behavior disorders. *Focus on Exceptional Children*, 31(7), 1. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=2081090&site=ehost-live>
- Caldarella, P., & Merrell, K. (1997). Common dimensions of social skills of children and adolescents: A taxonomy of positive behaviors. *School Psychology Review*, 26, 264-278.
- Cash, R. E. (2003). When it hurts to be a teenager. *Principal Leadership Magazine*, 4(2), 11-15.
- Cheney, D., & Bullis, M. (2004). The school-to-community transition of adolescents with emotional and behavioral disorders. In S. R. Mathur (Ed.), *Handbook of research in emotional and behavioral disorders*. (pp. 369-384). New York, NY US: Guilford Press. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=2005-02874-019&site=ehost-live>
- Cicchetti, D., & Toth, S. L. (1991). In Toth S. L. (Ed.), *Internalizing and externalizing expressions of dysfunction*. Hillsdale, NJ England: Lawrence Erlbaum Associates, Inc. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=1991-98394-000&site=ehost-live>
- Colvin, G. (2004). *Managing the cycle of acting-out behavior in the classroom*. Eugene, OR: Behavior Associates.

- Coutinho, M.J., Oswald, D.P., Best, A.M., & Forness, S.R. (2002). Gender and socio-demographic factors and the disproportionate identification of minority students as emotionally disturbed. *Behavior Disorders, 27*, 109-125.
- Crockett, J.B. & Kauffman, J.M. (1999). *The least restrictive environment: its origins and interpretations in special education*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Crundwell, R.C., & Killu, K. (2007). Understanding and accommodating students with depression in the classroom. *Teaching Exceptional Children, 40*(1), 48-54.
- Cullinan, D. (2004). Classification and definition of emotional and behavioral disorders. In S. R. Mathur (Ed.), *Handbook of research in emotional and behavioral disorders*. (pp. 32-53). New York, NY US: Guilford Press. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2005-02874-003&site=ehost-live>
- Doll, B. (1996). Prevalence of psychiatric disorders in children and youth: An agenda for advocacy by school psychology. *School Psychology Quarterly, 11*(1), 20-46.
doi:10.1037/h0088919
- Doll B., & Lyon, M.A. (1998). Risk and resilience: Implications for the delivery of educational and mental health services in schools. *School Psychology Review, 27*, 348-363.
- Dupper, D.R., & Bosch, L.A. (1996). Reasons for school suspensions: An examination of data from one school district and recommendations for reducing suspensions. *Journal for a Just and Caring Education, 2*(2), 140-150.

- Eddy, J. M., Reid, J. B., & Curry, V. (2002). The etiology of youth antisocial behavior, delinquency, and violence and a public health approach to prevention. In G. Stoner (Ed.), *Interventions for academic and behavior problems II: Preventive and remedial approaches*. (pp. 27-51). Washington, DC US: National Association of School Psychologists. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-03606-002&site=ehost-live>
- Falk, K.B., & Wehby, J.H. (2001). The effects of peer-assisted learning strategies on the beginning reading skills of young children with emotional/behavioral disorders. *Behavioral Disorders, 26*, 344-359.
- Farmer, T. W. (2000). Misconceptions of peer rejection and problem behavior: Understanding aggression in students with mild disabilities. *Remedial and Special Education, 21*(4), 194-208. doi:10.1177/074193250002100401
- Farmer, E.M. & Farmer, T.W. (1999). The role of schools in outcomes for youth: Implications for children's mental health services research. *Journal of Child and Family Studies, 8*, 377-396.
- Farmer, T.W., Quinn, M.M., Hussey, W., & Holahan, T. (2001). The development of disruptive behavioral disorders and correlated constraints: Implications for intervention. *Behavioral Disorders, 26*, 117-130.
- Field, S., & Hoffman, A. (2007). Self-determination in secondary transition assessment. *Assessment for Effective Intervention, 32*(3), 181-190.
- Fitzpatrick, J.L., Sanders, J.R., & Worthen, B.R., (2011). Program evaluation: Alternative approaches and practical guidelines. Boston: Pearson/Allyn and Bacon.

