Collaborative Consultation in the Schools: Effective Practices for Students with Learning and Behavior Problems was written with two different audiences in mind: university students and practitioners in the schools. University students are likely to be doing advanced work in special education, school psychology, school counseling, or educational administration. Practitioners in schools are currently employed in these professions and are being asked increasingly to help others, usually teachers or parents, solve learning and behavior problems. In this book, we present the consultation process as a collaborative, problem-solving endeavor designed to assist consultants in their work with students who have, or are at risk for, behavioral or learning problems. A key focus is on consultants bridging the gap between research and practice in schools. Whether it is designing an intensive academic intervention, assisting a teacher in improving his classroom management, or developing a transition plan for a student with a low incidence disability, the consultant should strive to initiate evidence-based practices whenever possible. A second key theme to this consultation text is providing interventions that are proportional to the students’ needs. Through data-based system change, schools are redistributing their resources along multi-tiered systems of support (MTSSs), so those in greatest need receive the most intensive help. MTSS (which includes response to intervention [RtI] and schoolwide positive behavior support [SWPBS]) requires collaborative consultation to be successful.

Consultation as a service delivery system in the public schools has increased in popularity since the late 1990s. Prior to 1990, most special and general educators were still expected to deal on their own with whatever problems they experienced in their teaching or management of children; indeed, those who sought help may have been regarded as unable to deal with the job of teaching and subtly, or overtly, rejected by their peers or supervisors. To a lesser extent, this isolationism continues today in our schools and can be a formidable barrier for school consultants. Good interpersonal, problem-solving, and communication skills; the building of trust; and a change in the school culture to be more collaborative can reduce these barriers, as we discuss at length in this text. The goal of collaborative consultation is synergism, wherein the dyad or team produce better results than if each person works in isolation. Adhering to the problem-solving process, including data-based goal setting and evaluation, is critical to achieving synergism.

Since the Education for All Handicapped Children Act of 1977, teacher assistance teams, student study teams, transition planning teams, and individualized education programming teams and a host of other formal and semiformal team arrangements have been developed to meet the needs of students who require some degree of assistance to be successful in school. Indeed, it would be surprising to find a school today that did not depend on its student study team to discuss and develop interventions for students at risk of school failure. These team interactions also meet the needs of parents in their efforts to understand and support their children.

Beyond what takes place in team meetings is a real need for everyday assistance for both special education teachers, who are providing direct teaching services to students with disabilities, and general educators, who are charged with teaching students with disabilities in addition to a large cadre of other vulnerable and marginalized students. This text is primarily devoted to helping those who assist special and general educators and support services personnel to deal with the everyday, ongoing challenges presented by underperforming students. Most school personnel are involved in problem-solving student problems case by case, whether formally or informally. Some believe that greater efficiencies and a larger impact can be made by changing how the school operates. MTSSs can happen in a school only when school personnel have learned the value of collaborative problem solving as opposed to isolated work. In an MTSS school, school personnel have a shared sense of responsibility to the students and frequently examine data and discuss how to improve student outcomes. Job descriptions and expectations have changed accordingly. Special education teachers are increasingly leaving their resource room and special day classes to consult with general education teachers. School psychologists are embracing more intervention-based assessments and are taking increased responsibility for assisting in the development and evaluation of appropriate interventions. School counselors are more likely to see if they can be of assistance with some referrals through consultation with teachers and parents in conjunction with individual or group counseling efforts. Mentor teachers,
vice principals, and others are also seeing their roles expand to include consultation, particularly when engaged in school reform. We hope that the combination of scientifically based practices, practical advice, and case studies presented in this text will assist the reader in providing effective consultation to colleagues and families.

NEW TO THIS EDITION

The fifth edition has been updated significantly. It includes a new chapter (Chapter 8) on transition planning for students with disabilities preparing for adulthood (this chapter is co-authored by Edwin Achola). The main thrust of this revision has been to update the evidence-based practices based on current research and to add video clips to the text and activities to provide additional details and dimensions to the concepts. We also replaced the term response to intervention (RtI) with the more encompassing term multi-tiered systems of support (MTSS) in order to emphasize the parallels between RtI and school-wide positive behaviour support (SWPBS). The fifth edition also provides more information on serving students with autism spectrum disorder (ASD), including a detailed case-study in Chapter 10. Finally, we provide more coverage on how technology can be used in consultation and professional development.

Some additional updates include the following:

- A description and possible implications of the Common Core State Standards for consultants (Chapters 1 and 7)
- More information on working with paraprofessionals (Chapter 2)
- A list of do’s and don’ts in using electronic communications in consultation (Chapter 4)
- Tips for providing legal testimony (Chapter 5)
- Information and activities on the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPPA; Chapter 5)
- Changes included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (Chapter 6)
- The theory and research on microaggressions experienced by cultural and language minorities (Chapter 4)
- An expanded treatment fidelity section has been included, along with a treatment fidelity assessment observation form (Chapter 3)
- An effective instruction observation/feedback form for school-based consultants (Chapter 7)

We think one of the most valuable additions to the text has been the insertion of video clips. Short, 2- to 3-minute video clips introduce the reader to important concepts. Longer clips are contained in the activities. Course instructors or staff members involved in professional development can show these clips and engage in highly nuanced, relevant discussions. Thus, the development can show these clips and engage in highly nuanced, relevant discussions. Thus, the

**Activity 2.3**

Watch the tutorial on how to conduct an antecedent, behavior, and consequence (ABC) analysis at https://www.youtube.com/watch?v=GxdIM8kHuY and complete the

**Acknowledgments**

We would like to acknowledge Edwin Achola’s contributions to Chapter 8. As a co-author of this chapter, his insights and expertise on transition planning are essential to the final product. We would also like to thank the following reviewers of the fifth edition: John D. Hall, Arkansas State University, Cindy Topdemir, University of South Florida, Elena Zaretzky, University of Massachusetts, Boston.
Chapter 1

Overview of School-Based Consultation

Learning Outcomes

1.1 Define the terms consultation and collaboration.
1.2 Summarize multiple characteristics of collaborative consultation.
1.3 Recognize the unique individual roles and interactions that the consultant, consultee, and student contribute to the collaborative consultation paradigm, as well as the fluidity of the consultant/consultee roles in schools.
1.4 Explain the need for process expertise and content expertise in the role of an effective consultant.
1.5 Distinguish among primary, secondary, and tertiary levels of intervention.
1.6 Summarize the major historical trends in education as they pertain to school-based consultation.
1.7 Describe some of the major research issues related to consultation practices.

You are the newly appointed resource specialist (or school psychologist or counselor) at Whittier School, a K–6 school in the Bellflower school district. Your job includes being a consultant to teachers, parents, and others about student learning and behavior/adjustment problems. Ms. Jones, an experienced third-grade teacher, stops you in the hallway one day in early October and says, “You’ve got to do something about Johnny B. He really needs a lot of help.” How would you proceed?

Ms. Nguyen, principal of Martin Luther King Jr. High School, wants you to explain your role as a consultant to the teachers. Consider what you may include in a 5-minute presentation at the next teacher staff meeting regarding the purpose of school-based consultation.

How you proceed is a function of many variables, such as your personal philosophy of professional practice; the expectations of your supervisors and coworkers; and factors such as caseload, established precedents, your reinforcement history, and your training. We believe that a consultation-based service delivery model is, for most referrals and most constituents (that is, teachers, parents, and other consultees), an appropriate and useful approach when used with other service requirements of your position as a special education teacher, school psychologist, or school counselor.

CONSULTATION AND COLLABORATION: DEFINITIONS, DISTINCTIONS, AND CHARACTERISTICS

Researchers in the field of consultation have worked to refine the definitions of collaborative consultation from the perspectives of the public schools. The definition that best reflects the focus of this text is the following: Collaborative consultation is a process in which a trained, school-based consultant, working in an egalitarian, nonhierarchical relationship with a consultee or as a member of a team, assists that person or team in her or their efforts to make decisions and carry out plans that will be in the best educational interests of her or their students. All the concepts in this definition are found among the definitions listed in Figure 1.1.
Chapter 1 • Overview of School-Based Consultation

Definitions/descriptions of consultation:
Consultation is a process that “involves professionals collaborating to use information to plan academic or behavioral treatments” (Ysseldyke, Lekwa, Klingbeil, & Cormier, 2012).
Consultation “provides a means for teachers to learn strategies to deal with presenting problems” (Coffee & Kratochwill, 2013, p. 2).
Consultation is a problem-solving process that can be initiated and terminated by either the consultant or consultee…for the purpose of assisting consultees to develop attitudes and skills that will enable them to function more effectively with a client, which can be an individual, group, or organization (Brown, Pryzwansky, & Schulte, 2011, p. 1).
Consultation is “procedurally operationalized through a series of well-defined stages (including problem identification, problem analysis, plan development, plan evaluation), wherein consultees develop and implement coherent, coordinated intervention plans across home and school settings” (Sheridan, Swanger-Gagné, Welch, Kwon, & Garbacz, 2009, p. 477).

Definitions/descriptions of collaboration:
“Interpersonal collaboration is a style for direct interaction between at least two coequal parties voluntarily engaged in shared decision making as they work toward a common goal” (Friend & Cook, 2009).
Collaboration is “a reciprocal relationship and training based on using equally the group leaders’ and the teachers’ knowledge, strengths, and perspectives” (Webster-Stratton, Reinke, Herman, & Newcomer, 2011, p. 509).

FIGURE 1.1 Definitions and descriptions of the terms consultation and collaboration

The terms egalitarian and nonhierarchical are important to this definition because consultees, who are usually teachers or parents, are much more likely to engage in the consultation process when they believe they have at least as much input into the planning process as the consultant (Kelleher, Riley-Tillman, & Power, 2008). This is in contrast to an expert stance, in which the consultant develops an intervention plan based on a referral and the consultee is primarily, if not solely, responsible for carrying out the recommended interventions. We do not mean to suggest that consultants and consultees engaged in collaborative consultation lack expertise. Often the consultant is well versed in consultation strategies and is knowledgeable about assessments and interventions; the consultee is often well-informed about the needs and strengths of the student in question. Through collaboration, a better intervention is developed, implemented, and maintained than if either worked in isolation (i.e., collaboration produces synergism). In schools, the roles of the consultant and consultee are not static. A special education teacher or school psychologists could find him- or herself to be a consultant in one conversation and a consultee in the next. In some cases, such as when graduate students are training to become skilled consultants, the consultant may have little knowledge about academic and behavioral assessments and interventions, but by focusing the discussion on finding solutions and documenting outcomes, the consultee arrives at a better place from which to help his or her student.

ACTIVITY 1.1
Speak to several people outside your field of professional interest and ask them what images or expectations come to mind when they hear the word consultant: What percentage of people use the word expert? How often do they mention the concept of collaboration? Also, ask people in public schools to define consultation. What is their image of what a consultant does, or should do?

COLLABORATIVE CONSULTATION AS AN INDIRECT SERVICE

The initial purpose of the school-based consultation is to provide improved service to a third party, the student. Through the consultation process, however, the consultee’s competence should be enhanced. Thus, consultation is a form of capacity building (Ysseldyke et al., 2012). In schools, the consultee (typically a teacher) usually does most of the in-classroom or
on-the-playground implementation, and the parent, as consultee, does most of the at-home implementation. The consultant may be involved in teaching the consultee skills so he or she is able to implement the intervention, or the consultant may collect data on how well the interventions are working or data on whether the interventions were implemented, but ultimately the consultee is the primary interventionist. In other words, the consultant provides indirect support to students by enhancing the capacity of the consultee, who provides the direct support. Thus, consultation is generally considered an indirect service. Collaborative teaming, such as general education and special education teachers coteaching a class or a leadership team planning the implementation of schoolwide positive behavior support (SWPBS), will involve both direct and indirect services. Yet the same core characteristics of consultation—egalitarian, data-driven, problem-solving, capacity enhancing, and evidence-based—apply to effective teams.

**Collaboration** refers to a very specific kind of consultation, one characterized by a reciprocal relationship that is nonhierarchical. Defined in this way, collaboration may seem very different from forms of consultation practiced in the business, medical, or military arenas; it is not necessary in collaborative consultation that any one person is the expert. This is true because collaborative consultation takes place between or among two or more people, with the role of expert shifting periodically among the participants. For example, a student study team (SST) meeting might involve the regular education teacher as an expert in curriculum and teaching method; the counselor as an expert in explaining how a student’s approach to tasks stems from family and cultural dynamics; the psychologist or special education teacher as an expert in suggesting a contingency reinforcement plan, a memory-enhancing system, or a teaching approach that the teacher might use to increase content retention; the student’s mother as an expert in reviewing how she assists and encourages the student with his academic work; and the student as an expert in his interests, learning strategies, and reinforcers. As these participants collaborate with one another in understanding a problem and designing a program, they are sharing their expertise, with each party contributing a varying amount depending on the nature of the referral. A main goal of collaboration is to establish **synergism** in which working as a group leads to better student outcomes than if each collaborator worked in isolation.

**Activity 1.2**

Watch this video and discuss signs that synergism is occurring for Kevin.

The philosophy of seeking synergism also extends to plan implementation. Although the primary person carrying out the plan is usually either the general or special education classroom teacher, the other team members contribute their expertise in ways appropriate to their training and experience. In the SST case just described, plan implementation might involve the counselor working with the parents on ways to improve homework completion, the psychologist assisting the teacher in implementing a token economy to improve classwide compliance, the special education teacher providing a targeted reading intervention, and the student self-monitoring and helping the consultee fine-tune the classroom reinforcement system. This example demonstrates how expertise and mutual assistance are the two major components of a collaborative consultation model.

A third major component of collaborative consultation is **problem solving**. Consultants are employed for the express purpose of solving the learning and behavior problems exhibited by schoolchildren. Generically, problem solving refers to a structured set of steps or procedures intended to assist the consultee in addressing a student academic or behavioral problem. The problem-solving steps may also be applied to identifying and implementing school improvement (see Chapter 8). The problem-solving process may take many forms or styles, depending on the nature of the problem, the philosophical beliefs of both consultant and consultee, the constraints or limitations of the setting, the availability of specific kinds of help, and so on. The steps in problem solving are discussed in detail in Chapter 3.

Figure 1.2 showcases the personal view of the first author (Kampwirth) regarding the collaborative consultation method.
In my way of conducting collaborative consultation, I give a lot of emphasis to the possibility that consultees can, and should, be strongly encouraged to think through their own ideas about how to solve the referral problems. This may not seem feasible. After all, if the consultee knew a solution to his referral question, why wouldn’t he just implement it and save time and energy? Also, if the consultee’s referral has been sent to you for your assistance, doesn’t he have a right to expect that you will have, and impart to him, expert knowledge?

My experience has taught me that consultees, both teachers and parents, when faced with relatively difficult problems in learning and/or behavior, sometimes get confused, or stuck, in their thinking. They probably have tried some solutions, and when these haven’t worked, they’ve experienced some level of doubt regarding their usually dependable problem-solving strategies, and they feel as though they don’t know what to do next. Or they have an idea but they just aren’t sure about it, and they would like to discuss their idea with someone else. This someone else becomes their consultant. It is hoped that this person acknowledges the consultee’s experience and expertise by doing at least these two things:

1. Ask the consultee to review what she has done to improve the situation so far, and how these efforts have worked.
2. Encourage the consultee to tell the consultant what she (the consultee) wants to do next. Use questions such as “Given what you’ve told me, and in light of your understanding of the problem at this time, what would you like to try next?” “You’ve tried a number of things so far. What are you thinking of doing tomorrow?” “So far you’ve felt like what you’ve tried just hasn’t been the best solution. What’s next? What do you want to try now?”

I refer to this effort at intervention development by consultees as the ACCEPT method, ACCEPT being an acronym that acknowledges the consultant’s philosophy about the consultee’s contributions and that stands for the following behaviors, which, to me, are at the heart of collaborative consultation:

A **Acknowledging** the consultee’s predominant role in carrying out the planned interventions, usually in his classroom (or home), in the context of that setting, and in his style.

C **Commenting** positively on the efforts the consultee has made to date in trying to solve the problem, and the effort he is expending now on behalf of the student.

C **Convincing** the consultee that he has good ideas to offer, and that you, the consultant, would like to hear them.

E **Expecting** that the consultee will take the lead in the development of ideas if encouraged to do so, and expecting that the consultee will give equal weight to the consultant’s ideas.

P **Pointing** out possibilities for effective interventions based on the consultee’s ideas. This involves taking his ideas and helping him think through their pros and cons and the details of implementation. In this way, you provide your content expertise in the context of his ideas. When collaborative consultation is working well, the consultant’s role is that of **facilitator** of the consultee’s ideas.

T **Treating** the consultee as an equal. One of the hallmarks of a collaborative model is that it brings adults together in an atmosphere of mutual respect. Both are equally expert, both need help from the other, and both give ideas and contribute to the final solutions.

**LIMITS TO A COLLABORATIVE CONSULTATION MODEL**

This model does not always work as planned. Some consultees seem bereft of ideas, or they appear to be too irritated by the problem to be able to think clearly. Some get in a punishment mode, particularly in regard to serious behavior problems, and they are not able to think positively. Some think only of ways of reacting to a referred student rather than more systemically. Some always prefer to think that someone else (e.g., special education, or a more restrictive setting) should take over the student and solve his problem that way. Others are simply deferential to the consultant; they cannot get over the consultant-as-expert idea. They assume it’s easier to get you to solve the problem, to determine the interventions and their implementation. That way, if it doesn’t work, guess who’s to blame? Last, some are too inexperienced, or at least act that way, and they simply need more direct help.

