

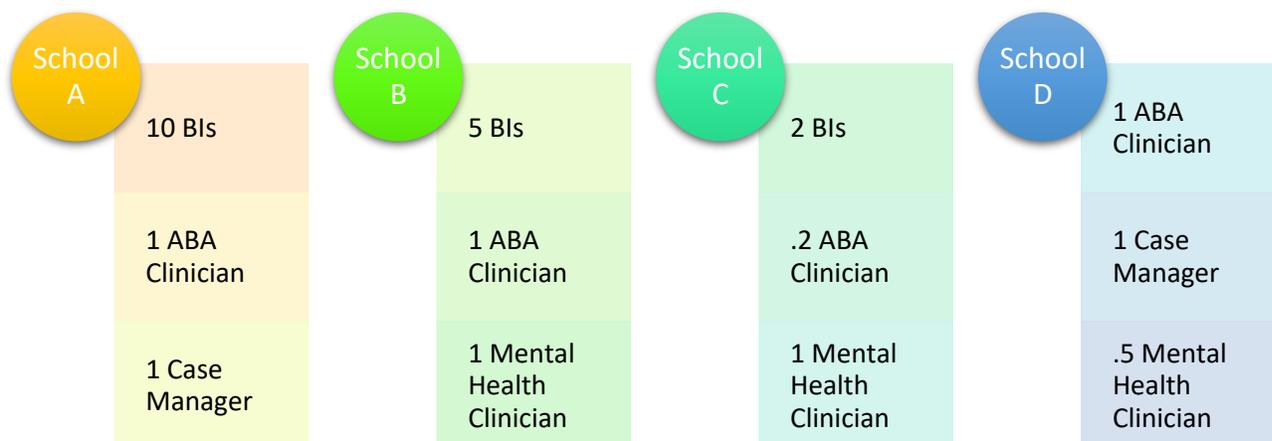
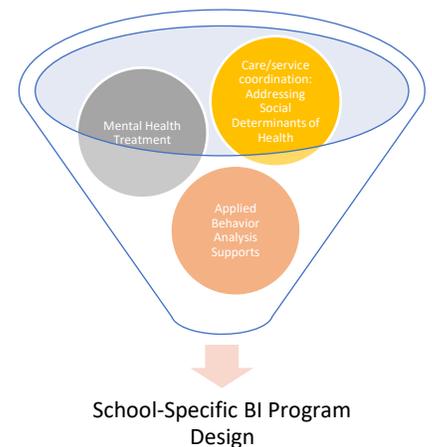
Success Beyond Six Behavior Intervention Services

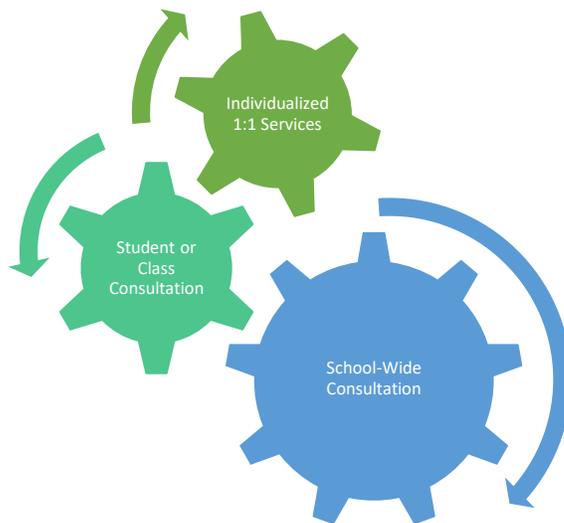
Behavior Intervention [BI] Programs in Vermont schools often seem different across regions. The programs themselves may have different names, and the provider titles may vary. The vision, the values, and practices, however, are largely consistent across the state. This document will provide a shared set of definitions that can be used for discussing these services at the statewide level.

Essential Ingredients

The clinical roles in BI programs are likely to have a behavior and mental health focus, and providers have overlapping expertise. Contracts also often include care/service coordination to support children and families in addressing social determinants of health and reducing the risk of Adverse Childhood Experiences [ACES].

Contracts often involve mixing and matching services and roles based on the specific needs of the school. Looking around the state now, there can be a wide array of contract designs:





BI programs are designed to work within a Multi-Tiered Systems and Supports [MTSS] framework.

All BI clinicians support schools with individual, class, and school-wide supports, but each role has a different focus, expertise, and cost for the position associated with it.