- Fleming, J.E., & Offord, D.R., (1990). Epidemiology of childhood depressive disorders: A critical review. *Journal of American Academy of Child and Adolescent Psychiatry*, 29(4), 571-580.
- Furlong, M.J., Morrison, G. M., & Fisher, E.S. (2005). The influences of the school contexts and processes on violence and disruption in American schools. In P. Clough, P. Gerner, J.T. Pardeck , & F.K.O. Yuen (Eds.), *Handbook of emotional and behavioural difficulties in education* (pp106-120). London: Sage.
- Garnezy, N., Mastern, A.S., & Tellegen, A. (1984). The study of stress and competence in children: the building block for developmental psychopathology. *Child Development*, 55, 97-111.
- Gresham, F.M. (2002). Teaching social skills to high-risk children and youth: Preventative and remedial strategies. In M. Shinn, H. Wallace, & G. Stone (Eds.), *Interventions for academic and behavior problems II* (pp. 403-432). Bethesda, MD: National Association of School Psychologists.
- Gresham, F.M., & Kern, L. (2004). Internalizing behavior problems in children and adolescents. In R.B. Rutherford, M.M. Quinn, & S. R. Mather (Eds.), *Handbook of research in emotional and behavioral disorders* (pp. 262-281). New York: Guilford.
- Guetzloe, E. (1999). What can we do to stop students killing students? *Council for Exceptional Children Today*, 5, 14.
- Hallahan, D. P., Kauffman, J. M., & Pullen, P. C. (2009). *Exceptional learners: An introduction to special education* (11th ed.). Boston, MA: Pearson/Allyn & Bacon.

- Hallenbeck, B. A., Kauffman, J. M., & Lloyd, J. W. (1993). When, how, and why educational placement decisions are made: Two case studies. *Journal of Emotional and Behavioral Disorders, 1*(2), 109-117. doi:10.1177/106342669300100204
- Hallenbeck, B.A., & Kauffman, J.M. (1995). How does observational learning affect the behavior of students with emotional or behavioral disorders? review of research. *The Journal of Special Education, 29*, 45-71.
- Hammen, C., & Rudolph, K.D., (2003). Childhood mood disorders. In E.J. Marsh & R.A. Barkley (Eds.), *Child Psychopathology* (pp. 233-278). New York: Guilford Press.
- Hayling, C., Cook, C., Gresham, F.M., State, T., & Kern, L. (2008). An analysis of the status and stability of the behaviors of students with emotional and behavioral disorders. *Journal of Behavioral Education, 17* (1), 24-42.
- Henley, M, & Long, N. (1999). Teaching emotional intelligence to impulsive-aggressive youth. *Reclaiming Children and Youth: Journal of Emotional and Behavioral Problems, 7*(4), 224-229.
- Henley, M., Ramsey, R.S., & Algozzine, F., (2002). *Characteristics of and strategies for teaching students with mild disabilities* (4th ed. pp. 313-328). Boston: Allyn & Bacon.
- Hieronymous, A.N., Hoover, H.D., Oberley, K.R., Cantor, N.K., Frisbie, D.A., Dunbar, S.B., Lewis, J.C., & Lindquist, E.F. (1990). *Iowa Tests of Basic Skills*. Chicago, IL: Riverside.
- Hodges, K. (2004). The Child and Adolescent Functional Assessment Scale (CAFAS). In M. E. Maruish (Ed.) *The use of psychological testing for treatment planning*