**SUGGESTIONS**

Collaborative consultation sometimes seems to break down because the ideas from the consultee are inappropriate in some way. Some teachers and parents have only a limited number of ideas for intervention. When you sense that this is true, the collaboratively oriented consultant most certainly can suggest interventions. My opinion is that it is best to come up with two or three viable interventions, based on best practice, and to ask the consultee...
what she or he thinks of each intervention. Which of the ideas is the consultee attracted to? Which does the consultee seem able and willing to do? The interventions you suggest should meet at least the following criteria:

1. **Treatment acceptability:** If the consultee doesn’t accept an intervention as something she is willing to do, you either have to be a good salesperson and convince her of its merits through the use of social influence (Erchul & Martens, 2002), or try to modify it. The teacher may agree to try the intervention (possibly under duress), give it a half-hearted try, claim it didn’t work (it probably didn’t), and require you to think of another idea. You never know what interventions meet the criteria of treatment acceptability until you suggest them. What you do know is that, if the intervention is not acceptable to the person who is to implement it, it is not likely that it will ever be implemented as intended.

2. **Treatment validity:** Is there research support for the idea? Best practices are those that have at least some degree of support, either from the literature or from your own experience or knowledge base.

3. **Treatment ethics:** The concern here is about the appropriateness of an intervention from the standpoint of the students’ best interests; their dignity as people; probable benefits versus risks; and an orientation toward replacement of, rather than suppression of, challenging behaviors.

4. **Treatment integrity (fidelity):** Was the treatment implemented correctly? This, of course, won’t be known until the treatment is tried.

5. **Treatment effectiveness:** Is the treatment working? By what standards? Does it need to be changed? Again, these answers aren’t known until the treatment has been tried for a sufficient amount of time to determine its effectiveness.

It is also important to stick to the referral and not to wander off in other directions. It may be tempting to think that a given consultee needs help in many areas of which he may not be aware. Except in serious cases (abusive behavior toward students; chaotic, dangerous classroom management practices; personal problems that are affecting the classroom), it is best to establish well-defined goals relative to the referral problem, work toward solving them, and let other issues emerge as the consultee feels the necessity of dealing with them. Remember that change is difficult; overwhelming a consultee with your ideas about how to make the classroom or home perfect may be regarded as intrusive and perhaps overwhelming. No one wants assistance from an intrusive person who wants to tell other people what to do. Do a good job helping the consultee with his current concerns and he will get back to you later about other issues, or you can bring them up later.

Last, but nonetheless important, consider the role of family and culture. Interventions that are selected need to be sensitive to the student’s cultural and family background.

**FIGURE 1.2 (Continued)**

**DEFINING CHARACTERISTICS AND EXPECTATIONS OF COLLABORATIVE CONSULTATION**

The following are expectations about the nature and characteristics of collaborative consultation:

1. The consultant is a trained professional. Consultants can be working in various professions and can include special education teachers, general education teachers, mentor teachers, school counselors, school psychologists, administrators, and nonschool personnel. In addition to their own area of expertise, a consultant is able to engage in a problem-solving process.

2. Establishing a relationship based on mutual respect and trust is essential for successful consultation.

3. The nature of the referral problem directs the problem-solving processes. Chapter 2 lists consultants’ roles and activities; it is common for practitioners to shift among them.

4. The consultant and the consultee both must make a valid effort to engage in the problem-solving process if consultation is to occur. The ultimate power in the consultation process rests with the consultee because she or he is primarily responsible for carrying out the jointly agreed-on interventions. The consultant’s contribution is to provide an objective analysis of the referral problem and information useful in intervention design, monitoring, and evaluation. The consultant may use interpersonal strategies to improve the likelihood that the consultee will implement agreed-on interventions.

5. The purpose and the process of consultation interact and must be considered simultaneously. This is especially true in a collaborative consultation approach in which nonhierarchical, egalitarian positions are occupied by both the consultee and the consultant, who are both involved in idea generation within a problem-solving context.
6. Systemic variables impinge on the consultant, consultee, and student and must be considered as integral parts of the process. School consultants and consultees always operate within a larger set of conditions, including not only legal and ethical mandates but also societal expectations, cultural norms, district and school-level guidelines, and family concerns. The interventions discussed, particularly at group meetings (such as SST, etc.), need to gain at least tacit approval from all constituents.

7. Consultation is governed by certain ethical guidelines that influence consultant roles as well as the process of consultation. Chapter 5 discusses ethical and advocacy issues in consultation. Practical examples demonstrating the influence of these factors appear in the case studies in Chapter 9.

8. There is an emphasis on record review, observation, and interview as assessment methods (rather than published norm-referenced tests of cognition, processing, and achievement).

9. Collaborative consultation seeks solutions, not labels. The goal is to identify the level of support a student needs within the least restrictive environment. While some students may need special education and related services in specialized settings to be successful, most students who manifest learning and/or behavior problems can be successful in general education with targeted interventions and ongoing consultation support. Whenever possible, it is best to solve problems in the context in which they occur.

10. School consultants must be experts in process (the “how” of consultation; see Chapter 3) but not necessarily in all possible content. For example, a newly minted school counselor with little classroom experience may still be able to assist an experienced teacher with a concern about a student. The school counselor can share her classroom observations, point out patterns in the student’s record, and engage the teacher in the problem-solving steps (described in Chapter 3); the end result should be better than if the teacher had tried to address the problem on his own. The consultant’s job is to facilitate the thinking of these primary-care providers (i.e., parents and teachers serving as consultees) so these individuals can feel empowered to carry out their ideas about how to best assist the student under the guidance and encouragement of the consultant.

11. Occasionally consultees may bring information into the discussion that is more closely related to their personal lives and problems than to the learning or behavior problems of the referred student. The consultant has to be careful not to confuse the consultative relationship by taking on the role of a counselor to the consultee. Decisions about the relevance of any particular piece of information are not always easy to make, but it is usually best to steer the conversation gently back to the appropriate work-related problem. Of course, if the consultant perceives that the consultee does have a personal problem that should be dealt with, whether it is affecting the referral problem or not, she may refer the consultee to a resource where he can get whatever help is needed. Because it is possible for a consultee to have personal issues that interfere with his ability to view the referral problem objectively, the consultant may need to mention any concerns she has to the consultee in a helpful and positive way (Caplan & Caplan, 1993).

12. The goal of collaborative consultation is to improve the functioning of the student while enhancing the capacity of the consultee. In fact, building capacity so that other children may benefit from better teaching, classroom management, and/or parenting is what makes consultation efficient as well as effective.

**ACTIVITY 1.3**

In small groups, discuss the expectations about the nature and characteristics of collaborative consultation presented above. Are these essential characteristics and goals? What others might be added?

Formal consultation, in which a clearly defined consultee approaches an identified consultant for assistance in a specified space over a specified amount of time, is the exception rather than the rule. Consultations on the fly or via e-mail may be more common. Jacob, Decker, and Hartshorne, (2011, p. 191) wrote, “the role definition, the process of goal setting during consultation, the responsibilities of the consultant and consultee, and the parameters of confidentiality” should be discussed prior to offering consultation services. In our experience, however, school-based consultation is generally more informal, although it is a good idea to review the above
expectations with school staff members on an annual basis. The more serious the referral concern, the more formal the consultation may become. Student study team (SST), individualized education program (IEP), or transition planning or implementation team meetings are examples of where more formal consultations are likely to occur. It is important for these teams to take time periodically to examine the extent to which they are adhering to the above expectations and problem-solving processes. Busy school personnel are keen to work on and, ideally, solve student challenges, yet the importance of examining how well the consultation processes is working to determine if it could be more effective cannot be underestimated.

**THE TRIADIC NATURE OF CONSULTATION**

The most common form of consultation in schools consists of interactions among a consultant, the consultee(s), and a student. As Figure 1.3 shows, the consultant and the consultee interact freely in a nonhierarchical, reciprocal relationship. Because the consultant may or may not have any direct interaction with the student, consultation is usually considered an indirect service. However, school-based consultants typically, at a minimum, observe the student in the classroom or other setting (playground, lunchroom, etc.). Often the consultant offers some type or degree of direct service to the student, such as modeling an instructional technique or collecting intervention fidelity and/or effectiveness data.

**THE ROLE OF PROCESS AND CONTENT EXPERTISE IN CONSULTATION**

People generally relate the concept or practice of consultation to activities carried out by skilled businesspeople, engineers, and medical professionals, and the public tends to think of consultation in terms of expertness. In the business world, a consultant may be hired to solve a particularly tricky problem in production, merchandising, or taxation. The hiring firm expects that the consultant will have expertise in the area and will propose a solution that has a good chance of working well. For this level of expert consultation, business executives expect to pay well.

One might expect that successful consultants working in the schools with teachers and parents should also adopt a stance of expertise. We take the position that expertness should be expected in the area of *process* and that it is highly desirable but not sufficient in the area of *content*. By *process*, we mean the interactions that occur between the consultant and the consultees through which a behavior or a learning problem is approached and solved; it is concerned with *how one acts* as a consultant. *Content* refers to the actual ideas that the consultees will implement, such as a behavioral contract, cooperative learning, phonemic awareness instruction, or a token economy; it represents *what people will do* as a result of consultation. Collaborative
consultation requires expertise in process; without such expertise, the process disintegrates, resistance increases, and consultees become dissatisfied with the consultative approach for dealing with their needs and the needs of their students. Consultants’ ability to engage consultees in a productive process may be determined by their interpersonal skills as well as their knowledge of consultation processes. The content consultants are expected to provide includes knowledge of empirically supported intervention. However, the consultee determines what is practical to apply given the context of the referral (Kelleher et al., 2008). As indicated by the definitions, the collaborative approach depends on a degree of mutual expertise in problem solving, resulting in content decisions that are jointly generated and approved by both the consultant and the consultee(s) within a nonhierarchical, reciprocal relationship (Friend & Cook, 2009).

**ACTIVITY 1.4**

Discuss the role of process versus content. Do you think a school consultant needs to have a set of interventions for every problem or issue a teacher or parent can describe? How might you deal with a consultee who insists on your having answers for every problem?

**CONSULTATION AT DIFFERENT LEVELS OF PROBLEM SEVERITY**

Caplan (1964) described three levels of intervention: primary, secondary, and tertiary. These three levels are also referred to as universal, selective, and indicated (Frank & Kratochwill, 2009); as core, targeted, and intensive (National Association of State Directors of Special Education, 2005); and as Tier 1, Tier 2, and Tier 3 (Sugai & Horner, 2009). A multi-tiered system of support (MTSS) typically incorporates the three levels of interventions, including explicit data-based decision rules for when students need to progress from one level of support to another (Sugai & Horner, 2009). Common MTSSs include response to intervention (RtI) for addressing academic skill deficits and schoolwide positive behavior support (SWPBS) or positive behavioral interventions and supports (PBIS) for addressing behavioral concerns. RtI and SWPBS/PBIS are complementary systems that are implemented, ideally, in concert with each other because behavioral problems often affect achievement, and achievement problems lead to behavioral problems for many students. MTSS is described at length in Chapter 3; however, a quick review of the types of consultation and interventions that may occur at each of the three levels is provided here.

Tier 1, or universal prevention, involves taking action to ensure that students are unlikely to develop learning or behavioral difficulties. Sufficiently sequenced curriculum, effective teaching methods, and explicit classroom rules are all part of universal prevention. Examples of interventions at this level include Success for All (Slavin, Madden, Dolan, & Wasik, 1996), Peer-Assisted Learning (U.S. Department of Education, 2013), and Safe and Civil Schools (Sprick, 2009). Professional learning communities (PLCs) are popular for consulting with teachers on improving their classroom management or teaching methods, grade-level teaming is common for improving universal services at a grade level, and implementation teams are helpful for improving schoolwide functioning. These different types of teams are discussed in greater detail in Chapter 8. Individual consultants may also attempt to improve the general education instruction through coaching or problem-solving consultation. It is not uncommon for a consultant who is following up on a student referral to discover that the problem lies not with an individual student but with the teacher’s poor teaching (i.e., a problem with Tier 1).

Tier 2 or targeted interventions involves actions taken when a student appears to be having difficulties adapting to behavioral or academic expectations. Small homogeneous groupings, parent conferences, in-class modifications, social skills training, and other mild forms of intervention are common during this stage. Targeted interventions should involve some type of supplemental instruction to teach directly and provide additional practice on the skills the student failed to develop in the primary/universal stage (Gersten et al., 2008). Often the consultation at Tier 2 takes place at a formal SST meeting.

The referral problems are more serious at the Tier 3 or intensive level; major steps need to be taken (e.g., one-on-one or very small group, targeted instruction; reading recovery; special education services; alternative education). Those concerned with the student’s welfare need to
consult with each other and develop plans collaboratively that are in the best educational interest of the student. Typically this collaboration occurs with a schoolwide team, such as the section 504 team or an IEP team, which develops individualized, daily, and closely monitored interventions. Wraparound services (Eber, Nelson, & Miles, 1997) that involve out-of-school agencies such as community mental health, respite services, and social services are also examples of collaborative efforts at the tertiary level.

In a school setting, most referrals for consultant assistance are for either Tier 2 or Tier 3 interventions, which is unfortunate. More emphasis on preventive programs, especially for students who are at risk, has been recommended for decades (Meyers & Nastasi, 1999). However, pressures to deal with current severe problems, combined with inadequate staffing ratios, have slowed the impetus to a prevention-oriented service delivery approach. Bergan (1995) observed that this may be true partly because no specific funding exists for universal prevention services, while funds do exist for placing and supporting students in special education services. Although the 2004 reauthorization of special education law now allows a portion of federal funds for special education to be used for universal prevention purposes, there is no mandate to do so.

Once plans for any of the three levels have been developed and are being implemented, the role of the collaborative consultant becomes largely one of monitor and evaluator. The teacher or parent consultant will need some assistance in implementing the intervention with integrity and collecting progress monitoring data. Ongoing evaluations of the fidelity and effectiveness of the interventions are necessary to ensure that the desired outcomes are attained.

**ACTIVITY 1.5**

Reflect on your experiences in schools. How were interventions for students with disabilities and for other at-risk students developed? Did the level of support seem to meet the level of need? Are the administrative and support staff members proactive, or is it a wait-to-see-who-fails model? Who monitored and evaluated these interventions? Did these processes seem well-structured or rather casual?

**RECENT CHANGES IN EDUCATION AFFECTING SCHOOL CONSULTATION**

**Common Core Standards**

During the 1990s and into the 21st century, an educational movement focused on improving student outcomes through establishing rigorous standards and measuring students’ progress toward the standards became the dominant reform initiative. Known widely as standards-based reform, this movement culminated in the development of the Common Core State Standards (CCSS). This set of English language arts and mathematics standards represents learning goals for what students should know and be able to do at the end of each grade level. The goal is to have similar standards across the nation that emphasize rigorous content and critical thinking skills such as analysis, synthesis, and problem solving. At the time of this writing, 43 states have adopted the CCS and joined one of two different consortiums formed to develop large-scale tests of these standards. States, districts, and publishers are currently scrambling to develop curriculum to teach the CCS. Implementation of the CCS has also encouraged teachers to participate in professional development to learn instructional strategies to promote student attainment of the CCS. Thus, many educators are feeling the pressures to change their teaching practices along with learning new curriculum, which presents a unique opportunity for school-based consultants to improve Tier 1/core instruction.

**ACTIVITY 1.6**

Watch the video clip at https://www.youtube.com/watch?v=5s0Rk9sER0 on Common Core State Standards (CCSS). Discuss what you have heard about the CCSS in schools and in other settings. Are people expressing excitement, trepidation, or a little of both?
Chapter 1 • Overview of School-Based Consultation

No Child Left Behind

In 2002, the No Child Left Behind (NCLB) Act, a far-reaching piece of federal legislation, was passed by Congress. It is essentially a reauthorization of the Elementary and Secondary Education Act of 1965. Its requirements include annual testing in reading and math of all students in grades 3 through 8, as well as the provision of additional funds to support schools that are consistently underachieving. It has particular relevance for students with disabilities because it requires that these students participate in the high-stakes testing that is required by this act and that school and district administrators be just as responsible for the performance of students with disabilities as they are for students without disabilities. NCLB is an attempt to close the gap between the actual and expected level of student performance, particularly among the lowest achieving students (Bolt & Roach, 2009), such as students with disabilities, English language learners, and students from economically impoverished families. Educators know that lofty goals from the federal level do not necessarily lead to meaningful change at the local school level. It is still up to the local level to provide the planning and programs that meet the federal mandates. Many educators have expressed concern that the focus on students’ test scores has deleterious effects, such as narrowing the curriculum through the exclusion of subjects that are not included in the testing program, like art, music, and community service (Bolt & Roach, 2009) and a reduction in the educator’s autonomy in deciding what and how to teach (Meyers, Roach, & Meyers, 2009). Thus, NCLB is an influential and somewhat controversial piece of education legislation.