Because BI Program staff are trained to modulate between individual- and population-level

supports, BI Program are well-positioned to support schools in their transition to Act 173's census-based funding approach for special education.

Role Descriptions

Roles, qualifications, and supervisory structures are described here, with their service functions in the grid that follows.

1. **Behavior Interventionist [BI]:** A bachelor-level staff person¹ who provides one-to-one or small group assistance to students struggling with a disability in a classroom, community, or school setting within the context of an individualized behavior support planning process. The BI works directly with a student in his/her education program and provides support and services to help the student develop skills, reduce behavior issues and increase the student's ability to access his/her education. The BI is trained, supported

¹ From DMH BI Minimum Standards: Required education: Bachelor's Degree, or pursuing Bachelor's Degree*, preferably in human services field. May have relevant experience in exchange for human service degree. Must have good judgment, empathic, believe in inclusion, and some experience (may be less than a year) in working with children, youth and families. BIs who are pursuing but have not yet obtained a Bachelor's degree have an additional level of supervision and training requirements in order to achieve the skill set identified in the Registered Behavior Technician™ (RBT®) task list within six-months.

and clinically supervised by a clinical supervisor who is a master's-level mental health clinician or a Board-Certified Behavior Analyst.

2. **ABA Clinician:** A master's-level clinician who has an Applied Behavior Analysis [ABA] certification, is working toward their ABA certification, or has completed a six-course ABA training sequence. The role of the ABA clinician can have a student and/or a school focus.
 - a. **Student focus:** The ABA clinician designs the behavior treatment for the students in the BI program. The ABA clinician uses their clinical expertise to perform Functional Behavior Assessments [FBAs], to develop and make ongoing adjustments to student-specific behavior plans, to coach parents and team members in use of behavior plans, and to train and supervise Behavior Interventionists. The ABA clinician is often called on to train and support teachers and work with school and IEP teams for the student.
 - b. **School focus²:** In this model the ABA clinician works with classroom teachers and administrators to apply an ABA approach at a population-level intervention. The clinician's role could also include student-specific FBAs, treatment planning, and consultation of students identified by the school that are not direct recipients of BI services.

IF ABA clinicians are not already a Board-Certified Behavior Analyst themselves, ABA clinicians are supervised by a Board-Certified Behavior Analysts.

3. **Mental Health Clinician³:** A master's-level clinician with a mental health degree (clinical mental health counselor, psychologist, social worker, or marriage and family therapist). The Mental Health Clinician focuses on the social/emotional/therapeutic needs of a student caseload and/or school population, providing individual, group, and family therapy, crisis response and intervention, and case management. The mental health clinician is supervised by a licensed clinical supervisor and receives group supervision.

² School Wide Behaviorist (LCMHS) or School-Based Behavior Consultant (NCSS) or Behavior Specialist (HC)

³ School-Based Clinician [CSAC, LCMHS], Family Worker [HC] are other terms.

4. **Care/Service Coordinator:** A bachelor's-level service provider who coordinates care for the student in the BI program. This staff person can serve as the liaison between the school team, community providers, and the family. The care/service coordinator helps the student and family address barriers to learning driven by social determinants of health and can provide in-home coaching and parenting support for caregivers and family, and helping the student access supports outside of school, such as respite and/or high interest activities, that may improve social and emotional functioning.

Services

Some services are only provided by a clinician with a specific set of qualifications and training, and some services can be provided by a range of clinical roles.

Individualized Behavior Support:

- 1:1 behavior, social and skills training and support for children
- Implementation of ABA behavior plan
- Substitute and vacation services
- Coordination with treatment team and school team

Individual and Family Treatment:

- Diagnosis, assessment, evaluation, and treatment of children's mental health issues using evidence-based practices (see below)
- Supportive counseling for children and their caregivers
- 1:1 Social skills support and development for children

Group Interventions (both for client/non-client)

- Pro social skill building and mental health support groups
- Clubs/groups/Activities before or after school
- Leading/co-leading whole classes, morning meetings, etc.
- Social thinking: Superflex curriculum etc.