- outcome assessment* (pp. 405-441). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.
- Ishii-Jordan, S.R. (2000). Behavioral interventions used with diverse students. *Behavioral Disorders, 25*, 299-309.
- Jolivet, K., Stichter, J.P. & McCormick, K.M. (2002). Making choices – improving behavior – engaging in learning. *Teaching Exceptional Children, 34* (3), 24-30.
- Kandel, D.B., Raveis, V.H., & Davies, M. (1986). Suicidal ideation in adolescence: Depression, substance abuse, and other risk factors. *Journal of Youth and Adolescence, 20* (2), 289-309.
- Kanner, L. (1962). Emotionally disturbed children: A historical review. *Child Development, 33* (1), 97-102. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=1963-00882-001&site=ehost-live>
- Kauffman, J. M. (1999). How we prevent the prevention of emotional and behavioral disorders. *Exception Children, 65*, 448-468.
- Kauffman, J. M. (1976). Nineteenth century views of children's behavior disorders: Historical contributions and continuing issues. *Journal of Special Education, 10* (4), 335. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=6562726&site=ehost-live>
- Kauffman, J. M., Bantz, J., & McCullough, J. (2002). Separate and better: A special public school class for students with emotional and behavioral disorders. *Exceptionality, 10* (3), 149-170. Retrieved from

<http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=7586002&site=ehost-live>

- Kauffman, J. M., & Landrum, T. J. (2006). *Children and youth with emotional and behavioral disorders: A history of their education*. Austin, Tex: Pro-Ed.
- Kauffman, J. M., & Landrum, T. J. (2009). *Characteristics of emotional and behavioral disorders of children and youth* (9th ed.). Upper Saddle River, N.J: Prentice Hall.
- Kauffman, J.M. & Pullen, P.L. (1996). Eight myths about special education. *Focus on Exceptional Children*, 28(5), 1-16.
- Kazdin, A. E. (1997). Practitioner review: Psychosocial treatments for conduct disorder in children. *Journal of Child Psychology and Psychiatry*, 38 (2), 161-178.
doi:10.1111/j.1469-7610.1997.tb01851.x
- Kendall, P.C., Brady, E.U., & Verduin, T.L. (2001). Comorbidity in childhood anxiety disorders and treatment outcome. *Journal of American Academy of Child and Adolescent Psychiatry*. 40 (7), 787-794.
- Kohn, A. (September 1993). Choices for children: Why and how to let students decide. *Phi Delta Kappan*, 8-20.
- Kritsonis, W. A., & Cloud, M. (2006). National agenda: Alternative discipline consequences to enhance student achievement. Technical report for Prairie View A.M. Online submission. December 2006.
- Landrum, T.J., & Kauffman, J.M. (2003). Emotionally disturbed education of. In J.W. Guthrie (Ed.), *Encyclopedia of education* (2nd ed., pp. 726-728). New York: Macmillan Reference.

- Landrum, T.J., Tankersley, M., & Kauffman, J.M. (2003). What's special about special education for students with emotional and behavior disorders? *The Journal of Special Education, 37*, 148-156
- Luborsky, L., McLellen, A.T., Diger, L., Woody, G., & Seligman, D.A. (1997). The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice, 4* (1), 53-65.
- Masia, C. L., Klein, R. G., Storch, E. A., & Corda, B. (2001). School-based behavioral treatment for social anxiety disorder in adolescents: Results of a pilot study. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(7), 780-786.
doi:10.1097/00004583-200107000-00012
- Mayo, T. (1839). *Elements of the pathology of the human mind*. Philadelphia: A. Waldie.
- Metfessel, N.S., & Michael, W.B. (1967). A paradigm involving multiple criterion measures for the evaluation of the effectiveness of school programs. *Educational and Psychological Measurement, 27*, 931-943.
- Moffitt, T.E., & Caspi, A. (1995). Childhood predictors differentiate life-course persistent and adolescence-limited antisocial pathways among males and females. *Developmental and Psychopathology, 13*, 355-375.
- Moffitt, T. E., Caspi, A., Rutter, M., & Silva, P. A. (2002). Sex differences in antisocial behaviour: Conduct disorder, delinquency and violence in the Dunedin longitudinal study: Book review. *The European Journal of Psychiatry, 16* (3) Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2003-04355-013&site=ehost-live>