Individuals with Disabilities Education Act

In 2004, the U.S. Congress passed the Individuals with Disabilities Education Improvement Act (IDEA) to replace previous laws governing the provision of special education services. Laws governing special education services and funding have existed since the passage of P.L. 94-142 in 1975. These laws guarantee the rights of students with disabilities to receive a free and appropriate public education (FAPE) in the least restrictive environment (LRE) and the rights of their parents to due process if they believe their child’s access to FAPE is limited by school personnel. The various iterations of IDEA also describe the eligibility criteria for determining whether special education services are needed and provide safeguards to ensure a student’s misconduct does not result in disciplinary actions that impinge upon his or her FAPE. The 2004 IDEA differed from previous reauthorizations in its alignment to NCLB. For example, like NCLB, IDEA 2004 emphasizes student outcomes, including performance on large-scale assessments as well as better assessment of students’ present level of performance. Both NCLB and IDEA also require teachers to be “highly qualified” and emphasize “scientific, research-based interventions,” otherwise termed evidence-based interventions (EBIs). Some IDEA requirements that are of specific interest to school consultants include the following:

• **Early Intervention.** IDEA 2004 promotes providing services to students at risk for academic or behavioral disabilities before they are identified as disabled. Specifically, schools can apply a portion of their federal special education funding to provide EBIs to students who need extra academic and behavioral supports to succeed in the general education environment (Sec. 613(f)). This funding can be used to provide professional development, direct services, and assessment. IDEA 2004 clarifies that teachers and specialists may screen students to determine whether an intervention is needed and which intervention will be most effective without parental consent (Sec. 614(a)(1)(B)). Thus, there is support for school psychologists, special education teachers, and other specialists to (1) establish school-wide screenings (also known as universal assessment) that identify which students need supplemental instruction, (2) consult with teachers on developing evidence-based interventions, and (3) provide professional development to the teaching staff on EBIs. These activities require consulting with teachers on assessment data and generating intervention ideas prior to the student being referred for special education services. This type of consultation is considered primary prevention.

• **Specific Learning Disabilities Eligibility.** IDEA 2004 redefined evaluation for a specific learning disability (SLD) to be based on the outcome of evidence-based interventions rather than a discrepancy between a child’s intelligence and achievement. In fact, state departments of educations can no longer require school systems to find a severe
discrepancy between achievement and intellectual ability in order to qualify a student for special education due to a learning disability. The law and regulations also encourage “a process that determines if the child responds to scientific, research-based interventions” (Sec. 614(b)). A child who has had a lack of appropriate instruction, including scientifically supported methods for teaching reading, cannot be identified as a child with a disability. This represents a major shift in how the largest group of students with disabilities could potentially be evaluated. However, local education areas could decide to keep the cognitive-achievement discrepancy if not outlawed by the state. Further, many interpreted changes in the law as promoting a processing strength and weakness (PSW) model toward determining SLD eligibility (Learning Disabilities Association of America, 2010). Thus, depending on the state or district, three different eligibility criteria may be applied: (a) cognitive-achievement discrepancy, (b) the PSW model, and (c) intervention-based assessments or response-to-intervention (Hagans & Powers, 2013); in the case of California, all three are sanctioned. In fact, Zirkel and Thomas (2010) found the vast majority of state laws permit the LEA to choose between the cognitive-achievement discrepancy or the PSW model and intervention-based assessments (formerly termed RtI), with 14 requiring some intervention component. From a consultation perspective, there should be greater demand for collaborative consultation around designing, implementing, and monitoring interventions and less emphasis on engaging in traditional testing, which typically requires little collaboration.

**ACTIVITY 1.7**

Search online for the 2010 White Paper by the Learning Disabilities Association of America on evaluation, identification, and eligibility criteria for SLD. Download and read both this paper and the 2010 response offered by the Consortium for Evidence-Based Early Intervention Practices. Discuss the major points of contention.

- **Inclusion and Least Restrictive Environment (LRE).** Almost since its inception, special education law has promoted educating students with disabilities with their typically developing peers to the maximum extent possible. Special education services can be provided in a continuum of settings, ranging from general education (least restrictive) to pull-out resource support, to most of the day or the full day in a special education classroom, to a special education school with a student population comprising exclusively students with disabilities (most restrictive). In Daniel R. R. v. State Board of Education (1989), the court indicated a two-part test for determining compliance with the requirement for placement in a least restrictive environment (LRE):
  
  First, we ask whether education in the regular classroom, with the use of supplementary aids and services, can be achieved satisfactorily for a given child. If it cannot and the school intends to provide special education or to remove the child from regular education, we ask, second, whether the school has mainstreamed the child to the maximum extent appropriate. (p. 1048)

  Today, the term mainstream has been replaced by inclusion, reflecting an increased emphasis on providing accommodations and modifications in the general education program so that an even wider range of students with disabilities may experience success (Mastropieri & Scruggs, 2000; Serge, 2009). Some general educators are concerned that they are overburdened with too many issues and demands and cannot keep up with the pressures they already have. They believe that inclusion is a difficult proposition if sufficient time and resources are not provided; however, some see added benefits, such as being prompted to attempt new instructional methodologies (Ryan, 2009) or teaming with a special education colleague. The courts have not tended to agree with arguments that inclusion is overly burdensome to general education teachers, citing the law as having precedence over the objections of some general educators, so the inclusion movement has progressed, prompting general educators to seek ways to make it work. In-service training, workshops on curriculum modification, teaching methods, coteaching or team teaching, peer tutoring, group work, and other modifications are now common in schools that have embraced the
inclusion philosophy, which necessitates individual or systemwide collaboration practices. Collaborative consultation is key to inclusion of students with disabilities in general education settings. Some benefits of full inclusion include providing positive behavior and academic models to students with disabilities, increasing access to general education curriculum by teachers certified to teach that particular subject, increasing personal contact of typically developing students with students with disabilities, and avoiding the disruptions of pull-out programs or behavioral grouping/academic tracking associated with full-day special education programs.

*Due Process*. Special education students are guaranteed procedural safeguards. For example, major changes to a student’s educational services or placement cannot be made without parental input, and all students have a right to a free and appropriate public education (FAPE). Sometimes parents and school personnel disagree on the best course of action for a student with special needs. Under IDEA, parents have the right to an impartial due process hearing to determine whether their child is receiving FAPE and whether compensatory education is warranted if FAPE or the responsibility to consult with parents about their child’s educational program has been compromised (Sec. 615(f)). District personnel can invite parents to engage in mediation prior to a due process hearing in an attempt to prevent a potentially expensive and acrimonious disagreement. Collaborative consultation with parents when disagreements emerge, rather than after a complaint has been filed, may be an even more effective method than mediation for avoiding due process hearings. Roter et al. (1977, as cited in Jacob, Decker, & Hartshorne, 2011) found that medical doctors who were better at listening to their patients, laughed and told jokes more, and spent more time educating their patients were the subject of fewer malpractice suits than those who did not engage in these behaviors. This may be the case for school personnel as well; in other words, time and effort spent getting to know parents, listening to their concerns, and providing good information proactively saves district resources that would otherwise be diverted to settle a grievance. Settling a legal case can be costly and stressful; however, school personnel should not adopt an “avoid legal conflict at all cost” policy by capitulating to unreasonable requests. Zirkel’s (2013) research found that districts prevail in 85% of due process hearings, particularly those involving eligibility and services for specific learning disabilities.

*Positive Behavioral Support, Functional Behavioral Assessment, and Manifestation Determination*. To promote FAPE, special education law requires school personnel to conduct a functional behavioral assessment and implement a positive behavioral support plan (i.e., a Tier 3 intervention) if a student’s behavioral disability is interfering with her ability to access curriculum and instruction. Chapter 6 provides a detailed description of this process, but needless to say, this assessment and intervention process requires considerable collaboration among many stakeholders. One of the safeguards afforded to special education students is they cannot be subjected to the same disciplinary actions applied to non-special-education students if the infraction was a manifestation of their disability. Thus, when a special education student violates a school rule, his IEP team must determine whether the violation was a result of his disability and whether appropriate behavioral supports were in place prior to the infraction. If it is determined that the infraction was a manifestation of the student’s disability or a response to insufficient behavioral supports, he cannot be removed from his current educational setting through expulsion or prolonged suspension (with the exception of some very serious infractions such as possessing a weapon). Typically, a school psychologist or some other behavioral specialist conducts the manifestation determination. Due to the high stakes of the outcomes and the need to negotiate competing demands, such as protecting the student’s FAPE while maintaining a safe and orderly school climate, the school psychologist will need to apply the highest level of collaborative consultation competency to conducting the manifestation determination.

*Transition Planning*. Special education students often require more assistance than typically developing students in transitioning from preschool to elementary school, elementary to middle school, middle school to high school, and high school to adulthood. Because students with disabilities have not had the success that students without disabilities enjoy in adulthood (National Organization on Disability, 2004), IDEA requires school personnel to collaborate with students, their parents, and adult services agencies to produce a plan
and provide services to improve students’ postsecondary outcomes. Collaborating with students and parents can be difficult if the parents and students disagree on what outcomes to target and how best to achieve them (Powers, Geenen, & Powers, 2009). Collaboration across agencies, such as vocational rehabilitation services, adult medical services, and institutions of higher education, remains a challenge (Johnson, Stodden, Emanuel, Luecking, & Mack, 2002). Therefore, collaborative consultation skills are essential to fulfilling the transition-planning mandate. Transition planning is typically coordinated by a special education teacher who is the student’s case carrier or transition specialist.

**ACTIVITY 1.8**

Observe this video of an IEP team meeting. What was the purpose of the meeting? Some common topics in an IEP meeting include transition planning, reviewing annual goals, developing a behavior plan, FAPE, and LRE. How collaborative was the group? How much emphasis was placed on the student’s outcomes compared to the special education processes (e.g., completing all the forms and informing parents about their rights)?

**Response to Intervention/Multi-Tiered System of Services**

Both IDEA and NCLB emphasize accountability, evidence-based practices, and integration and consistency between general and special education (Ysseldyke, Burns, & Rosenfield, 2009). A prime example of changes in practice that resulted from this merger is response to intervention (RtI). The term responsiveness to intervention was first proposed by Frank Gresham (2001), who suggested providing increasingly more intense interventions and monitoring for students who remained below grade-level expectations despite receiving scientifically based interventions. For a short period, around 2000, the term resistance to intervention was popular because it emphasized that secondary/selective/Tier 2 or tertiary/indicated/Tier 3 interventions should be applied only after primary/universal/Tier 1 prevention had been attempted and failed. For example, a student should not be considered for special education eligibility if she has not received adequate general and supplemental education instruction. The term resistance became response in order to acknowledge that many students have a positive response to intervention and thereby do not show “resistance,” but the essential premise remains. Specifically, an RtI service delivery model establishes assessment and intervention tiers that provide students with learning and behavioral difficulties services and monitoring proportional to their needs. Determining which student receives which level of service should be a widely collaborative process, particularly if all the potential resources of a school (including general and special education) are to be considered.

RtI is both an instructional model that can help to prevent reading and other learning problems and a special education eligibility model (Torgeson, 2007). For reasons discussed in Chapter 3, the term RtI to describe tiers of services to address academic needs systematically has been replaced with the term multi-tiered system of services (MTSS), which is a more comprehensive term. MTSS will be used primarily in this text to describe this type of system delivery. The term intervention-based assessments will be used in this text in lieu of the term RtI for special education eligibility decision making.

Consensus on how many service tiers to offer or what exactly occurs at each tier has not been reached (Kame’enui, 2007). It is common, however, to conceptualize a three-tier model (see Gersten et al., 2008), as we describe here. Tier 1 (core) constitutes good general education instruction, including high levels of academic engagement, positive classroom management, and differentiated instruction. Assessment at Tier 1 should involve universal screening of all students three or more times a year. Students who fail to attain grade-level benchmarks on the screening receive a predetermined intervention, such as small-group instruction on letter sounds, based on their performance on the screening. This is known as a standard protocol to assessment and intervention (Fuchs & Fuchs, 2006), and it is designed to capture students who are falling behind early before deficits become entrenched and difficult to remediate. Several good screening assessments are available, such as the Dynamic Indicator of Basic Early Literacy (Good & Kaminski, 1996) and the math, spelling, and reading assessments found online at AIMSweb. Developing the intervention
protocol, which is delivered largely in general education, requires a collaborative effort among school staff members. Similarly, collaborative consultation is required to determine criteria for success or failure at each level. Specifically, how long should an intervention be implemented before it is deemed unsuccessful? What is the criterion for success or failure? If the intervention is deemed a failure, do you adjust the intervention or progress to the next tier?

A student who progresses to Tier 2 (targeted intervention) should receive a different, more intense intervention compared to Tier 1, not just more of the same. Fuchs and Fuchs (2006) described increasing the intensity of an intervention as involving one or more of the following: (a) more teacher-centered, explicit, and systematic instruction (b) for longer durations, (c) more frequently, (d) in smaller or more homogeneous groups, and (e) provided by personnel with more training or expertise. Along with a more intense intervention, assessment becomes more frequent and targeted at Tier 2. Students’ progress toward intervention goals should be monitored on a weekly basis, or once a month at a minimum, in order to make midcourse corrections to interventions that are not producing the desired results. An assessment technique known as brief experimental analysis (BEA) can be applied to determine which of myriad sound interventions best suits an individual student’s needs. BEA is an assessment practice that provides a series of short interventions to determine which intervention produces the most promising effects. Thus, BEA can assist consultants in suggesting interventions to consultees (Noell, Freeland, Witt, & Gansle, 2001). Tier 3 (intensive intervention) can involve increased individual or small-group instructional time; extended-day school; summer school; or special, alternative, or non-public-education services. In the case of special education, data gathered from the other tiers on rate of progress and intervention responsiveness can be used to guide development of the individualized education program. In fact, proponents of RtI highlight the utility of the intervention-based assessment data for designing IEPs compared to the lack of treatment utility associated with traditional cognitive/achievement discrepancy assessment methods (Reschly, 2008; Tilly, 2008). As we discuss in Chapter 8, a shift to an RtI/MTSS service delivery model will require targeted and sustained system-level consultation.

**THE PRESENT STATUS OF COLLABORATIVE CONSULTATION IN SCHOOLS**

Whatever the specific area of concern (curriculum, behavior problems, cultural diversity, physical plant use, expertise sharing, decision-making systems, materials sharing, and so on), all can be discussed in an atmosphere that encourages shared problem solving. The older top-down, hierarchical, authoritarian administrative models are mostly passé. The challenge now is for educators, including teachers, support staff members, and administrators, to realize that models of shared-governance, site-based, community-organized, and collaborative schools are not easy to develop or implement; it takes a new degree of commitment and cooperation to make these models work.

One of the reasons consultation is emerging slowly is the usual reason for the slowness of change in schools and other large-scale bureaucratic organizations: habit strength. In regard to an approach to responding to the needs of students referred for learning and/or behavior problems, many continue to prefer, or at least persist in, the long-established model of refer-test-place, which has dominated the special education–general education partnership for many years (Ysseldyke, 1986). In the refer-test-place model, a student is referred, and some degree of effort is made to resolve the problem through suggestions generated by the SST. A period of time goes by,
during which the problem doesn’t resolve easily, and the team decides to generate an assessment plan to determine if the student is eligible for services as a student with a disability. The most likely category the student will be eligible for is learning disabilities simply because it covers approximately 40% of those eligible for special education services (U.S. Department of Education, 2009); the odds are about three out of four that, if an assessment plan is generated and the assessment takes place, the student will be found eligible for such services (Ysseldyke, 1986; Ysseldyke, Vanderwood, & Shriner, 1997). The student will most likely be given services in a special education resource services program (RSP) for one or two periods a day with unpredictable results. Students with behavioral difficulties often experience punishments like office disciplinary referrals (ODRs), suspension, and expulsion meted out in response to each infraction. The behaviors are likely to worsen over time, and males and African Americans are more likely to receive harsher punishments, which is further indication of the ineffectiveness and inequality of this common practice.

One of the goals of collaborative consultation is to change this picture dramatically. MTSS constitutes a very different approach, one where the process of collaborative consultation assumes a much stronger role, with the goals being to forestall placements outside the general education program as often as possible and to provide positive, proactive behavioral supports. MTSS essentially promotes such collaborative consultation practices by focusing on students’ outcomes rather than deficits. However, simply providing a description of MTSS practices is not likely to result in change. Real change requires fostering or capitalizing on educators’ desire to change, restructuring the role of some school personnel, expanding the knowledge and skills of all educators through targeted professional development, and changing the way the system supports some professional practices (e.g., collaborative consultation) while discouraging others (e.g., searching for pathology within the child). A survey of urban school psychologists found participants rated consultation as the most valuable practice among all of their activities; however, they engaged more frequently and felt more competent in traditional assessment activities (Stoiber & Vanderwood, 2008). The authors concluded that a “practice gap” exists between what school psychologists value and what they do and do well. One reason for the practice gap may be a lack of knowledge. For example, a survey of 249 California school psychologists found that many did not know how to graph progress-monitoring data or how to apply decision rules to determine if a child was responding to an intervention (Powers, Hagan, & Busse, 2008). And 1 in 10 reported that they knew very little about academic interventions, yet all of the respondents indicated they were very knowledgeable about cognitive assessments. Another example of the research-to-practice gap was found by Walsh, Glaser, and Wilcox (2006), who reviewed a random sample of 72 teacher preparation programs and concluded most teacher preparation programs are not teaching the science of reading. Specifically, they found only 11 of the 72 taught future teachers to target the five core reading skills identified by the National Reading Panel, while many emphasized exposure to literature and making lessons fun (rather than research based) as the best way to teach students to read. This finding has significant implications for the quality of Tier 1/core instruction. Thus, change may need to include modifying how training programs prepare teachers, special educators, school psychologists, counselors, administrators, and other support staff members.