Family Engagement, Coaching, and Therapy

- Home and school-based meetings with caregivers

- Parent psychoeducation
- Family therapy
- Home visits
- Communication by phone or face to face meetings with parents

Care/Services Coordination

- Mandated reporting and case coordination with DCF
- Assessing, developing treatment plans
- Facilitation of referrals for clients/ non-clients and families to DA services and other community providers including pediatricians, dentists, psychiatrists
- Coordination and facilitation of various meetings
- Provide resource information for client and families including but not limited to food, housing, recreational, educational, etc.
- Linking client and non-client caregivers to holiday giving programs; out of-school care and enrichment programs (including summer camps); and scholarships to assist caregivers in accessing these resources

Transportation

- For client or family member to various appointments or meetings
- To school or other community activities (varies based on program)

Meetings: Student-Specific and Standing School Meetings

- EST
- IEP
- PBIS
- Social Emotional Learning committee
- 264
- 504
- SST
- Faculty meeting
- Team meetings
- Safety Planning
- Crisis teams

- Parent teacher conferences
- Disciplinary action meetings
- Pediatric and psychiatric care conferences.
- Re-entry and discharge meetings

Functional Behavior Assessment

- A systematic method of assessment for obtaining information about the purposes (functions) a problem behavior serves, conducted by an ABA Clinician.
- Involves data collection and tracking over time.
- Results are used to guide the design of an intervention plan for decreasing problem behavior and increasing appropriate behavior, implemented typically through 1:1 behavior supports.

Mental Health Consultation

- Consultation to school staff for interventions related to non-client children with unmet social, emotional and behavioral needs.

Crisis Intervention

- Crisis planning for children, caregivers, and school staff
- Behavior interventions for clients on demand (varies based on role)
- Response to suicidal ideation /risk assessments

Supports to School Community: Behavioral Consultation, Mental Health Consultation, Teacher and Staff Engagement, Coaching, and Training,

- Increasing the knowledge base of school staff regarding mental/emotional/social/behavioral health issues either individually or in group settings
- Planning, organizing and facilitating professional development trainings for school staff
- Providing emotional support to faculty due to (own personal issues?) challenges related to work
- Participating in in-service training days
- Attend field trips, dances, graduations, assemblies
- Monitoring of hallways, bathrooms, recess, lunch and start and end of day

Clinical Documentation

- Ongoing documentation of services completed with clients, providers, school staff and caregivers (clinical assessments, diagnosis, and intake paperwork on all new clients; treatment notes and bi- yearly development and review of treatment goals with clients and their families; and standardized tools such as the Child and Adolescent Strengths and Needs.)

Service Table

- The shading below indicates alignment with the MTSS tiers: blue and purple = tier 3; purple = tier 2; purple and pink = tier 1.
- Dark green = student-specific direct services; green = student-specific indirect services; light green = non-student specific services
- Starred (*) items are Medicaid-reimbursable services
- Remote = can this service be provided if school is happening remotely

SERVICE	RECIPIENT OF SERVICE	BEHAVIOR INTERVENTIONIST	CARE/SERVICE COORDINATOR	ABA CLINICIAN – STUDENT FOCUS	ABA CLINICIAN – SCHOOL FOCUS	MENTAL HEALTH CLINICIAN	REMOTE
INDIVIDUAL BEHAVIOR SUPPORT *	student	x					partial
INDIVIDUAL THERAPY *	student					x	full
CRISIS ASSESSMENT AND RESPONSE*	Student + staff	x	x		x	x	full
PSYCHIATRIC CONSULTATION / MEDICATION MANAGEMENT*	student		Provided by psychiatrist, but facilitated by x		Provided by psychiatrist, but facilitated by x	Provided by psychiatrist, but facilitated by x	full

SEL GROUP INTERVENTIONS	Student and student body			x	x	x	full
FAMILY ENGAGEMENT, COACHING AND THERAPY *	student + caregivers + siblings		X	X	x	x	full
TRANSPORTATION	student	x	x			x	n/a
VACATION SERVICES*	student	x					partial
SUBSTITUTE COVERAGE*	Student	x					partial
FUNCTIONAL BEHAVIOR ASSESSMENT *	student			x	X		n/a
DATA TRACKING AND ANALYSIS*	student			x	X		n/a
CARE/SERVICE COORDINATION*	student		x	x	x	x	full
MENTAL HEALTH ASSESSMENT AND PLAN *	student					x	full
BEHAVIOR CONSULTATION	student + school staff	x		x	X	x	full
MENTAL HEALTH CONSULTATION	Student + school staff			x	x	x	full
CLINICAL DOCUMENTATION	student	x	x	x	x	x	full
TEACHER ENGAGEMENT	Staff + administr		x	x	x	x	full

T AND COACHING PLANNING, PREP, AND CLEAN-UP PROFESSIONAL DEVELOPMENT TRAINING TRAINING OF SCHOOL STAFF TEAMING (INVOLVEMENT IN STANDING SCHOOL TEAM MEETINGS)	ation							
	Student + student body	x		x		x	x	full
	DA staff	x		x	x	x	x	full
	Teachers and staff				x	x	x	full
	Standing school meetings	x		x	x	x	x	full

What Sets Designated Agency BI Programs Apart from other Support Options Available to Schools?