- Morrison, G. M., Anthony, S., Storino, M., & Dillon, C. (2001). An examination of the disciplinary histories and the individual and educational characteristics of students who participate in an in-school suspension program. *Education and Treatment of Children, 24*(3), 276-293. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2001-10220-004&site=ehost-live>
- Nolen-Hoeksema, S., Girgus, J.S., & Seligman, M.E. (1992). Predictors and consequences of childhood depressive symptoms: A 5-year longitudinal study. *Journal of Abnormal Psychology, 101* (3), 405-422.
- Oswald, D.P., Coutinho, M.J., Best, A.M., & Singh, N.N. (1999). Ethnic representation in special education. The influence of school-related economic and demographic variables. *The Journal of Special Education, 32*, 194-206.
- Patterson, G.R., Reid, J.B., & Dishion, T.J. (1992). *Antisocial boys*; Eugene, OR: Castalia.
- Peacock Hill Working Group. (1991). Problems and promises in special education and related services for children and youth with emotional or behavioral disorders. *Behavioral Disorders, 16*, 299-313.
- Poland, S., & Lieberman, R. (2002). Best practices in suicide intervention. In J. Grimes (Ed.), *Best practices in school psychology IV (vol. 1, vol. 2)*. (pp. 1151-1165). Washington, DC US: National Association of School Psychologists. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-03715-072&site=ehost-live>
- Provus, M.M. (1971). *Discrepancy evaluation*. Berkeley, CA: McCutchan.

- Provus, M.M. (1973). Evaluation of ongoing programs in the public school system. In B.R. Worthen & J.R. Sanders, *Educational evaluation: Theory and practice*. Belmont, CA: Wadsworth.
- Rhode, G., Jensen, W. R., & Reavis, H.K. (1992). *The tough kid book: Practical classroom management strategies*. Longmont, CO: Sopris West.
- Roby, D. E. (2004). Research on school attendance and student achievement: A study of Ohio schools. *Educational Research Quarterly*, 28(1), 3-14. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=14387152&site=ehost-live>
- Rothman, D. J. (1971). *The discovery of the asylum; social order and disorder in the new republic*. Boston: Little, Brown.
- Rumberger, R.W. (1987). High school dropouts: A review of issues and evidence. *Review of Educational Research*, 57(2), 101-121.
- Schinke, S.P., & Gilchrist, L.D. (1984). *Life skills counseling with adolescents*. Baltimore, MD: University Park Press.
- Silver, S. E., Duchnowski, A. J., Kutash, K., & Friedman, R. M. (1992). A comparison of children with serious emotional disturbance served in residential and school settings. *Journal of Child and Family Studies*, 1 (1), 43-59. doi:10.1007/BF01321341
- Slotkin, J., Forehand, R., Fauber, R., McCombs, A., & Long, N. (1988). Parent-completed and adolescent-completed CDIs: Relationship to adolescent social and cognitive functioning. *Journal of Abnormal Child Psychology*, 16 (2), 207-217.
- Smith, E. R., & Tyler, R.W. (1942). *Appraising and recording student progress*. New York: Harper & Row.

- Snyder, H. (2000). Juvenile arrests 2000. *Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.*
- Stainback, W. C., & Stainback, S. B. (1996). *Controversial issues confronting special education: Divergent perspectives* (2nd ed.). Boston: Allyn & Bacon.
- Stein, M., & Davis, C.A. (2000). Direct instruction as a positive behavioral support. *Beyond Behavior, 10* (1), 7-12.
- Steinmetz, A. (1976). The discrepancy evaluation model. *Measurement in Education, 1* (7), 127-143.
- Stevenson, J., & Goodman, R. (2001). Association between behaviour at age 3 years and adult criminality. *British Journal of Psychiatry, 179* (3), 197-202.
doi:10.1192/bjp.179.3.197
- Suh, S., & Suh, J. (2007). Risk factors and levels of risk for high school dropouts. *Professional School Counseling, 10* (3), 297-306. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2007-07850-012&site=ehost-live>
- Sutherland, K.S., & Wehby, J.H. (2001). Exploring the relationship between increased opportunities to respond to academic requests and the academic and behavioral outcomes of students with EBD. *Remedial and Special Education, 22*, 113-121.
- U.S. Department of Education, (2007). *Twenty-ninth annual report to Congress on the Implementation of the Individuals with Disabilities Education Act*. Washington, DC: Author.
- Visser, J., Cole, T., & Daniels, H. (2002). Inclusion for the difficult to include. *Support for Learning, 17* (1), 23-26. doi:10.1111/1467-9604.00228