There is no one way to practice consultation, so it is not clear what a person means by consultation until she describes it in some detail or you see her doing it. Current practice varies across a wide range of philosophies, roles, activities, and contexts. The different models discussed in Chapter 2 indicate some of the variations currently practiced in the schools.

**RESEARCH ON THE EFFECTIVENESS OF SCHOOL CONSULTATION**

There has been a plethora of research on consultation; unfortunately, much of it has relied on demonstrating effectiveness based on the consultee’s satisfaction with the process. As VanDerHeyden and Witt (2008) stated, “Like much education research, consultation research languished in the world of self-report” (p. 117). However, the legislative mandate within NCLB and IDEA 2004 to consider scientifically based interventions has sparked a number of task forces to define criteria for determining whether an approach or intervention is sufficiently supported by scientific research. Division 16 of the American Psychological Association, the Research Task Force of the Council on Exceptional Children, and the Task Force on Evidence-Based Interventions in School Psychology (EBI Task Force) have all created guidelines for determining the quality and quantity of research needed to deem a particular educational strategy...
“evidence-based” (Gresham & Vanderwood, 2008). These specific criteria raise the issue of what consultation is (i.e., is it a skill, an intervention, or something else?) and how we measure its effectiveness. Conclusions about the effectiveness of consultation will most likely be made about the impact of specific strategies on a particular skill, setting, and population rather than a judgment about consultation effectiveness as a whole (VanDerHeyden & Witt, 2008).

An emerging issue within consultation research is fidelity. Researchers are interested in identifying the conditions that lead to high fidelity in both consultation processes and intervention plan implementation. To study the impact of consultation, one must first be able to verify through direct assessment that the consultation and the intervention occurred as planned (i.e., fidelity); second, one must be able to measure the impact of the consultation on the consultee’s behaviors and ultimately the student’s (client’s) outcomes. Currently, there is a dearth of research on assessing fidelity, and this lack is due to many issues, including the following: (a) some consultation behaviors may work better in some situations than others, (b) fidelity may be a function of the match between the intervention plan and the referral concern, (c) intervention fidelity instruments that are sensitive to change and demonstrate adequate reliability and validity are rare, and (d) it is not feasible to monitor the fidelity of some types of interventions (Sheridan, Swanger-Gagné, Welch, Kwon, & Garbacz, 2009). A more detailed discussion on implications of assessing and supporting treatment fidelity is provided in Chapter 3. To organize some of the many variables at work in the consultation process, Frank and Kratochwill (2009) proposed a taxonomy for consultation research based on four broad types of research (efficacy, transportability, dissemination, and/or systems evaluation) with level of intervention (core, targeted, and intensive) and setting (dyad, team, or system) nested within each of the four broad categories. Within this taxonomy there are as many as 36 categories of research that could be investigated for any given consultation strategy; most of the task forces mentioned above recommend that multiple studies be conducted to verify the effectiveness of an educational practice. The edited volume Handbook of Research in School Consultation (Erchul & Sheridan, 2009) contains a thorough analysis of the gaps in the current research base as well as promising methodologies for addressing these limitations. While much work remains to be completed to advance our understanding of the effectiveness of school consultation, the research to date is promising. Seventeen major reviews and meta-analyses have been published on the outcomes of school consultation, and the results consistently suggest improved outcomes for clients and consultees as a result of school consultation (Erchul & Sheridan, 2009).

At the systems level, there is evidence that districts that have adopted a consultation-based approach to dealing with referrals, rather than a refer-test-place model, place fewer students in separate special education classroom programs (Villa, Thousand, Nevin, & Malgeri, 1996) and reduce the overrepresentation of African Americans (Marston, Muyskens, Lau, & Canter, 2003). In one of the few long-term studies of the effects of consultation as an intermediate step in the referral process, Gutkin, Hemming-Stout, and Piersel (1988) found that referred children who were not evaluated for special education rose from 21% to 61% during the four years of their study. Torgersen (2007) examined data from 318 Reading First schools in Florida that had implemented an RtI (i.e., MTSS service delivery model) focused on providing high-quality instruction, collecting data to identify students in need of intervention, using data to adjust the intervention when indicated, and providing increasingly powerful tiers of service based on student need. He found special education identification rates and the proportion of students who had significant reading difficulties (defined as performing below the 20th percentile on reading tests) to decline dramatically over the first three years of the program.

**Summary**

The concept of collaborative consultation, problem solving, and MTSS were introduced. Educational policies such as IDEA, NCLB and Common Core were described as some examples of the macro-system influences that have made school-based consultation more valued than in the past. While the empirical support for specific consultation practices is building, and fidelity of consultation and intervention practices appears to be an important linchpin, systemwide consultation-based service delivery models, such as MTSS, are associated with positive results. The next chapters will explore different contexts and roles in consultation, ethical considerations, interpersonal skills in consultation necessary to the consultation process, and academic and behavioral assessment and intervention ideas that comprise the content of consultations.
References


Chapter 1 • Overview of School-Based Consultation


Consultation Models and Professional Practices

Learning Outcomes

2.1 Describe the questions a consultant faces in settling on a conceptual model.
2.2 Distinguish between two theoretical traditions of consultation: behavioral and mental health.
2.3 Give examples of a number of functional consultation models.
2.4 Compare and contrast various consultation configurations (i.e., individual, conjoint, team-based, and systemswide consultation).
2.5 Describe various contexts in which school-based consultation may take place, with particular focus on the student study team (SST).

José is a junior in a comprehensive high school. He has been referred to the counselor numerous times over the past two years because of low achievement, poor academic productivity, and general disinterest in school. Yet José shows considerable promise when engaged in mathematics, a subject he enjoys. You (the school counselor) would like to collaborate with José’s parents and teacher to develop a plan to increase José’s academic engagement. How might you begin? What is a reasonable goal to strive for with José?

Elise, a ninth-grade student with learning disabilities in reading and writing, is in danger of failing her general education classes in English and social studies. Elise has a difficult time reading the texts for these courses. You are the special education teacher consultant in this school. What are some ways of assisting Elise and her general education teachers with this situation?

A RATIONALE FOR A MODEL

A model is a way of conceptualizing or approaching a problem. A consultant is always, if only unwittingly, following a model. Consider the following questions as possible indicators of the type of model that may best encapsulate your approach to consultation:

1. Where is the origin of an academic or behavioral problem likely to reside, within the student, her family, teacher, peers, classroom, school, or some combination?
2. Is the goal of consultation to solve the student’s problem or increase the capacity of the consultee, or both?
3. Do you want to diagnosis and prescribe an intervention or are you interested in trying different interventions until you find one that works?
4. Are parents important partners in addressing students’ needs, or is it better for them to stand aside while the professionals get to work?
5. Is the consultant the expert, like the wise man on the mountain who provides a definitive answer to a problem when approached by the consultee, or is the consultant part of a team in motion adjusting strategies as interventions are attempted, or somewhere in between?
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6. Is it better to solve one student’s problem at a time or is it better to look for ways to improve the system?
7. Can students change? Can teachers and support staff members change? Can systems change?

This chapter reviews two theoretical traditions: behavioral and mental health. They are regarded as theoretical because they derive from well-established theories of human behavior. Also reviewed are some consultation models that can be applied easily in school settings.

TWO THEORETICAL TRADITIONS

Behavioral Paradigm

The behavioral model is built on the theories of learning that have been adapted by behaviorists such as Skinner, Bandura, and Meichenbaum (Conoley & Conoley, 1992) and made specific in the area of consultation by Bergan (1977) and Kratochwill and Bergan (1990). Essentially, a behaviorist believes that behaviors are a function of the contingencies that control them (i.e., their antecedents and consequences), and the functional relationships between behaviors and their environmental and cognitive (i.e., self-talk) contexts. Thus, a consultant trying to understand why a student is exhibiting a problem behavior in the classroom would search for potential triggers or reinforcing events in the classroom. A basic tenet of behaviorism is that all behavior is meaningful because it serves some function. The function of a behavior may not be apparent initially, but it exists.

Behaviorism has progressed in many ways over the 70 years of its existence. During the 1980s and 1990s, for example, there was an increasing interest in what is known as cognitive behavior therapy, which differs from more traditional behaviorism in its emphasis on internal, cognitive events. Traditional behaviorism was not concerned with internal events primarily because they could not be observed and counted. Now, however, it is widely recognized that ignoring internal mediating events leaves a gap in behaviorists’ ability to understand the source of human behavior (Alberto & Troutman, 2013; Schloss & Smith, 1998). Another major influence on current applications of behaviorism is the work of Bandura (1977), who hypothesized that social learning, or learning by observing models, is a major force in one’s learning history. Using role models and rehearsing specific behaviors under conditions of positive reinforcement are two of the behavior change techniques suggested by Bandura’s work.

BASIC CONCEPTS IN BEHAVIORAL CONSULTATION

Behavioral consultation involves providing indirect services in which the consultant collaborates with a consultee in order to improve the behavior of a client by following a four-stage interview (Hagermoser, Sanetti, & Kratochwill, 2008). The emphasis is on identifying and analyzing the client’s problems in order to design and evaluation interventions. Following the behavioral tradition, the student’s problem is defined in operational terms (i.e., very specific, overt, and measurable behaviors). Conditions that instigate or sustain the behaviors are identified, and an intervention plan that includes some type of modification to the contingencies that support the behavior is developed. The target behavior is measured repeatedly over time to determine if the behavior improves compared to preintervention (baseline) performance. Because of the emphasis on analyzing a behavior and the context in which it occurs, the term applied behavior analysis has replaced the former term behavior modification (Alberto & Troutman, 2013).

The basic paradigm for analyzing behaviors is to consider the antecedents, behaviors, and consequences. Antecedents are events that precede and are believed to be functionally connected to the target behavior. Antecedents can be either external or internal. Examples of external antecedents are a teacher’s direction to a student to do something, the behavior of the child sitting next to a target student, the difficulty of an assignment, and a fire-drill alarm. Internal antecedents may include hunger, one’s emotional state, and self-talk. Antecedents can be both proximal (occurring close in time to the actual behavior) or distal.
(occurring much sooner, possibly even in a different setting, than the target behavior). As with most variables that exist on a continuum, it is not always easy or practical to make the distinction between identifying any given antecedent as distal or proximal. In spite of this, the distinction is valuable because it reminds observers that any behavior may be a function of antecedents that occurred days earlier rather than simply those events that are currently happening. Distal antecedents include child-rearing practices, loss of a parent, events seen on television, habit strength, memories of a situation similar to a current situation, and so on. In fact, what often appears to be the immediate cause (proximal antecedent) of a child’s misbehavior may not be the main reason for the observed behavior. By knowing a child’s history and, when possible, something of the child’s inner life through counseling or reflective listening techniques, one may come to understand the distal antecedents of that child’s behavior. Gutkin (2012) has emphasized this point, suggesting that behavioral consultation needs to attend more seriously to distal antecedents by becoming “ecobehavioral,” by looking at the larger picture of a student’s life and history rather than just at immediate prompting events.

**ACTIVITY 2.1**

List, either by yourself or in a class group, all the antecedent reasons you can think of for classroom misbehavior (however defined). In other words, what prompts misbehavior in school? Determine which antecedents are distal and which are proximal.

**ACTIVITY 2.2**

Repeat Activity 2.1, this time focusing on academic learning problems. What are some reasons for poor academic performance? Which seem to be within the child and which are environmental?

Consequences (defined here as the effects of a behavior on the student) are ordinarily regarded as the events that follow a behavior. These events can be reinforcing, neutral, or aversive. It is the effect on a student that determines whether a consequence is reinforcing, neutral, or aversive, not the intention of the person who delivers the consequence. The student determines the effect, which might be the opposite of the effect that the person delivering the consequence intended. For example, teachers (and parents) often warn children not to tip their chairs back because they might fall. If they do fall, the effect may be reinforcing from the point of view of the adult because it validates the adult’s ability to predict events. Or it may be aversive if the child is hurt and the adult feels regret for not doing more to stop the child from falling. From a child’s point of view, the effect may be punishing if he gets hurt, or it may be reinforcing if he obtains some sort of pleasure from disrupting the classroom or obtaining approval from his peers, even if he does get hurt.

Alberto and Troutman (2013) describe consequences that increase the likelihood of a behavior occurring as positive and negative reinforcement. Positive reinforcement is receiving a desired object, activity, or communication contingent on performing the desired behavior. For example, a teacher may award a token or verbal praise to a student for completing his seatwork assignment. If the student desired the token or praise, and if everything remains the same, he will be more likely next time to complete his work. Negative reinforcement is removal of an aversive stimulus contingent on a behavior. The classic example is the harried mother in the grocery store who initially refuses to buy her child a treat but relents after the child has a temper tantrum. By relenting, the mother actually reinforces the tantrum behavior (making it more likely to happen next time), and her own acquiescing was negatively reinforced by the removal or cessation of the tantrum.
To view a video of this type of negative and positive reinforcement, also known as coercive pain control (Rhode & Jenson, 2010) see https://www.youtube.com/watch?v=OxdtMVww2q0. Because student’s noncompliance or work avoidance is negatively reinforced when teachers remove their demands, Rhode and Jenson, (2010) recommend that teachers use precision commands in which compliance is immediately reinforced, and the student receives a punishment after failing to comply with a request that has been repeated once. Punishment is the delivery of some aversive stimulus or removal of a desired stimulus in order to decrease a behavior (Alberto & Troutman, 2013). While punishment can be effective, it should never be humiliating or painful. Reinforcing positive and competing behaviors (i.e., work completion or compliance) is often both more productive and humane than punishing undesired behaviors.

In some cases, an action designed to be reinforcing, like delivering verbal praise, could be felt as a punishment (the student does not want any attention called to her). This case raises the question, “How does one know whether an adult or peer response to a targeted behavior is reinforcing or punishing?” The answer lies only in a careful study of the data. Is the targeted behavior decreasing as a function of the consequences it elicits? If so, then these consequences are probably best interpreted as aversive or punishing. Are behaviors increasing as a result of the responses that follow these behaviors? If so, then the consequences are probably positively reinforcing the behavior.

**ACTIVITY 2.3**

Watch the tutorial on how to conduct an antecedent, behavior, and consequence (ABC) analysis at https://www.youtube.com/watch?v=GxcIM8klHuY and complete the ABC analysis found on the video clip for the target behavior: yelling in the classroom.

**BASIC BELIEFS UNDERLYING A BEHAVIORAL APPROACH TO CONSULTATION**

The behavioral tradition focuses on behaviors that are either observable to the teacher or parent or reportable by the student; it contrasts with the medical-model approach, which focuses on pathology or sickness within the child. Hypothetical constructs and pseudo-explanatory concepts and labels, such as attention deficit hyperactivity disorder (ADHD), conduct disorder, or others listed in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), are not regarded as constructive except for purposes of communication among professional staff members and parents. The behaviorist does not say that a student is out of her seat and running around the room because she has ADHD. Rather, the behaviorist is inclined to say that the student engages in an excessive amount of out-of-seat behavior (operationally defined and usually determined in relation to a norm for a given classroom or other setting) and will help to develop an intervention to change the behavior by changing either the antecedent (adjust difficulty of seatwork, move desk to quiet corner, etc.) and/or consequence events (provide short breaks contingent on work completion, implement a self-monitoring program with a highly desired reward for improved on-task behavior, etc.). To learn if the intervention has been successful, a behaviorist charts the occurrence and duration of out-of-seat behavior or some other targeted behavior. The behaviorist’s goal is to reduce the frequency of symptoms because, as the behaviorist believes, the symptom is the disease (Ullmann & Krasner, 1965).

**ACTIVITY 2.4**

A teacher tells you that she is concerned about a student who is anxious. What else do you, as a behaviorally oriented consultant, want to know about the child? What are the behaviors of anxiety? Which can be treated, the anxiety or the behaviors? How might a traditional behaviorist differ from a cognitively oriented behaviorist in his approach to this problem?
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STAGES IN THE BEHAVIORAL CONSULTATION MODEL

Bergan (1977) and Bergan and Kratochwill (1990) have delineated four stages that form the structure of the behavioral consultation model: problem identification, problem analysis, plan implementation, and plan evaluation. Ideally, these stages occur over the course of three separate interviews, each on one of the following: problem identification, problem analysis and plan development, and problem evaluation (Martens & DiGennaro, 2009). In our experience, however, problem identification and problem analysis often occur together in schools in order to expedite the process. The trade-off of moving more quickly to plan development and implementation is associated with an increased risk of selecting the wrong behavior to target or incorrectly interpreting the function of the behavior. The following is a description of the activities carried on during these stages and an indication of some of the objectives that underlie each stage.

In problem identification, the consultant receives and discusses a referral with the consultee and attempts to clarify its nature. Is it primarily a behavior problem or a learning problem? How might the behavior be described operationally? The objectives of this stage are to assess the nature of the consultee’s concerns; prioritize problems; select target behavior(s); make an initial estimate of the problem’s seriousness; decide on tentative goals; discuss possible antecedents, sequences, and consequences (i.e., how the behavior unfolds in time); discuss possible data-collection ideas; and set a date for the next meeting. A consultee’s description of a problem may often seem overwhelming and confusing initially, particularly if the consultee’s descriptions are clouded by anger, frustration, or the intermixing of facts and opinions. Many students do not have just one problem and the temptation to try anything and everything at once in order to get immediate relief must be resisted for a more measured and precise problem analysis.