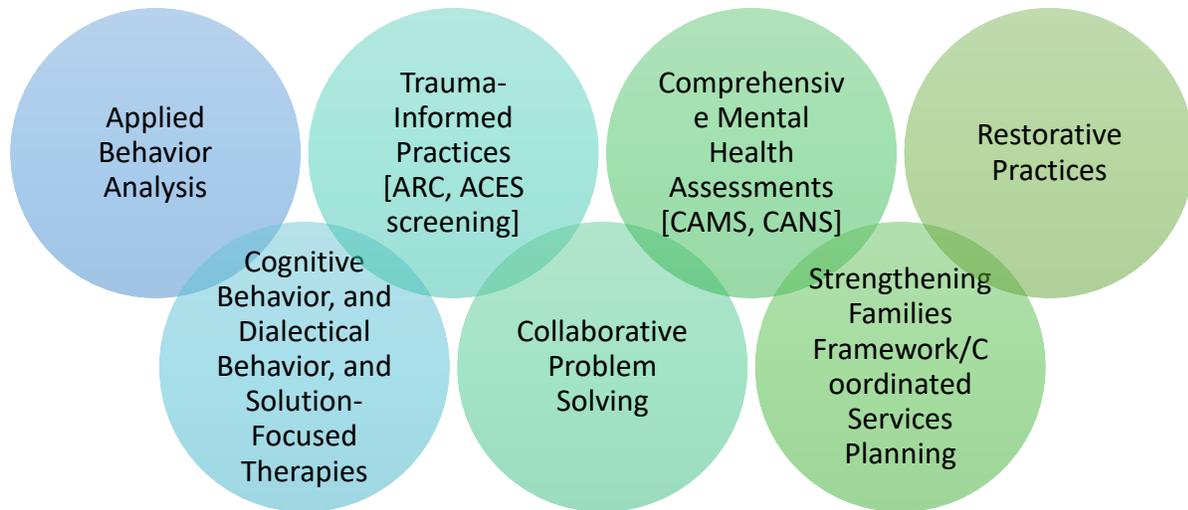
Clinical Supervision: A depth of clinical knowledge and expertise that is unique to the community mental health system.

Access to Mental Health Services: Because children are service recipients of the designated agency, they and their families have improved access to a broad array of wraparound home and community-based mental health and substance use disorder services.

Crisis Services: Schools get support from designated agency crisis teams to respond to children and youth who are in extreme states of dysregulation and distress.

Evidence-Based Practices: BI Program staff offer unique expertise in mental health and behavioral best practices. As designated mental health agency staff they receive ongoing training and supervision, as well as quality oversight from the Department of Mental Health to support fidelity to these practices. Here are

some of the evidence-based practices that may be used in different agencies around the state:



Detailed descriptions of these practices, along with their target age range, is available in the appendix.

Sample Service Packages

Designated agencies have the flexibility to work collaboratively with school partners to individualize service options based on local school and districts’ needs. This can range from a single student contract with a behavior interventionist, to a clinician providing mental health and behavioral expertise school/district wide, to a bundling of such services for greatest impact, financial savings and local control.

Service Package A: One ABA Clinician, one Mental Health Clinician and six Behavior Interventionists.

The school identifies a team to work with the DA staff leaders to determine how the services are distributed. There may be four tier 3 students needing intensive 1:1 intervention, and four tier 2 students with lesser support needs that share the remaining two BIs. The Mental Health Clinician provides home-school coordination and individualized or group mental health supports to some or all of



the eight identified students, while also being available to additional students the team identifies. The ABA Clinician provides training, supervision and programming for the students served by BI staff. And depending on the complexity and workload, the Clinicians can at times be available for other student/team consultations or trainings. The distribution of the work and expertise is directed by the school/DA team, allowing for fluidity as needs evolve.

Service Package B: One ABA Clinician, one Mental Health Clinician and four Behavior Interventionists.

One full time ABA Clinician be assigned to a school district for ease in teaming and efficiency. The ABA Clinician performs observation and assessment of referred students, Functional Behavior Assessments, development and ongoing adjustments of behavior plans, and training and supervision of the Behavior Interventionists. This model also supports a consultation approach on new students, training and supporting teachers and working with the school support teams and IEP teams.