- Walker, H. M. (1995). *The acting-out child; Coping with classroom disruption*. Longmont, CO: Sopris West.
- Walker, H.M. (2004). Commentary: Use of evidence-based interventions in schools: Where we've been, where we are, and where we need to go. *School Psychology Review, 33*, 398-407.
- Walker, H. M., Forness, S.R., Kauffman, J.M., Epstein, M. H., Gresham, F.M., & Nelson, C. M. (1998). Macro-social validation: Referencing outcomes in behavioral disorders to societal issues and problems. *Behavioral Disorders, 24*, 7-18.
- Walker, H.M., Ramsey, E., & Gresham, F.M. (2004). *Antisocial behavior in school: Strategies and best practices* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Wiley, A. L., Siperstein, G. N., Broutree, K. E., Forness, S. R., and Brigham, F.J. (2008). School context and the academic achievement of students with emotional disturbance. *Behavioral Disorders, 33* (4), 198.
- Wolf, M.M., Braukmann, C.J. & Ramp, K.A. (1987). Serious delinquent behavior as part of a significantly handicapping condition. *Journal of Applied Behavior Analysis, 20*, 347-359.
- Yin, R.K. (1984). *Case study research*. Beverly Hill, CA: Sage.

CHILDREN'S SQUARE U.S.A.-ACADEMIC CENTER

DAILY BEHAVIOR SHEET - LEVEL ONE

Name: _____ Date: _____

Status: _____ Teacher: _____ Student: _____

IEP OR INDIVIDUALIZED OBJECTIVES	Teacher's Report Card						TOTAL	COMMENTS:
	1	2	3	4	5	6		
BASIC EXPECTATIONS Completes All School Work and Assigned Tasks Shows On Task During Class Period Responds Positively to Questions and Prompts Follows Directions Uses Appropriate Language and Conversation In Assigned Areas Meets the standards of the state standards								
SOCIAL SKILLS Exhibits the Character Attributes Gets Teacher's Attention Appropriately Accepts Praise and Constructive Feedback With Good Graces Cooperates with Peers and Staff Shows Respect to Peers and Staff Demonstrates the Values Encouraged								

Staff Initials

Academic Time After School (A.T.A.S.)

Recreational Time After School (R.A.S.)

Sub Set	MTWTF	Change	1:30-2:30
Set 1	MTWTF	Change	1:30-2:30
Set 2	MTWTF	Change	1:30-2:30
Set 3	MTWTF	Change	1:30-2:30
Set 4	MTWTF	Change	1:30-2:30
Set 5	MTWTF	Change	1:30-2:30

COMMENTS:

Smiling 1 2 3 4 5
 Lines out of classroom 1 2 3 4 5
 Left Program 1 2 3 4 5

Homework for Tonight

Signature

CHILDREN'S SQUARE U.S.A.-ACADEMIC CENTER

DAILY BEHAVIOR SHEET - LEVEL TWO

Name: _____ Date: _____

IP OR INDIVIDUALIZED OBJECTIVES	TEACHING CONCEPTS							TOTAL
	HR	M	E	G	PE	L	IR	
BASIC EXPECTATIONS Completes All General Work and Assigned Tasks Stays On Task During Class Period Respects Personal Space and Property Follows Directions Uses Appropriate Language and Conversation If Assigned Alone: Task Must Be Finished If Assigned to a Group: Task Must Be Finished Directs Classroom Activities Can - Identify & explain the importance of the Product & Consequences Full Body Burial Controls Personal Space Body Shows Respect for Self Appreciates the Many Perspectives								

COMMENTS:

Sweating : 2 3 4 5

Times out of classroom : 2 3 4 5

Left Program : 2 3 4 5

Homework for Tonight

Academic Time: _____
 subject: _____
 subject: _____
 subject: _____
 subject: _____
 subject: _____

Recess Time After School: _____
 offense: _____
 UMass: _____
 Chicago: _____
 UMass: _____
 Chicago: _____
 offense: _____