ACTIVITY 2.5

Watch the video clip at https://www.youtube.com/watch?v=TsUP76Ek2RQ and discuss how the consultant helps the consultee operationalize and prioritize the behavioral concerns. What further data are needed to define the behavior in observable and measurable terms?

In problem analysis, the consultant delves further into the nature of the problem, usually by observing it directly, conducting a functional assessment if appropriate (see Chapter 6) to determine the function that the behavior serves, clarifying issues with the consultee, and brainstorming possible interventions. Other activities at this stage are to examine the data for patterns; solidify goals; verify antecedents, behavioral sequences, and consequences; determine the strengths and assets of the student; research school resources that can be incorporated into the planning; and design and get agreement about the intervention plan. If the behavioral consultation is being conducted in the collaborative mode, the consultee makes the final determination about what to implement and how to do it, with the guidance and facilitation of the consultant. Both parties discuss ongoing data-collection methods and treatment integrity checks, and schedule the next interview and/or observation.

ACTIVITY 2.6

Watch the video of a portion of a behavioral consultation interview at https://www.youtube.com/watch?v=RVfNZciZROI. Discuss whether the function of the target behavior (i.e., disruptive and poor task completion) is avoiding a task avoidance, attention seeking, or both. What might you look for in a classroom observation to confirm the function served by the behavior? How would the interventions differ depending on the results of the behavioral analysis?
In plan implementation, the consultee proceeds with the appropriate interventions. The consultant’s main objectives at this stage are to monitor what the consultee is doing (to ensure treatment integrity), suggest modifications as appropriate, and reinforce the consultee for her efforts. The consultant may also collect progress-monitoring data on the student to verify that the interventions are working.

For plan evaluation, Bergan (1977) suggests three steps: evaluating goal attainment, evaluating plan effectiveness, and planning postimplementation. The goals should have been established during the problem identification stage and should have flowed naturally from the nature of the problem. The primary objective of this stage is to determine how well the goals have been met. Continuation, modification, or termination of the plan is determined at this stage. A plan may look elegant and may have worked elsewhere, but the consultant and the consultee have to determine how well it has worked in the present case, which is always different in important, if subtle, ways from all other instances of similar problems.

Postimplementation planning refers to a discussion of how to proceed after the current consultative relationship is terminated. What steps should be taken to ensure that the problem won’t recur? Should data continue to be kept? In school consultation, consultants should learn to expect recurrence of problems from certain students and from certain teachers. Some cases resurface continually due to students’ home conditions, serious learning disabilities, or other biophysical or classroom ecological influences. Sometimes postimplementation simply means putting a partially successful case on the back burner while attending to more pressing cases, with the plan to return to the partially successful case at a later time.

**ACTIVITY 2.7**

Form teams of two (dyads). One person thinks of a social relationship problem she has experienced. The other person acts as a consultant and tries to get functional information about the problem from the consultee. The consultant asks for a behavioral definition of the social relationship problem and gets information about the antecedents and consequences, frequency of occurrence, durations, intensities, and so on. Then reverse roles.

**CURRENT THINKING ABOUT THE BEHAVIORAL MODEL**

Bergan (1995) has updated the behavioral model of consultation since its inception in 1977. He points to a widening literature base that supports this highly structured approach and indicates how it has assisted consultants and consultees in defining problems that can be operationalized and solved. He specifically indicates a problem-centered approach, which is not always evident in approaches taken by consultants who follow other theoretical or functional models. This approach avoids the focus on a referred student’s negative behavior and instead asks questions that focus on a program of possible skill development. For example, instead of asking, “What’s wrong with Johnny?” the consultant asks, “What skills does Johnny need to develop to be more successful?” While it is likely that referral questions may contain some explication of what a student is doing wrong (such as variations on “He won’t behave or do his work”), this is not necessarily the problem the consultant works on. Rather, it is more appropriate to stress the teaching goal for the student (such as “What social or academic skills does the student need to work on, and how can we arrange the environment, broadly defined, to see that this happens?”). Thus, “problems” are reframed in terms of a goal for improved performance and a series of steps or interventions to achieve the goal. This is the underlying assumption to problem-solving consultation, which is described in detail in Chapter 3.

The behavioral approach has considerable surface appeal in addition to a solid track record of empirical validation. Nevertheless, many teachers do not use behavioral approaches. Indeed, some teachers and administrators want nothing to do with them. Axelrod, Moyer, and Berry (1990) point to a number of reasons for this avoidance. Some teachers balk at this approach because data have to be kept, a teacher may have to change her own behavior, and
programs need to be individualized. Also, reinforcement is often misinterpreted as bribery. Some teachers believe in the Protestant ethic, by which they mean that students should do work because they are told to; thus, “bribing” them is unnecessary, even immoral. Such teachers believe that this behavioral approach may be all right for rats and pigeons, but not for people. Alberto and Troutman (2013) identified the main challenges to behaviorism in schools: (1) It requires a lot more effort on the part of the teacher than more indirect or avoidant methods and (2) educators’ philosophical beliefs often include the idea that learning should be child-directed and intrinsically motivating.

Most teachers have not been trained in behavioral techniques, and a behaviorist enthusiast may turn them off by conveying a superior attitude. Given the rich database that supports the behavioral approach, it is not surprising that those who have studied and applied it successfully might be evangelistic in their efforts to get others to use behavioristic methods. Astute behaviorally oriented school consultants need to guard against this attitude or impression. They need to remember that teachers usually don’t read the *Journal of Applied Behavioral Analysis*; may not be at all impressed with studies done under controlled conditions (which classrooms are not); and are primarily concerned with the students in their classrooms, not with others who seem to live in laboratories somewhere else.

**SUMMARY OF THE BEHAVIORAL MODEL**

This brief overview of the behavioral model presents a foundation for understanding and appreciating the contributions of this model to the consultation process. There is considerable overlap between what has been presented here as the behavioral model and what is presented later in Chapter 3 as a problem-solving model of consultation because behavioral consultation serves as a foundation for problem-solving consultation in the schools.

**Mental Health Paradigm**

The mental health tradition is based on psychodynamic theories of human interaction (Conoley & Conoley, 1992; Erchul, 1993). It was developed primarily Gerald Caplan. His seminal text, *The Theory and Practice of Mental Health Consultation* (Caplan, 1970), reviews the many intricacies of this complex model. In 1993 and again in 1999, Gerald Caplan and Ruth Caplan authored an updated text on the mental health model, which added the word collaboration to the title: *Mental Health Consultation and Collaboration* (Caplan & Caplan, 1993).

In strong contrast to the behavioral model, which emphasizes contingencies of reinforcement, modeling, and self-reinforcement, the mental health model stresses intrapsychic feelings and their effects on interpersonal relationships. Although the primary distinguishing factor in mental health consultation is its emphasis on intra- and interpersonal variables, it does not ignore environmental influences. Caplan makes many references to the importance of the ecological context in which behavior unfolds, such as communication patterns between the client and the consultee, and organizational and community influences on the behavior of both clients and caregiver-consultees. Mental health consultation also differs from behavioral consultation in its focus on the consultee rather than the client. The main goal of mental health consultation is to increase the capacity of the consultees. As such, researchers of mental health models of consultation often collect data on changes in the attitude or behavior of the consultee rather than the outcome of the client (Knotek, Kaniuka, & Ellingsen, 2009). For example, a research review by Brennan, Bradley, Allen, and Perry (2008) found sizable support for the effectiveness of mental health consultation on improving early childhood providers’ sensitivity, self-efficacy, confidence, job satisfaction, and observed and self-reported competency. Note, however, that the effect of mental health consultation on the young students’ outcomes was not a factor in the study.

Every school-based consultant needs to be sensitive to one of Caplan’s discoveries: When outsiders (consultants) enter the world of insiders (consultees), they need to understand that they are entering a world different from their own, one that has its own norms, beliefs, habits, and ways of doing things. No matter how expert a consultant may be, the consultee is largely responsible for the way in which an intervention is finally put into effect. Therefore, Caplan and Caplan (1993) stress the need for a collaborative approach to consultation. They discuss the
problems that arise when the consultant attempts to take over a case and assume the expert role. This stance may reduce the consultee’s involvement in the case and his subsequent willingness to generate or follow through on solutions to the referral problems.

KEY CONCEPTS OF THE MENTAL HEALTH MODEL
Caplan and Caplan (1993, pp. 21–23) list 14 basic characteristics of their mental health model. The following list adapts five of these characteristics as they apply to school consultation:

1. The relationship between the consultant and the consultee is coordinate and nonhierarchical. Throughout this text, we emphasize this basic tenet of the collaborative model. Even though the consultee has referred the problem to the consultant and might therefore be thought of as the dependent person in the dyad, the working relationship established in the collaborative model soon clarifies an equal-partners dyad.

2. Consultation is usually conducted as a short series of interviews. In public schools, there is not a lot of time for lengthy sessions between a consultant and a consultee. While it may be true in extreme cases that weekly meetings occur for some months, the usual case involves between two and five meetings, some of which may be brief phone or e-mail conversations.

3. The consultant does not get involved in the personal problems of the consultee. If it is clear that the consultee is undergoing some sort of emotional conflict that impedes her ability to carry out a consultation plan, the consultant should make an appropriate referral to another source for counseling.

4. A long-term goal of all consultation is to improve the on-the-job functioning of the consultee. Toward that goal, the consultant attempts to give the consultee skills, knowledge, confidence, and a sense of objectivity that the consultee may be lacking. These points will be useful in the consultee’s future cases.

5. The Caplans intend their model to be used primarily for mental health problems. However, the ideas discussed in their work can apply to any behavior or learning problem that a student is experiencing.

TYPES OF MENTAL HEALTH CONSULTATION
Caplan and Caplan (1993) discuss four types of consultation: client-centered case, consultee-centered case, program-centered administrative, and consultee-centered administrative. The first two types concern individual client (or small-group) issues, and the latter two are system-oriented. Another way to divide the four types is in terms of focus: on the consultee or on the client (or the program in the case of the program-centered administrative type).

- In client-centered case consultation, the consultant deals directly with a client (student) in order to provide some service (such as assessment or treatment) or to develop ideas that a consultee can use when working with the client. The consultant has little direct interaction with the consultee.

School-based example:
A teacher refers a student to the reading specialist because of the student’s significant reading delay. This specialist takes the student from the general education classroom, does some assessment work, and writes a report for the teacher telling him what he should do to help the student.

- In consultee-centered case consultation, the consultant deals directly with the consultee in order to assist the consultee in formulating a plan for dealing with the client. The consultant has little or no direct interaction with the client.

School-based example:
The reading specialist meets with the general education teacher, assists her in making a plan for helping the student, and monitors the plan as it unfolds. In this situation, the consultant may never meet directly with the student.
• In program-centered administrative consultation, the consultant evaluates a policy or program and develops a plan for improving it.

School-based example:
A reading expert, possibly from outside the district, is brought in to evaluate a school’s reading program and to develop a set of guidelines for improving it.

• In consultee-centered administrative consultation, the consultant works with a group of consultees to help them develop better ways of managing their program.

School-based example:
The consultant meets with members of the school’s leadership team to review their universal and targeted reading programs and results. The consultant then helps them improve the programs in order to have fewer students below reading benchmarks than they do currently.

Each of these four types is commonly used in the schools. Most of this text is devoted to individual or small-group consultation work; Chapter 9 focuses on the last two (administrative) types of consultation.

THE FOUR “LACKS” OF CONSULTEEs
Caplan and Caplan (1993) point out four “lacks” that may explain why a consultee has difficulty dealing with a client: knowledge, skill, confidence, and objectivity. In a situation in which knowledge is lacking, the consultee needs to know more about a targeted student or about techniques that can be used to assist the student. In school-based consultation, this lack occurs frequently. Some teachers do not know much about a student’s background or about cultural factors that may be influential. The consultee may be knowledgeable about one approach to teaching reading (whole language) but may lack knowledge of alternative approaches to try when her approach fails for some students. In this approach, the school consultant’s goal is to impart information to the consultee in order to help her deal more effectively with the student, hoping that these facts or insights will be used with other students as appropriate. Many topics designed to increase the knowledge base of consultees can be delivered in staff development in-services, which are discussed in Chapter 10. However, as discussed in Chapter 3, the likelihood of the consultee implementing the suggestions is very low unless coaching, performance feedback, and even test-driving intervention options accompany the imparted knowledge.

A lack of skill is diagnosed when the consultee has the requisite knowledge but doesn’t seem to know how to apply it successfully. The best way to diagnose this condition is to watch the consultee apply his knowledge to solve a particular problem. The consultant may observe that the consultee knows what to do but not how to do it. An example might be the use of contingency contracts. The consultee has written a good contract but does not enforce it consistently or tries to demand more than the contract calls for before delivering the specified reinforcer.

The third lack is confidence. Some teachers and parents simply lack confidence to try things they know how to do or could easily learn. They may have tried specific tactics in the past and believed they were not successful, or they may be currently dealing with what appears to be a more difficult or threatening situation and are fearful of trying something and possibly failing. Consider a successful teacher who takes on a new challenge of teaching a class for emotionally disturbed students. The behaviors of these students frighten the teacher. During the first few weeks, the teacher seems reluctant to implement the behavior management techniques that have always worked in the past and were part of the reason he was nominated for this position. He would benefit from having someone observe the interactions in the class and assist him in gaining more confidence in his ability to redirect these students. Gutkin (2012) wrote that a major problem with the medical model is its potential to “disempower the most important and accessible caregivers in the lives of children and
adolescents, namely, parents and teachers” (p. 5). If the consultant is the expert in the psychosocial causes of a student’s failure, then the consultees may feel they lack the efficacy to assist their child or student, and low self-efficacy leads to ineffective and less persistent problem-solving.

According to Caplan and Caplan (1993), the fourth lack, objectivity, is the most common “in a well-organized institution or agency” (p. 107). If consultees have the knowledge, skill, and confidence it takes to deal with their work-related problems but are still having difficulty, they may be letting subjective perceptions and judgments impair their ability to deal with issues involving students who present with difficult problems. Specifically, a consultant may be unable to perceive the student’s difficulties objectively due to (a) direct personal involvement, (b) simple identification, (c) transference, (d) character distortion, and/or (e) theme interference (Erchul & Martens, 2010).

A theme interference occurs when a previously unresolved problem affects the consultee’s expectations for solving the current problem. In general, these psychodynamic concepts explain a consultee’s ineffectiveness with his student in terms of some conscious or unconscious misrepresentation of the student. The consultant’s role in these situations is to help the teacher (or parent or administrator) to see the case in more objective terms, to reassess the behaviors of concern, and to point out that the student does not represent some class of people or perhaps some type of disability that shares common potential difficulties for the consultee.

**ACTIVITY 2.8**

A teacher consultee tells you that he expects the student to be loud and sarcastic because he has seen many children from similar home backgrounds “and they all act like that.” How would you, as a consultant, help this consultee understand that this line of reasoning may lead to a self-fulfilling prophecy? How might you help the consultee to be more objective in dealing with the student?

**ACTIVITY 2.9**

Select one of the Caplans’ four lacks. Discuss the way in which that lack may manifests itself among a group of teacher consultees. Do the lacks interact, or are they independent of each other?

It is interesting to note that the Caplans refer to objectivity as a possible lack on the part of consultees. Although the Caplans don’t discuss the lack of objectivity within the consultant in depth, it certainly may be a lack on the part of a school consultant in objectivity or any of the other three lacks. All consultants need to look continually at their own behavior and question themselves about the possibility that the plans they suggest might be the result of their own lack of objectivity in understanding either the consultee, the student, or both. There is no doubt that each of us has personal biases, beliefs that may not be appropriate, specific ideas that we like even though they may not be the most appropriate for any given situation, and so on. Sometimes we learn about this from our consultees, who question our ideas based on the objective facts. Self-reflection can guard against this possibility, as can reviewing your work with other competent practitioners in the schools.

**ACTIVITY 2.10**

List some common themes among school-based consultants that may interfere with their abilities to deal objectively and compassionately with students or consultees.
CURRENT APPROACHES TO THE MENTAL HEALTH MODEL

Caplan, Caplan, and Erchul (1995) presented their views on the importance of the shift to a collaborative model for school consultants who want to use a mental health approach. The Caplans wrote that the term consultant should refer to an outside expert who has psychological distance from the consultee and the situation. However, schools have embraced the idea that internal staff (counselors, special education teachers, school psychologists, curriculum specialists, mentor teachers, etc.) should engage in consultation. Mental health consultation has thus evolved to be more collaborative and less psychodynamically oriented than originally conceptualized by the Caplans (Knotek et al., 2009).

SUMMARY OF THE MENTAL HEALTH TRADITION

The mental health model espoused by the Caplans, along with its consultee-centered consultation (CCC) offshoot, is less commonly used in the schools than the behavioral model. The mental health model is important because it emphasizes aspects of interpersonal and intrapersonal relationship factors that are not regarded as important in the behavioral model.

FUNCTIONAL CONSULTATION MODELS

The process of consultation in the schools is continually evolving. However, most models applied in school settings have a strong base in the behavioral consultation tradition. Problem solving is present in most models of school consultation. The mental health emphasis on increasing the capacity of the consultee is also present in most contemporary models. All the models recognize the importance of collaboration, interpersonal skills, and knowledge of assessment and interventions. Thus, many of the models have a lot in common and can be distinguished by the particular component of consultation partnership or process that is emphasized.