The Mental Health Clinician focuses on individual and parent support to youth identified to work with the BIs and ABA Clinician. This position would focus on the social/emotional/therapeutic needs and interventions. The smaller caseload supports more intensive supports to alleviate the mental health barriers to success in school. This clinician can also focus on skill building approaches—potentially in groups that would allow for skill practice as well as the opportunity to serve students not directly working with the Behavior Interventionists. This position also takes the lead on case management and coordination with teams.



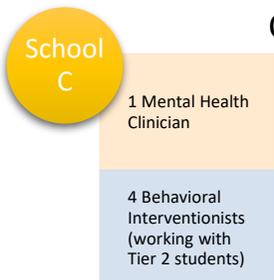
The Behavior Interventionists and Substitute BI team have been intensively trained and supported by the designated agency to build relationships with students and implement the behavior plans of the ABA Clinician with consultation and support on trauma and social/emotional needs from the Mental Health Clinician. They work 1-to-1 with students or potentially with a small group. The flexibility with the case rate model allows for changes in direct hours of

service as a student experiences success. A student who is doing well in a particular class may not need support during that time—allowing the BI to support another student. The Substitute position allows for coverage on days out but also supports options for double staffing or serving more children.

Like Service Package A, a key to this approach is teaming. The designated agency team would need to work closely with a school team that is able to prioritize student needs and define best utilization of school and DA staff. The team would need to meet regularly—typically a weekly meeting would allow the most flexibility and best utilization.

Service Package C: One Mental Health Clinician, four BIs

If a school identifies a group of students that would benefit from the support of a Behavior Interventionist, but that are not in need of a ABA Clinician and Care/Service Coordinator, the school could contract for a Mental Health Clinician to support the BIs. In addition to their role in the school as a school-based clinician, they would provide supervision to the BIs within the school that are supporting Tier 2 students. The Mental Health Clinician would be able to provide supports within the home if needed as well as link the student/family to other services that are available through the agency. The cost would be less than the contract amounts listed on the next page due to the fact that the BI would be following the schools disciplinary process while supporting the students.



These flexible service packages provide distinct benefits to school districts:

- Flexibility to serve more students
- The ability to reassign staff/services in a timely manner
- Easy access to expertise at no extra cost
- Strengthen relationships with DA staff who can be assigned for the whole school year
- Through the school/DA team, develop a high-level view of the student body and personnel needs to prioritize and manage
- Reduce mid-year applications that can be waitlisted

Appendix 1:

Evidence-Based Practices

Trauma Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.⁴ Providing care in a trauma-informed manner includes using principles and practices that promote a culture of safety, empowerment, and healing to increase overall health and wellbeing.

Applied Behavior Analysis (ABA) is the process of systematically applying interventions based on the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior. ABA focuses on behavior as a response to factors within the environment, and interventions seek to facilitate behavior change by altering these environmental factors. These interventions, which target both the reduction of problem behaviors and teaching socially appropriate replacement behaviors, are monitored and evaluated through ongoing data collection and analysis designed to be sensitive to the behaviors of interest. Treatment based on the principles and procedures of ABA has been used in a wide range of environments, including schools, residential settings, community-based programs, and clinic settings, to name a few. ABA has an extensive research base demonstrating its efficacy both as a stand-alone discipline and in conjunction with other evidence-based interventions.

Cognitive Behavioral Therapy (CBT) is a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel. It is used to help treat a wide range of issues in a person's life, from sleeping difficulties or relationship problems, to drug and alcohol abuse or anxiety and depression. CBT works by changing people's attitudes and their behavior by focusing on the thoughts, images, beliefs and attitudes that are held (a person's cognitive processes) and how these processes relate to the way a person behaves, as a way of dealing with emotional problems. Expected outcomes

⁴ Bassuk, E. L., Hopper, E. K., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*(3), 80-100

include improvement in quality of relationships, decrease in behavior problems, increase ability to tolerate distress and engage strategies that promote emotional regulation.

Dialectical Behavior Therapy (DBT) is a cognitive behavioral treatment. It emphasizes individual psychotherapy and group skills training classes to help people learn and use new skills and strategies to develop a life that they experience as worth living. DBT skills include skills for mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. The goal of DBT is to help clients build a life that they experience as worth living. In DBT, the client and the therapist work together to set goals that are meaningful to the client. Often this means they work on ways to decrease harmful behaviors and replace them with effective, life-enhancing behaviors. Expected outcomes include improvement in quality of relationships, decrease in behavior problems, increase ability to tolerate distress and engage strategies that promote emotional regulation and interpersonal effectiveness.