Conjoint Behavioral Consultation

Recognition of the central role of family-centered contingencies in the lives of children has prompted behaviorists, such as Kramer (1990) and Sheridan and Kratochwill (1992), to expand their ideas about behavioral applications to working with families. Referred to as conjoint behavioral consultation (CBC), it is defined as “an indirect service-delivery model that builds on positive parent-teacher relationships, integrates structured data-based problem solving and collaboration, and implements evidence-based interventions across home and school settings” (Sheridan et al., 2012, p. 24). In this system, both parents and teachers serve as consultees to prioritize simultaneously and jointly the need, identify resources in the child’s environment, develop and implement the most acceptable interventions, and determine the success of the intervention (Ysseldyke, Lekwa, Klingbeil, & Cormier, 2012). Ideally the increased complexity of the consultant’s data-gathering and communication efforts across two contexts is offset by synergism that emerges from parents and teachers working together to solve problems. Sheridan, Clarke, and Burt (2009) described CBC as progressing through three phases: (a) needs identification/needs analysis (building on strengths), (b) plan development and implementation, and (c) plan evaluation (checking and reconnecting). These phases closely parallel the four stages of problem-solving/behavioral consultation.

In a study of 52 students with disabilities, Sheridan, Clarke, and Burt (2009) found CBC to lead to sizable changes in behavior, based on repeated direct observations, with an average effect size of 1.08 for home-based interventions and 1.11 for school-based interventions. According to Cohen (1988), effect sizes over .80 are consider large. In addition, indirect measures of CBC effectiveness found parents and teachers to rate the consultation as highly acceptable, and 100% of the parents and 94% of the teachers indicated that the student had met or partially met his or her intervention goal. In another study, Garbacz and colleagues (2008) found a partnership-centered approach to CBC to be associated with teachers’ acceptability and satisfaction with the process. Their definition of a partnership orientation included a focus on strengths; on promoting skill development and teaming; on effective communication; and on presenting as an encouraging, sensitive, and responsive partner. While the extent to which different consultants employed partnership-promoting strategies was not found to be associated
with parents’ acceptability and satisfaction with the CBC, the authors conclude that CBC as a whole is an effective process for engaging families.

More recent research found that the quality of the family–school partnership mediates the effectiveness of CBC. In the only large-scale, randomized trial of the efficacy of CBC published to date (Sheridan et al., 2012), teachers in the CBC group reported significantly more positive relationships with parents compared to teachers in the control group (i.e., business as usual; Sheridan et al., 2012). Students in the CBC group demonstrated greater improvements in social skills, as reported by both parents and teachers, and more improved adaptive skills, as rated by their teachers, compared to students in the control group. Students in both groups were selected to participate in the study based on teacher referral for disruptive classroom behaviors. Over the course of an 8-week intervention, the teacher, the consultant, and the parents of two to three students met for four or five CBC sessions. Across the 113 students in the CBC group, the consultants made an average of one home visit to help the parents integrate the intervention into their daily routines. Clearly, this study illustrates that CBC is not simply inviting parents to a meeting. Rather, CBC involves multiple meetings with an emphasis on relationship building and supporting not only teachers in their classrooms but parents in their homes as well. The authors conclude that “CBC proactively structures continuity through the establishment of relationships and partnerships between home and school, exemplified through practices promoting shared ownership, mutual goals setting, joint planning and cooperative plan implementation” (Sheridan et al., 2012, p. 40).

**Instructional Consultation**

Rosenfield, Silva, and Gravois (2009) describe instructional consultation (IC) as having a dual focus: on both content and process. The content imparted includes assessment methods that can guide instruction, evidence-based academic and behavioral interventions, fidelity assessments, and decision-making rules. The important processes include the problem-solving steps, developing a consultee-centered working relationship, and an emphasis on collaboration. Like the other models, the intent of IC is to improve students’ performance by improving the capacity of their teachers. The distinguishing feature of IC is a focus on improving student outcomes in order to reduce inappropriate referrals or eligibility for special education (Rosenfield et al., 2009). The heavy emphasis on effective instruction assumes that many students, particularly those who are designated as learning disabled, are actually curricular or instructional casualties rather than disabled. IC consultants are trained to identify and support a variety of instructional interventions that seek to improve the match between the developing capabilities of the student and curricular demands in order to improve student academic engaged time, a major contributor to academic success. IC manuals such as the *Instructional Consultation Teams Training Manual* (Gravois, Rosenfield, & Vail, 2002, as cited in Rosenfield et al., 2009) promote the portability of this set of practices. The Level of Implementation Scale–Revised (LOI-R) can be used to assess how well school personnel implement IC, including the collaborative consultation process and the tiered service delivery system, in order to direct further professional development (Rosenfield et al., 2009).

IC is often described as being delivered by a schoolwide team (see the description of student support teams later in this chapter), but it also involves consultation within a dyadic relationship because a case manager is assigned to consult with the consultee prior to and after the IC team meeting (McKenna, Rosenfield, & Gravois, 2009). The IC stages, as described by Rosenfield, Silva, and Gravois (2009), are:

- **Contracting**—discussion of the collaborative consultation relationship, problem-solving process, and teacher’s expectations in order to ensure that the teacher is committed to this type of problem solving.
- **Problem identification and analysis**—prioritize a target behavior; develop an operational definition of the behavioral concern; collect baseline data on the behavior; and set short-term, interim, and long-term performance goals.
- **Intervention design**—a detailed, evidence-based intervention plan is developed, including who will conduct which parts of the plan and how and when the effectiveness of the intervention will be monitored.
• *Intervention implantation and evaluation*—ongoing progress-monitoring data are collected and graphed, and changes to the intervention are made if a lack of growth over baseline is apparent.

• *Closure*—plans for maintaining the student’s improved progress are discussed, and the case is summarized in writing and formally concluded.

Program evaluation studies indicate that IC is effective in reducing inappropriate referrals to special education, including curbing the disproportional placement of culturally and linguistically diverse students into special education, and results in a large proportion of students meeting their intervention goals (Rosenfield et al., 2009). Rosenfield and colleagues also report that teachers are overwhelmingly satisfied with the process, which is a very positive outcome given that many students who were referred to the IC team did not end up in special education (which is often the teacher’s desired result behind the initial referral).

**Ecobehavioral Consultation**

As the name implies, this consultation model combines ecological systems theory with behaviorism. Urie Bronfenbrenner (1979) proposed understanding development, including ways to influence a developing child, by examining her changing environment. In this model, development is viewed as a series of mutual accommodations or transactions between the child and her environment, including settings that are far removed from the actual child, such as federal legislation on special education services or a district-level policy on retention standards. A student’s difficulty is conceptualized in terms of a mismatch between the developing capabilities of the child and the demands of the system in which the problem occurs (e.g., Spanish class; Ysseldyke et al., 2012). Sources of support for addressing the problem may be found in other contexts in which the child is engaged (e.g., algebra class, home, church, soccer team). Ecological systems theory also stresses focusing on conditions that can be modified (number of books in the home, number of minutes spent reading with parents) rather than a child’s social address (nationality, ethnicity, class, neighborhood), which is generally immutable (Bronfenbrenner, 1989). Ecobehavioral consultants often attempt to intervene in multiple contexts, including the internal functioning of the child (Bonner, 2005). Unlike behaviorism’s narrow focus on observable behaviors, ecobehaviorism does consider the child’s cognition, motivation, prior learning, and attributions in identifying ways to help (Bonner, 2005). Ecological models of consultation are also more focused on systemwide prevention efforts compared to strictly behavioral or mental health traditions. Waiting to intervene once a problem has become serious or entrenched is ineffective and inefficient, as evident by the large number of students with mental health and educational problems and the relatively low success rate of special education, counseling, and psychotherapy (Gutkin, 2012).

**Consultee-Centered Consultation**

Consultee-centered consultation (CCC), a current mental health model, is more similar to the behavioral tradition because it embraces a problem-solving process and addresses a wider range of problems beyond mental illness (i.e., academic concerns, behavioral excesses, professional development; Knotek et al., 2009) and uses more behavioral techniques (modeling, coaching, and performance feedback in addition to psychodynamic techniques; Erchul & Martens, 2010). The key components of the CCC model are shared decision making and an emphasis on mutuality in all stages of the process. CCC emphasizes the consultant–consultee relationship as the primary vehicle by which problem solving occurs. Problem solving in CCC is less prescriptive than in behavioral models because the consultant and consultee together modify the conceptualization of the problem throughout the process (Newman, Ingraham, & Shriberg, 2014). The goal is to reconceptualize the problem (referral) in a new way so the consultee’s skills are expanded and the professional relationship between the consultee and the client is improved (Newman et al., 2014). Some ways to reconceptualize a problem are (a) brainstorm other possible explanations for the behavior; (b) refocus on what the client can do rather than the child’s deficits; (c) selectively, skillfully, and gently challenging a consultee
when needed; and (d) acknowledge the consultee’s strengths and knowledge through onedownmanship (Newman et al., 2014). A consultant employs onedownmanship by appearing less knowledgeable or experienced than he actually is, that is, by asking a naïve question that is easy for the consultee to answer or making a comment to the effect that what the consultee can do is amazing.

**ACTIVITY 2.11**

Some people can understand models better if they are pictured rather than defined with words only. Select two or more of the models or traditions described in this chapter and draw a Venn diagram in which assumptions, activities, or emphases that are shared between or among the models are listed in the overlap between the circles, and those that differ are listed in the nonoverlapping parts of the circles.

**CONSULTATION CONFIGURATIONS AND SETTINGS**

School consultants work with individual consultees (in a formal meeting or quick conversation in the hallway or lunchroom) and with teams of other consultants and consultees, including conjoint consultation with parents and teachers, student study teams, individualized education program teams, and transition teams. Many chapters in this book present information about individual consultee work, in which the consultant accepts a referral from the consultee, meets individually with him, and together they work out a plan for understanding and dealing with the referral. Although there are variations in this scenario (such as two consultants or consultees, more than one client, and teaming), generally this one-on-one model remains the most common form of school consultation. It is popular and practical mainly because it involves the least number of individuals. Excessive reliance on team-based meetings is often regarded as impractical and/or frustrating in schools because of the conflicting demands and time limits on team members. In addition, large teams (exceeding six or more individuals) may be associated with diminishing returns. It is widely recognized, however, that individual consultation by itself has serious limitations. The IC model combines individual and team consultation by having the IC team dispatch an IC team member to consult with the referring teacher (McKenna, Rosenfield, & Gravois, 2009).

Under a tiered service delivery model, such as multi-tiered system of support (MTSS), consultation may progress from the one-on-one microlevel to a team approach in order to bring more resources to designing a targeted or intensive intervention. Some potential benefits of the team approach include a wider diversity of ideas about how to solve the problem (Cramer, 1998; DeBoer, 1995), more possibilities for change within a context of ownership and empowerment (Basham, Appleton, & Dykeman, 2000; Maeroff, 1993; Sarason, 1990), and ideas generated in a team spread throughout the team and often beyond in a ripple effect that has a potential impact on the larger environment of the school or district (Thomas, Correa, & Morsink, 1995). Whether consulting occurs in a dyad or team, school personnel meet routinely to discuss and problem-solve on behalf of students. Some of the most common consultation configurations are described next. Chapter 10 is devoted to issues of system-level improvement through consultation with teams of constituents at the local school or district level.

**Beginning Teacher Support Consultation**

Almost a quarter of public school teachers leave their schools within the first five years of teaching, and among high-poverty, low-performing schools, up to one-third to one-half of teachers leave within their first five years (Shernoff, Mariñez-Lora, Frazier, Jakobsons, Atkins, & Bonner, 2011). The high turnover makes schoolwide improvement difficult. To improve new teachers’ effectiveness and curb high rates of attrition among novice teachers, some states and districts have implemented support programs. For example, the state of California has funded the Beginning Teacher Support and Assessment (BTSA) program since 1992. The three major
components of this program are collegial reflection with a veteran teacher, professional development in the form of in-services offered by the district, and formative assessment of the new teacher’s teaching practices (Lovo, Cavazos, & Simmons, 2006).

Formal programs to induct new teachers into the teaching profession are believed to offer many benefits, including retention of new and veteran teachers, improved teaching effectiveness among beginning teachers, and improved job satisfaction and leadership skills among veteran teachers (Jofitus & Maddox-Dolan, 2002). Whether as part of a formal induction program or an informal mentoring relationship, experienced teachers or related support staff members can assist new teachers by modeling effective teaching practices, observing and providing feedback on the new teacher’s practices, sharing or jointly developing lesson plans, collecting and discussing student data, and generally boosting the new teacher’s confidence. In this type of collaboration, the “client” is the class or classes taught by the new teacher. As the consultant in this situation, you might ask the beginning teacher to identify three students—one performing above average, one performing at an average level, and one performing below average—to discuss each time you meet. This will give you an opportunity to talk about ways to differentiate instruction.

Shernoff and colleagues (2011) combined peer-nominated mentors, coaches, and professional learning communities (PLCs) to support beginning urban teachers. The coach and mentor intentionally targeted the three strongest predictors of teacher attrition: (1) poor classroom management skills, (2) failure to engage students, and (3) feelings of isolation. The coaches were selected based on their teaching experience. The mentors were selected by their peers because they were seen as influential and socially connected. The mentor was vital to helping the beginning teacher establish social relationships that are the foundation of teacher retention. The coaches, mentors, and PLCs helped the beginning teachers realize that there are multiple pathways to teaching effectiveness. Any beginning teacher support program should be adapted to the individual teacher’s context and not be overly burdensome. For example, the beginning teachers in Shernoff’s program found it difficult to complete fidelity checklists after each weekly coaching contact. However, they were able to complete fidelity checks once a month.

**Professional Learning Communities**

Professional learning communities (PLCs) are groups of educators who meet routinely to identify and scale up instructional practices that are deemed effective based on student data, observation, and reflection. PLCs may employ a variety of structures and processes. For example, a PLC may be formed based on sharing the same grade-level or content area. PLCs may be developed to support beginning teachers or teachers whose students perform below expectations on the state test or universal screeners. A PLC could be a group of like-minded educators who want to improve their teaching. PLC participants can include general and special education teachers as well as support staff and administrators. A defining feature of a PLC is engagement in a continuous improvement cycle. Thus, participants examine student data to identify groups of students or specific learning outcomes to target for improvement.

Kevin Feldman (2013) wrote that “to significantly improve teacher instruction, the PLC process must move beyond simply talking about various forms of student data, brainstorming possible teaching strategies and the like to concretely demonstrating/observing/modeling the actual teaching that is producing the data being discussed.” Accordingly, PLCs may use video-recorded or live observations of its members engaged in teaching. Feldman (2011) describes the Learning Walk, in which the PLC team uses a structured observation form to note effective teacher practices and strategies in need of improvement, debriefs immediately after the observation with the teacher, and then engages in a longer reflection at the end of the day. The Learning Walk discussions begin with affirmations and validations of the teacher’s practices followed by nonjudgmental questions (e.g., I wonder what would have happen if...?) and concludes with a few goals for the teacher to work toward. A facilitator can maintain a clear focus on students’ observable responses to instruction while (ideally) conveying sensitivity and trustworthiness. Understandably, a teacher may be reluctant to put himself before the scrutiny of his peers. However, building a culture of trust and continuous improvement, in which all staff members engage in shared inquiry and problem solving for the benefit of the students,
facilitates implementation of Learning Walks. One way to foster teachers’ willingness to participate in Learning Walks may be to begin with modeling lessons or discussing students’ work in the PLC. By delivering, not just describing, a lesson to her peers, a teacher may find the feedback helpful and nonthreatening (Feldman, 2013).

Collaborating with Paraprofessionals

The No Child Left Behind Act defines a paraprofessional as a school setting employee “under the supervision of a certified or licensed teacher” in a variety of learning environments. This vague designation encompasses well over 1 million individuals who take on a variety of classroom responsibilities, including instructional support, clerical assistance, student supervision, tutoring, managing classroom materials, and providing accommodations to students with disabilities in general education classrooms (Ashbaker & Morgan, 2013). Names for these professionals can vary from place to place, such as teacher aide, instructional assistant, or teaching assistant, but the responsibilities are analogous. Ashbaker and Morgan note that, while teachers and paraprofessionals collaborate in the education of students, teachers have more training and responsibilities, including the responsibility to supervise the paraprofessional. In some instances, role confusion occurs and the paraprofessional undertakes the teacher’s responsibilities to communicate with parents and plan instruction. This is most likely to occur when paraprofessionals are assigned to assist one student (i.e., one-on-one; Giangreco, Suter, & Doyle, 2010). Clear communication between teachers and their assigned paraprofessional enhances the efficiency of their collaborations, as well as their satisfaction with the working arrangement. The job duties for paraprofessionals vary; thus, it is important for the teacher to set the tone for the working relationship by clearly communicating expectations, and the paraprofessional should seek out mentoring and training opportunities in the absence of clear supervision.

Paraprofessionals, like all other staff members at a school, are a valuable resource. They can be an integral part of an MTSS by assisting with universal screening, circulating praise or tokens to students who are on-task during whole-group and independent seatwork, and providing targeted instruction in small group. Paraprofessionals are often underutilized or used inappropriately due to lack of training, high turnover, educators who undervalue their potential contributions, and educators who do not know how to supervise paraprofessionals effectively (Giangreco et al., 2010). For example, a paraprofessional might be relegated to exclusively making copies and posting artwork on the bulletin board. Some of the following strategies can be used to support paraprofessionals and reduce turnover:

1. Acknowledge their contributions.
2. Ask them about their ideas for improving the classroom or a student’s performance, and really listen to them.
3. Provide written plans for their daily or weekly activities.
4. Set aside some uninterrupted time to consult about the plans and how things are going.
5. Provide ongoing professional training.
6. Entrust them with important activities (small-group or one-on-one instruction) once sufficient training has been provided.
7. Discuss their career goals with them; many paraprofessionals have the potential to become wonderful teachers, school psychologists, or counselors if the career path could be made more tangible.
8. Advocate for them to get livable wages and benefits.

Coteaching for Inclusion

For many years, the special education resource specialist in the public schools was expected to set up a classroom designed to provide special education services on a pull-out basis. Students would leave their general education classrooms for part of their school day to be given special assistance in these resource rooms. Over the past 20 years or so, this model has changed from an emphasis on pull-out to one that emphasizes inclusion and push-in, in which the resource specialist teacher provides specialized assistance to students and consults with general education teachers about modifications and accommodations for students with disabilities, as well as
others, and even coteaches the class. Similarly, special education students, who would traditionally be educated in a self-contained classroom of all special education students, are being included more and more often in general education, often with the support of their special education teacher. Coteaching, which occurs most frequently between special and general educators, is an excellent opportunity to provide teachers with a colleague with whom to reflect and problem-solve.

Coteaching can take many different forms. The most common is called the one teach, one assist model in which the general education teacher provides whole-group instruction while the special education teacher circulates through the room redirecting students’ attention and offering assistance (Solis, Vaughn, Swanson, & McCulley, 2012). A limitation of this model is that the special education teacher is relegated to the position of an aide, which doesn’t take full advantage of his skills and expertise. Other, more equitable models include forming two homogeneous or heterogeneous groups to be taught by each teacher, setting up centers, and coteaching a whole class. Researchers have consistently found students with and without disabilities to benefit socially from inclusion supported by coteaching (Scruggs, Mastropieri, & McDuffie, 2007; Solis et al., 2012). However, the impact on student achievement is less certain. Coteaching models that emphasize explicit instruction, formative assessment, and individualized instruction on basic skills appear to produce the best results (Solis et al., 2012).

Effective and accepted coteaching requires considerable collaboration. Prior to engaging in coteaching, the teachers should discuss their expectations, roles, goals, and demands of the setting (Solis et al., 2012). As illustrated in the video at https://www.youtube.com/watch?v=_pnxst7dkLk, the relationship between the two teachers is paramount to the success of the coteaching experience. As the teachers in the video suggest, coteaching requires ongoing negotiating and planning. One of the most common complaints about coteaching is not having enough time to plan (Solis et al., 2012). School consultants can help coteachers find the time to plan by taking over their class for an hour a week. School consultants can facilitate the planning and negotiating by offering structure to the discussion (i.e., problem-solving process), emphasizing interpersonal skills that promote coteaching (e.g., active listening, acceptance, assertiveness, willingness to take feedback), and helping to gather needed resources.

Meyers, Gelzheiser, and Yelich (1991) compared the quality and quantity of consultation between resource specialists and general education teachers in pull-out and inclusion programs. They found consultation in the inclusion program to occur more frequently and to be more focused on instructional issues such as lesson planning, and they found the pull-out consultation to focus more on individual student progress and need. The general education teachers in the inclusion program learned more instructional strategies from the consultation than those in the traditional pull-out program.

**Individualized Education Program Team**

A student’s special and general education teachers are required to meet with the student’s parents and related support staff members at least once per year to discuss the student’s progress and set goals for the upcoming year. Individualized education program (IEP) teams must determine the level of support the student will require to meet these goals, including specific instructional, curricular, and/or testing accommodations (Bolt & Roach, 2009). For a good overview of IEPs, see the short video at https://www.youtube.com/watch?v=QMctXPmG7bc&list=PLnLrBBRIDLZyxy7QeNvdXG1uAdCeWRtv.

Typically the case manager for the student, often a special education teacher, acts as the consultant by arranging and facilitating the IEP meeting. The overall goal of the IEP team is to ensure that the student with a disability is provided a free and appropriate public education (FAPE) in the least restricted environment (LRE). Clearly, these are rather broad terms, and team members may not always agree that the IEP meets these federal mandates. Contention can arise about whether a student qualifies for special education, whether a student is receiving sufficient services and supports, and the extent to which the student participates in general education programs. To qualify, a student must (a) meet one of 13 disability categories and (b) need special education services to access general education curriculum and instruction, and (c) the
identified disability cannot be due cultural or language differences, poor instruction, or excessive absences (i.e., these are exclusionary categories). The emphasis on need is due to a common misunderstanding that if a child meets the definition of a disability, such as demonstrating a cognitive/achievement discrepancy or having a medical diagnosis of ADHD, the child automatically qualifies for special education. If there is evidence that a student is relatively successful in the general education curriculum, such as average or above average grades, state test scores, and so on, the school does not need to assess for special education. The consultant should be sure to examine multiple indicators of the student’s functioning, including interviewing the person who made the referral to special education, before determining whether testing is necessary. Parents and teachers may make inappropriate referrals for special education services because they are unaware of other sources of support or they have an exaggerated view of the student’s problems. The consultant should always respond to a referral from a collaborative problem-solving approach.

IEP teams also require considerable consultation skills because many different people from different disciplines may be involved. Depending on the student’s needs, speech and language therapists, occupational therapists, physical therapists, nurses, administrators, vocational rehabilitation workers, counselors, school psychologists, assistive technology experts, and/or transition specialists, in addition to the student, his family, and his teachers, can be involved. Scheduling is one of the challenges to collaborating with so many different specialists to provide the best program. The case manager should balance the needs for these services with the disruption they may have on the student’s schedule. The case manager should also consider if the skills and knowledge of some of the specialists are being underutilized. The IRIS Center at Vanderbilt University has prepared some online modules on working with nurses, assistive technology specialists, and counselors to provide quality programming to students with disabilities. Consultants should stay focused on developing an IEP that enhances the educational outcomes of the student and meets all legal due process mandates.

At least once every three years, the students’ special education program must be reexamined to determine whether the program is working and to plan for the future. Whether the student continues to qualify for special education is a focus of the triennial only in the event that members of the team suspect that the student either no longer needs the services or additional services are required to sustain progress (National Association of School Psychologists, 2004). However, it is common, though unnecessary, to administer a battery of tests to reestablish the existence of a disability for special education qualification. Data from multiple sources, gathered through a variety of methods, should be considered in these triennial evaluations.

**TRANSITION PLANNING TEAMS**

Since 1990, the Individuals with Disabilities Education Act (IDEA) has required IEP teams to engage in transition planning for students with disabilities over the age of 15 to prepare them for adulthood. Thus, the IEP team not only discusses what programs, services, and accommodations a student needs for the next year, they also discuss how these services should be implemented in order to meet the students’ future goals. Transition planning should occur in the following areas, if needed: postsecondary education, vocational training, integrated employment, housing, community participation, and recreation/leisure. Transition planning is complex, not just because of the multitude of contexts and developmental changes to be consider but because of the variety of professionals involved. Transition planning requires sharing information, joint planning within and across agencies, and respecting each person’s roles (Michaels & Lopez, 2005). Collaborative consultation skills, such as active listening, outcomes-oriented discussions, valuing other’s perspectives, effective communication, and follow-through, are essential to effective transition planning. Michaels and Ferrera (2005) suggest employing person-centered planning (PCP), which promotes student and family involvement and self-determination, to have more collaboration in transition planning. PCPs and family-centered planning are described in more detail in Chapter 10.
Student Study Teams

The student study team (SST) is essentially a general education (Tier 2) procedure to assist students in solving academic and behavior problems that arise even with good instruction and classroom management (Burns, Wiley, & Viglietta, 2008; Safran & Safran, 1996). Within an MTSS, an SST would be held after universal interventions have been attempted and failed.

ACTIVITY 2.12
Consultation can be very formal (e.g., IEP that involves legal counsel) or informal (e.g., a quick hallway discussion with a colleague) between passing periods. Discuss some of the pros and cons to both formal and informal consultation.

SST MEMBERS

The members of an SST are usually consists the referring teacher; general and special education teachers; administrators; support service providers (school counselor, school psychologists, nurse, etc.); the parents; and, in some cases, the student. Because of a long-standing tendency to view the SST meeting as a procedural necessity to qualify a student for special education services, it may be wise to limit special education staff involvement until the purpose of the team is clearly established as being to develop interventions, not to begin the special education eligibility process (Powers, 2001). Given the large caseloads of many support service providers, it is suggested that specialists attend only when the referral relates to their particular area of expertise. Thus, the nurse would attend SSTs only when there is a health concern, and the speech pathologist would assist when a language or articulation problem appears evident. Of course, any of the support service providers should attend and perhaps even facilitate the SST if they have expertise in problem-solving consultation. For secondary students with multiple teachers, it is not always necessary to have all six or eight teachers attend. Rather, it might be more efficient to gather information from all the teachers in the form of a progress report and then invite the teachers who have the most and least success with the student to the meeting. This way, the teachers who have experienced some success can share strategies with the teacher(s) who is(are) struggling to meet the student’s needs. Parental participation in the SST is essential. Parents can provide information that no one else can provide about the student. They can also be part of the interventions. To increase parental participation, the school consultant can contact the parents by phone or e-mail to prepare them for the meeting by explaining the purpose of the meeting and what it will look like. One school prepared a video and posted it on video for parents to watch (see https://www.youtube.com/watch?v=Z5tjAFtQreQ). We found that having the teacher, rather than the consultant, make the initial contact by inviting the parents to the SST was associated with improved parental attendance at the SST (Powers, 2001).

The makeup of an SST varies considerably across districts, as do the power relationships of members. Designated school consultants need to study the dynamics of these teams (as well as IEP teams) to be as effective as possible. The SST member roles include a facilitator or leader (who may or may not be a school administrator), a recorder (someone assigned to keep notes on the procedures), the referring teacher(s), and a timekeeper. A survey of SST members across Ohio found that school psychologists (24%) led the team most often, followed by the principal (18%) and a rotating chair (14%; McNamara, Rashee, & Delamatre, 2008).

PURPOSE OF THE STUDENT STUDY TEAM

SSTs are defined differently throughout the country. There is no one format or approach that defines the activities of these teams. Indeed, they can have different approaches and styles in different schools within a district. What they do share is a common philosophy and common purposes: to work together to solve learning and behavior/adjustment problems of students, and to try to solve these problems within the context of general education. SSTs have general education functions and are intended primarily to be sources of assistance for general education teachers. The SSTs should have at least the following goals:
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1. Help students at risk for school failure and their teachers by providing alternatives in terms of teaching and behavior management strategies.

2. Curb learning and behavioral problems and unnecessary placement in special education.

3. Operationalize and prioritize the target behavior, including measuring baseline (preintervention levels), and set a goal for short-term (6 to 8 weeks) improvement.

4. Redirect resources through teamwork and brainstorming to apply evidence-based interventions and to monitor progress toward the goal.

5. From an administrative standpoint, provide a method for tracking cases, coordinating services, collecting treatment fidelity, and meeting again to determine the outcome.

To meet these goals, the SST usually meets on a weekly basis for about 25 minutes (longer if translation to a second language is needed). Students referred to SST, either prior to or following referral to a school-based consultant, are considered to have achievement or social-personal-behavioral issues that are serious enough to prompt the teacher to seek assistance from others. The purpose of the SST is to review the teacher’s or parent’s concerns about a student, to study the classroom or wider school issues associated with the student’s difficulties, and to recommend specific interventions designed to ameliorate the difficulties. Ideally, the SST will follow the problem-solving consultation steps detailed in Chapter 3. Only after a serious effort is made to deal with the problems at the general education classroom level, including robust, targeted, and monitored interventions, should the SST consider a referral for assessment for possible special education consideration. Within an MTSS service delivery model, students are referred to the SST only after universal interventions, including high-quality and differentiated instruction, have failed to produce the desired results.

School consultants need to be aware of the dynamics of multidisciplinary teams in the schools. Most teams take their job seriously and try to develop interventions that are appropriate for the general education setting. Sometimes team members have agendas that, for various reasons, may not be in the best interest of the referred student. Part of the consultant’s job is to keep the meeting focused on the relevant facts and the available data by following the problem-solving consultation process. Kovaleski, Gickling, Morrow, and Swank (1999) found SSTs that failed to implement the problem-solving practices fully were no more successful at increasing students’ academic learning time than schools that had no such team in place; conversely, teams that fully engaged in the instructional-consultation-team model produced significantly greater effects in terms of student academic learning time. In some schools, there may be a feeling that if the teacher has referred a student, that is reason enough to go immediately to the assessment for special education phase. If this happens, the case takes on a whole new perspective: Does the student have a disability that meets federal and state criteria? Unfortunately, this new emphasis may detract from the efforts of educators to continue to assist the student in general education. Because students who are assessed for special education and related services are usually found to be eligible for such services (Ysseldyke, Vanderwood, & Shriner, 1997), some teachers may assume that a student will soon be receiving special education services once a referral for assessment is made and may discontinue general education interventions for that student.

Despite the best intentions, a plan developed by the SST will fail on occasion. The SST needs to determine whether to revise and retry an intervention package or to refer the student for a special education assessment. The SST will need to consider whether the interventions were sufficiently robust and intense to suggest general education alone cannot meet the student’s needs. In the case of academic deficits, these modifications should include providing supplemental instruction that is more targeted (focused on a narrow set of specific skills) and explicit (teacher-centered), and in a smaller grouping (to allow for higher response rate and corrective feedback), than is common instructional or classroom management practices. Documentation should include the frequency and duration of this supplemental instruction as well as how well it adhered to a plan based on the student’s individualized needs and evidence-based practices (i.e., intervention integrity). The student’s response in terms of progress-monitoring data should be analyzed. These and other concepts are discussed in detail in Chapter 3. When a teacher or parent makes a referral to the SST, what he or she typically really wants is assistance so that he or she can keep the student in the general education program. In fact, a survey of 123 educators...
found that over 60% do not expect the outcome of an SST to be referral to special education (Lee-Tarver, 2006).

The essential purpose of an SST is to do group problem solving. This implies that the members of the group agree, at least to some extent, on the nature of the problem, the kinds of data that are needed to understand the problem, and how to develop appropriate interventions. Just how any SST goes about this is a function of the style of the formal or informal group leader. The formal leader is often an administrator or a designee. An informal leader may be appointed or may simply emerge based on a variety of factors. Sometimes, one of the student’s parents may emerge as the informal SST leader by virtue of her or his forceful personality. Although school personnel are always nominally in charge, a parent may be the person who most strongly influences whatever decisions are made. In any event, the group leader may find that the process bogs down for a variety of reasons, such as disagreement about the nature of the problem, what should be done about it, or the role of the regular educator in the intervention process.

Meyers, Valentino, Meyers, Boretti, and Brent (1996) found that SSTs vary considerably in their approach to group problem solving. There are no federal government requirements or guidelines for the conduct of these meetings, so each state is allowed to implement its use as it sees fit. Some states have no regulations or guidelines; hence, implementation becomes a local district or area issue, which obviously leads to diversity in processes, goals, and outcomes. Three potential areas of difference across teams are their varied perspectives about seeing problems as student deficits (focus on presumed intra-child weaknesses) or student assets (focus on student strengths), teacher skills (focus on how the teacher can bring his skills to bear on concerns about a referred student) or teacher deficits (focus on subtle or serious mistakes the teacher is making), and student needs (focus on one student at a time) or system needs (focus on how a whole school or district can change its approaches). Influential groups such as the National Association of State Directors of Special Education (2005) and the National Association of School Psychologists (2009) have explained essential components to response to intervention (RtI)/MTSS that can guide and somewhat standardize the SST process. For example, the National Association of State Directors of Special Education (NASDE) and the National Association of School Psychologists (NASP), as well as other organizations, suggest that SSTs function as problem-solving teams by (a) defining the problem, (b) analyzing the problem, (c) developing and implementing a plan, and (d) evaluating whether the plan worked. In fact, most SST models that have empirical support, including the IC teams described previously, rely to some extent on engaging in problem-solving consultation.

**SST Strategies**

Several strategies, many of which are used extensively in business, can be used in group problem solving. *Brainstorming*, or divergent thinking, allows the free development and expression of ideas in order to develop creative solutions. Some school personnel may be uncomfortable with brainstorming if it seems to be taking participants too far afield or consuming precious time. For those wishing to try brainstorming, Parsons and Meyers (1984) suggest following some explicit steps to ensure that the process does not deteriorate into chaos. First, clarify and agree on the general topic. Second, establish a time limit; they recommend 5 minutes. Third, try a warm-up activity, possibly brainstorming about an irrelevant topic or deliberately coming up with ridiculous ideas. Fourth, have the consultant act as recorder. Fifth, have participants list ideas: Censor nothing; record them all. Sixth, after the time limit has elapsed, evaluate, clarify, and elaborate on ideas. If a group seems reluctant to participate in brainstorming out loud, they may feel more comfortable writing their ideas on cards, not signing the cards, and then having all the ideas read and recorded without reference to the ideas’ originators. People who haven’t tried brainstorming are often amazed at the results and are often eager to try it again.