Solution-Focused Therapy (SFT) / (Brief Therapy SFBT) places focus on a person's present and future circumstances and goals rather than past experiences. In this goal-oriented therapy, the symptoms or issues bringing a person to therapy are typically not targeted. Expected outcomes include improvement in quality of relationships, increased recognition of strengths and problem solving skills, decrease in behavior problems, increase ability to tolerate distress and engage strategies that promote emotional regulation and interpersonal effectiveness.

Collaborative Assessment and Management of Suicidality (CAMS) is a clinical philosophy of care. It is a therapeutic framework for suicide-specific assessment and treatment of a patient's suicidal risk. It is a flexible approach that can be used across theoretical orientations and disciplines for a wide range of suicidal patients across treatment settings and different treatment modalities. The clinician and patient engage in a highly interactive assessment process and the patient is actively involved in the development of their own treatment plan. Every session of CAMS intentionally utilizes the patient's input about what is and is not working. All assessment work in CAMS is collaborative; we seek to have the patient be a "co-author" of their own treatment plan. Expected outcomes include improvement in quality emotional regulation. Reduction in suicidal ideation or planning and increase in available coping skills to manage suicidal ideation.

Collaborative Documentation (CD) is a process in which clinicians and clients collaborate in the documentation of the Assessment Service Plan documentation of the Assessment, Treatment Plan, and Progress Notes. CD is a clinical tool that provides clients with the opportunity to

provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understanding of important issues and focus on outcomes issues and focus on outcomes. The Client must be present and engaged in the process of documentation development.

Coordinated Services Planning: A *Coordinated Services Plan (CSP)* is a written plan developed by a team for a child/youth who requires services from more than one agency. It is designed to meet the needs of the child within his or her family or in an out-of-home placement, and in the school and the community. Eligible children and youth are entitled to receive a CSP developed by a service coordination team including representatives of education, the appropriate departments of the Agency of Human Services, the parents or guardians, and natural supports connected to the family. The CSP includes the Individual Education Plans (IEP) as well as human services treatment plans or individual plans of support and is organized to assure that all components are working toward compatible goals, progress is monitored, and resources are being used effectively. <https://ifs.vermont.gov/docs/sit>

Strengthening Families Framework: Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building five protective factors:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children.

For more information about the Strengthening Families Framework in Vermont, visit here: <https://cssp.org/wp-content/uploads/2018/08/Vermont.pdf>

Restorative Practices: “Whole-school restorative approaches build healthy school climates by creating space for people to understand one another and develop relationships; when things go wrong, restorative approaches create space to address needs, repair relationships, and heal. Restorative practices provide meaningful opportunities for social engagement that foster empathy and mutual responsibility for the well-being of individuals and the community. Proactive practices intentionally build trust and understanding within the community to ensure a healthy supportive climate and environment. When things go wrong, restorative practices

engage those affected and create space so that individuals and communities can effectively identify, understand, and address harms and needs—this facilitates healing.”⁵

Collaborative and Proactive Solutions (often referred to as Collaborative Problem Solving):

Collaborative & Proactive Solutions (CPS) is the non-punitive, non-adversarial, trauma-informed model of care developed by Dr. Ross Greene, author of *The Explosive Child*, *Lost at School*, *Lost & Found*, and *Raising Human Beings*. The CPS model is recognized as an empirically-supported, evidence-based treatment by the [California Evidence-Based Clearinghouse for Child Welfare](#) (CEBC). The model is based on the premise that challenging behavior occurs *when the expectations being placed on a kid exceed the kid’s capacity to respond adaptively*, and that some kids are lacking the *skills* to handle certain demands and expectations. The model focuses on identifying the *skills* the kid is lacking and the *expectations* he or she is having difficulty meeting (in the CPS model, those unmet expectations are referred to as *unsolved problems*). Then the goal is to help kids and caregivers solve those problems rather than trying to modify kids' behavior through application of rewards and punishments.⁶

⁵From *Whole-School Restorative Approaches Resource Guide*, Jon Kidde, Consultant, Vermont Agency of Education, December 8, 2017, retrieved July 23, 2020

⁶ <https://www.livesinthebalance.org/about-cps>, retrieved July 23, 2020