Exploring *alternate explanations* is the attempt to view a problem from a completely different perspective. Attempts to fix a problem often fail because the root of the problem is misunderstood. For example, it is common to conceptualize a student’s acting-out behavior as attention seeking and lack of achievement motivation, when the actual cause may be that the work is too difficult. In general, educators tend to focus more on the consequences (seeking attention)
rather than the antecedents (difficult task). So it is a productive endeavor for the members of the team to try to reconceptualize the problem in a new way.

**Intervention resources** are readily available from Web sites like Intervention Central and books such as Burns, Riley-Tillman, and VanDerHeyden’s (2012) *RTI Applications: Academic and Behavioral Interventions*. Academic and behavioral interventions are also described in Chapters 6 and 7 of this book and in the case studies in Chapter 10. There is no need to re-create the wheel when it comes to designing interventions. However, just because an intervention appears in a book or Web site does not necessarily mean has been scientifically tested. The What Works Clearinghouse is a good resource for examining whether an intervention is empirically supported. Keep in mind, however, that an intervention that is empirically supported may not work for a particular student or context. Thus, it is critically important that the intervention fidelity and the student’s response to the intervention be closely monitored. A different, empirically supported intervention should be attempted if the original intervention package was either not implemented or ineffective.

Districts and local educational agencies have developed myriad forms for SSTs to use to keep track of the referrals, proceedings, data, and plans that the SSTs discuss or develop. Figure 2.1 gives an example of one such referral form. Figure 2.2 is a form used for organizing the initial and follow-up SST meetings. It delineates the major areas to be discussed by a team, as does the agenda in Figure 2.3, which discusses problem-solving consultation.

After the team meets and discusses the areas listed in Figures 2.2 and 2.3, and action is taken, the team meets again on the date listed as the follow-up date unless some contingency suggests the need for an earlier meeting. Note that it is extremely important to reconvene to determine whether the interventions were implemented as planned and their effects. During the initial meeting, team members may make overly heroic offers of help, only to find later that they cannot follow through. If the integrity of the intervention is not assessed and documented at the follow-up meeting, someone in the future may erroneously assume the student failed to respond to a rigorous intervention that was, in fact, never implemented. At the next and subsequent meetings, the team again discusses the target student, discussing how well the interventions were implemented and comparing the student’s current performance to the baseline data. The SST then makes a data-based decision to modify, continue, or discontinue the interventions. If the intervention has failed or it required considerably more resources than could be sustained in general education, the team may elect to pursue a different, more intense intervention, such as special or alternative education.

A copy of each form containing the information gathered and decisions made should be sent to each participant and all others mentioned on the forms, and always including the student’s parents. In the interests of economy, a single copy of the forms intended for use by all involved school personnel may be kept in a confidential place within the school. School personnel will be informed of this procedure. Obviously, whoever is the recorder will need to be given time to put his notes in good order for appropriate distribution. The recorder may also consider using a laptop and projector while compiling the notes in order to allow the entire team to see the notes as the meeting progresses.
## PROBLEM-SOLVING INTERVENTION SUMMARY

<table>
<thead>
<tr>
<th>Initial Date</th>
<th>Meeting Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Student:** ____________________________  **Grade:** ____________________________

**TEAM MEMBERS:**

Student strengths:

Identify the most significant concern (be very specific):

Current level of performance (frequency, accuracy, or duration):

**INTERVENTION PLAN:**

<table>
<thead>
<tr>
<th>Start date:</th>
<th>Acceptable level of performance (long-term goal):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intervention goal:

<table>
<thead>
<tr>
<th>Who will implement plan?</th>
<th>Method to measure performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Who will consult/assess intervention fidelity?</td>
</tr>
<tr>
<td></td>
<td>Who will measure performance?</td>
</tr>
<tr>
<td></td>
<td>How often?</td>
</tr>
</tbody>
</table>

Follow-up date: _______________

**FIGURE 2.2** Problem-solving intervention summary form
### PROBLEM-SOLVING INTERVENTION SUMMARY

**Page 2**

<table>
<thead>
<tr>
<th>Student: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention goal:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention 1:</th>
<th>Person(s) who will implement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome:</td>
<td></td>
</tr>
<tr>
<td>New action:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention 2:</th>
<th>Person(s) who will implement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome:</td>
<td></td>
</tr>
<tr>
<td>New action:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention 3:</th>
<th>Person(s) who will implement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome:</td>
<td></td>
</tr>
<tr>
<td>New action:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current level of performance:</th>
<th>Intervention integrity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Goal met?** Y N

The discrepancy between student performance and the intervention goal was:

- [ ] reduced
- [ ] maintained
- [ ] increased

**Decision:**

- [ ] Discontinue, goal achieved
- [ ] Continue intervention
- [ ] Modify intervention
- [ ] Refer to special education
- [ ] Refer to other program
- [ ] Develop 504 plan

**Follow-up date:**

**FIGURE 2.2 (Continued)**
THE IMPORTANCE OF STRUCTURE

SST members have generally come to understand the need for providing a good deal of structure in these team meetings. Poorly organized meetings tend to be inefficient and unproductive; busy teachers and others resent having to attend them. Elements of structure include having a set schedule for when the team will be meeting and who will be on it, with at least a week’s notice given to expected attendees, along with the names of the students to be discussed. At least a week is needed to inform parents so that they can make arrangements if they plan to attend. In addition, the referring teacher and others who have information to contribute need time to prepare themselves and gather relevant data. Conversely, SSTs should not allow too much time to lapse between the referral and the team’s or team member’s response. If the SST’s schedule is full, a team member may be dispatched to consult with the referring teacher or parent to begin the problem-solving process and offer some relief until the meeting can be scheduled.

It is highly recommended that the referral process and scheduling be conducted in as transparent a manner as possible. In some schools, the SST coordinator acts as a gatekeeper by picking and choosing which students to bring before the SST. This approach is not recommended because it can give the SST a reputation of being arbitrary and capricious and thus breed hostility among your colleagues. Rather, an open schedule whereby anyone can sign up for an available time slot allows your colleagues to feel that they have equal access to the SST. If one teacher is referring too many students, someone from the team may want to consult with him individually to provide some core instructional support, such as improving his classroom management skills.

Consideration needs to be given to how long the team will meet and how much time will be devoted to each student. Although it is possible to spend 1 full hour on one student, this is rarely necessary. By displaying an agenda with time limits, like the one in Figure 2.3, and designating a timekeeper to move the discussion along, the SST can move through the problem-solving stages efficiently and avoid getting bogged down in the problem identification phase. Spending more than a few minutes on problem identification places the team at risk for getting stuck in admiring, rather than solving, the problem. A suggested length for the SST is between 25 and 35 minutes, or 50 to 70 minutes if the SST is being translated into a language other than English to accommodate the parents. Devoting less than 25 minutes to problem solving on behalf of a student who has failed to respond to universal interventions is unlikely to result in systematic and collaborative interventions (Powers, 2001). Conversely, holding lengthy meetings is likely to decrease the team’s future agility in responding to a failed plan because members become less willing to continue to problem-solve a case in which they have already devoted extensive time (Sprick, 1999). It may be unduly rigid to impose time limits because some students have a much more involved history and present with many more challenges than do others. Different teachers may have tried many interesting interventions before coming to SST, and these take time to be discussed. The development of plans in some cases is more involved than it is in others. All of these reasons, in addition to not wanting to rush parents who probably are not used to such a structured situation, suggest some flexibility may be beneficial. A
For October 12—Martin Luther King School
7:30—Sammy Wilson (initial meeting), Persill (teacher); Jordan (speech pathologist), and Kirsch (reading specialist); parent invited
8:00—Shawna Cutrell (follow-up number 3); Zill (teacher); House (RSP teacher); parent invited
2:30—Bill Loftus (follow-up number 1), Simpson (teacher); Alvarez (nurse); parent invited

**FIGURE 2.4** Sample SST schedule

total time limit, however, is recommended to ensure that the SST can address all the students on the schedule. An example SST schedule for one day is presented in Figure 2.4.

A survey of 113 teachers from five schools found that teachers identify two keys to an effective SST: sufficient time to meet, and adequate number and sufficiently trained SST members (Yetter & Doll, 2007). SSTs that are task-focused, have suitable decorum (i.e., members arrive on time and stay for the entire length of the meeting), and avoid disenfranchising members through noncollaborative or antagonistic interactions or lack of follow-through were viewed by educators to be more acceptable and effective (McNamara et al., 2008). The behavioral dimensions and indicators of the IC team described by McKenna, Rosenfield, and Gravois (2009) and the SST self-study guide checklists provided by Powers (2001) and Burns et al. (2008) may be helpful resources for forming or improving upon an existing SST. Additional details about SSTs appear in Chapter 3, with the description of how the SST can contribute to MTSS through problem-solving consultation.

**ACTIVITY 2.13**
Research the similarities and differences between a problem-solving SST and a prereferral to special education SST. Which one is intervention focused? Which one is within-child deficit focused? What are the advantages and disadvantages of both?

**Roles, Skills, and Activities of School-Based Consultants**

The primary role of a school-based consultant is to provide assistance to other school personnel and parents to improve a student’s learning and/or behavior. As previously indicated, this primary role requires skills in communication, interpersonal effectiveness, and problem solving. This section delineates additional roles of school-based consultants, the skills they need to be effective in these roles, and some of the numerous activities they engage in while carrying out these roles.

**ROLES**

The word *roles* refers to the perceived purposes or reasons for the existence of an activity. People are employed, generally, to engage in role-specific behavior, which is often spelled out in a job description provided to a prospective employee. Job descriptions for special education teachers, school counselors, and school psychologists often refer to consultation as an expected role. In some states, this expectation is spelled out in laws or regulations. For example, in its Education Code, the state of California defines the role of resource teachers in part as the “provision of consultation, resource information, and material regarding individuals with exceptional needs to their parents and to regular staff members” (California Education Code 30 EC 56362). It is important that consultants establish their roles with consultees so role confusion does not happen. Two possible role confusions are (a) the consultee assumes the consultant will step in an “fix the client,” possibly by removing the child from the classroom or providing some direct service like counseling or reading interventions; and (b) the consultee thinks the consultant will “fix the consultee” by acting as the consultee’s therapist. The consultant should ensure that the consultee understands her role by establishing goals, a timeline, and individual responsibilities for collaboration while maintaining professional boundaries (Jacob, Decker & Hartshorne, 2011).
Chapter 2 • Consultation Models and Professional Practices

The following are some of the services that have been found appropriate for school-based consultation:

1. **Information delivery.** The consultant gives consultees information, ideas, facts, and opinions about students’ learning and behavior/adjustment problems. For example, consultants may provide an explanation, in practical terms; peer-assisted learning to improve academic engagement; review of methods of teaching sight vocabulary to students who are not profiting from whatever methods are currently being used; or assistance to a teacher in the development of a contingency contract.

2. **Coordination/facilitation/coaching.** The consultant develops collaborative ways of facilitating planning for targeted students. An example is organizing a structured meeting of the regular education teachers to discuss a targeted student and ways to differentiate instruction. Consultants need to think of themselves as habit-change coordinators—persons who recognize that, to change the behavior of targeted students, the adults who control antecedents, contingencies, and activities need to change the way they respond to these students. This involves changing the behaviors (habits) of the adults who provide direct services (teaching, parenting) to students. One way to change the consultee’s behavior may be to provide demonstration lessons in general or special education classrooms in an effort to show, for example, how to provide accommodations and modifications for students with disabilities and other at-risk students. Instructional coaching and professional learning communities (discussed at length in Chapter 10) have been found to change teachers’ behaviors. Likewise, treatment fidelity checks add a measure of accountability that can tip a teacher toward trying something new.

3. **Indirect service provision.** The school-based consultant acts indirectly in the service of students by working directly with teachers and parents, who in turn (for the most part) are the direct service providers to the students. The chapter-opening vignettes illustrate the need for this type of service. Although some part of the program developed for a student may involve direct services on the part of the consultant (such as counseling or specific skill development, or coteaching activities), it is generally understood that the primary service providers are the general or special education teacher, the parents, specialist, or an outside agency.

4. **Assessment.** School-based consultants can conduct observations; review records; and interview the teacher, student, and parent to help define the problem. A good definition of the target behavior is key to setting goals and measuring improvement (or lack of improvement), which in turn improves intervention effectiveness. It is difficult for a teacher to observe a student systematically while teaching. The consultant can assist with collecting baseline, progress, and treatment integrity data. A consultant’s primary interaction with the student may now be through observation, usually in the consultee’s classroom or on the playground, but his or her contributions to the student’s progress can be significant.

**SKILLS/KNOWLEDGE**

To carry out the roles we have described, the school consultant needs to be skillful in a number of areas. Here is a sample of the skills crucial to the practice of school-based consultation:

1. **Communication.** Consultants spend much of their time simply talking and listening. Teachers, parents, bus drivers, administrators, and others need someone to talk to when they are unable to solve the puzzles created by students who aren’t being successful in school. Because this is such a key role for the consultant, there is an expanded discussion of communication skills in Chapter 4.

2. **Problem solving.** The consultant engages consultees in the process of problem definition, analysis, plan implementation, and plan evaluation. He interprets and breaks down barriers, encourages participation in the collaborative problem-solving process, facilitates the development of plans, and monitors implementation of these activities. An expanded look at the process of problem solving through an MTSS appears in Chapter 3.

3. **Knowledge of reliable, valid, and repeatable assessments and evidence-based interventions.** Closely related to facilitative problem solving is the expectation that the consultant will be able to assist with the actual development of an intervention plan, follow through with some
degree of implementation monitoring, and assist with ongoing evaluation of the intervention. Some of the skills used in these activities include the following:

- Prioritizing and defining the problem.
- Evaluating factors contributing to the problem.
- Interpreting data and analyzing the forces related to nonproductive student and teacher behaviors.
- Identifying relevant evidence-based interventions and reliable, valid, and repeatable assessments.
- Monitoring the implementation of these plans.
- Evaluating the success of the plans.

4. Interpersonal effectiveness. A basic question that should be asked following an initial consultation session is “If I have met once with a consultee, will he or she want to meet with me again?” A large part of the answer is determined by the degree to which the consultant manifested the skills previously listed, in addition to her interpersonal skills. Because this set of skills is so important, we have given detailed attention to it in Chapter 4. The following is a brief list:

- Convincing people that consulting with them will be productive.
- Negotiating an intervention plan through a nonhierarchical relationship.
- Reinforcing both the consultees and the client’s effort.
- Projecting a positive can-do attitude and celebrating success.

**ACTIVITY 2.14**

Discuss which of the above sets of skills are most important to the consultation process and outcome. How do you develop and continue to improve these skill sets?

**ACTIVITIES**

To describe how consultation actually appears, we provide the following sample of the major activities of consultants, many of which have been alluded to in the discussion of roles and skills:

- **Conducting interviews or facilitating discussions.** This is the primary activity of consultants, and Chapter 4 devotes considerable space to it. Group-oriented interview procedures, such as those found in SST and IEP meetings, are discussed in this chapter and in Chapter 3.

- **Observing interactions.** It is quite common for a consultant to provide a fresh perspective by observing a student or the interactions of a number of students, or classroom or playground dynamics. The observations may be informal or naturalistic, resulting in a general impression and possibly a narrative description of the ecological influences on the students’ learning. The observations may be more formal, such as counting the number of times a student produces an accurate academic response in 10 minutes. Problem-solving consultation requires some type of baseline (preintervention student functioning) by which the intervention goal and results are determined. Consultants’ observational data may be an important source of baseline data. These activities are discussed in Chapters 3 and 6 (for behavior-related issues) and Chapter 7 (for teaching-learning issues).

- **Reviewing records.** Taking time to review a student’s records to determine what others have said and done on her behalf is essential. If you review the student’s records before meeting with a consultee, he will be favorably impressed by your diligence. Further, you can begin the problem-solving process by identifying from the records, or possibly by examining some of the student’s classwork, a couple of behaviors to target for intervention.

- **Coordinating services.** Teachers are more likely to implement interventions if someone else figures out the schedule and gathers the material. Whenever there are more than two people involved in an intervention, someone must take charge of the process to see that all parties fulfill their roles. Otherwise, plans can go awry and confusion can develop. A consultant may be involved in face-to-face interactions, phone calls, faxes, e-mail, in-house memos, and so on.
**Keeping accurate records.** When a consultant meets with a teacher, a parent, or an administrator about a student, she should keep a written record of that interaction and provide a copy of it to the consultee or place it in a central location where others can see it, such as a running log of events that may be filed in the student’s school records. Consultation records document what has been discussed and planned and keep participants aware of progress toward their goals. In complex cases especially, it is important to leave a paper trail attesting to everyone’s efforts. Special education due process hearings, mediations, and court cases are sometimes won or lost on the strength of a district’s documentation of its efforts (Prasse, 2008). Forms for keeping accurate records are presented in Chapters 3 and 4.

**Coordinating or presenting in-service staff development activities.** Because this activity is so important and involves so much detail, a portion of Chapter 10 is devoted to it.

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**Summary**

Two consultation traditions that are relatively well known and well respected (behavioral and mental health) are summarized in this chapter, as are other functional models, roles, skills, and activities used by consultants. The behavioral problem-solving model is the more common of the two traditions and has a much stronger research base. We make numerous references to this model in the chapters that follow, particularly in Chapter 3, where the problem-solving steps are described within a larger multi-tiered system of support (MTSS) service delivery model. Although the problem-solving model is currently dominant, the Caplans’ ideas (contained in the mental health model), especially about consultee roles, add another dimension to the dynamics of the consultation process.

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Chapter 2 • Consultation Models and Professional Practices


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