Innovative Interventions for Disability Services in Complex Rural & Urban Contexts

STEPHEN J. BAGNATO, Ed.D., NCSP
Professor of Psychology & Pediatrics
University of Pittsburgh
School of Education
LEND Center-UCLID Disabilities Institute
UPMC Children's Hospital of Pittsburgh
bagnatos@pitt.edu

TOM FARMER, Ph.D.
Professor of Psychology-in-Education
University of Pittsburgh
School of Education
TFARMER@pitt.edu

MIYA ASATO, M.D.
Pediatric Neurologist
Associate Professor of Medicine
Director, LEND Center
University of Pittsburgh
asatomr@upmc.edu

KAREN SHEPHERD, M.Ed.
CEO, Pace School-PLAID
Pittsburgh, PA
kshepherd@paceschool.org

TRACY LARSON, Ed.D., NCSP
Director, Early Childhood Partnerships
HealthyCHILD
Tracy.larson@pitt.edu

SHERRI LANDIS
CEO, Arc of Pennsylvania
Include Me
slandis@thearcpa.org

GUY CARUSO, Ph.D.
Western PA Director, Institute on Disabilities
Temple University
guy@temple.edu

CHALLENGES OF SERVICES IN DIVERSE CONTEXTS

Challenges of creating innovative intervention models for individuals with disabilities differs across rural and urban contexts, yet encompasses many similar overarching principles, practices, and system of care frameworks. Documenting the **models' "active ingredients" for success** requires ingenuity, flexibility, and collaboration **via Community-University partnerships (CUPS)**. These partnerships involve both formal & informal sources of support with schools, clinics, agencies, non-profits, and a "participatory action research" approach. **Challenges of diverse contexts** include: sufficient & trained personnel; identifying natural community informal and formal supports; administrative support for change to full-service schools/agencies; non-profit resources; university partnerships; experience for community-based service & research; distance and travel; need for tele-health consultation and internet access; new approaches for interdisciplinary collaboration; and consensus decision-making supported by on-line access. **Our poster highlights 4 evidence-based models of interdisciplinary and interagency education and behavioral health supports in VA, WV, AL, and PA.** We will identify "active agents" of the programs which lead change by interdisciplinary professionals, parents, advocates, and self-advocates exemplifying the change that happens through true on-site consensus and collaborative decision-making **about what will work, for whom, and under what conditions.**

MODEL SNAPSHOTS OF COMMUNITY-UNIVERSITY PARTNERSHIPS (CUPS)

- **Directed Consultation (DC)**
- **PLAID**
- **Include Me (IM)**
- **HealthyCHILD (HC)**

Directed Consultation (DC) is an intervention support framework in which data is gathered and used to inform and tailor professional development to contextual factors within and impacting classroom and community settings. These contextual factors include the skill set of service providers, needs of youth, school & community initiatives, and available resources. DC is a strengths-based approach that is centered on the person-in-context, clarifying leverage points in the ecology, and selecting interventions based on individual care providers strengths and needs. Ultimately, DC promotes solutions that are responsive to immediate stakeholder (i.e., family, teachers, other care providers) concerns, youths' needs, and ongoing real-world issues which can improve sustainability of evidence-based practice. **There are four components of DC: (1) pre-intervention observations and interviews, (2) a professional development workshop, (3) on-line training modules, and (4) on-going implementation meetings.**

These activities are typically led by an intervention specialist who has strong training and background in consultation, conducting ecological interventions, and developing and guiding teams of support for individual students and classrooms. In general, the process of DC begins with the collection of data to guide professional development (i.e., workshops and modules). A scouting report (i.e., interviews with relevant stakeholders and observations in primary ecologies and contexts) is generated and used to inform the initial and ongoing consultation meetings. These meetings provide time for discussion of how to implement various features of the training within each setting. This includes formative feedback from the intervention specialist in which "problems" are re-organized into opportunities for learning. DC

meetings are uniquely positioned to offer a "just-in-time" approach to PD as youth move from less (universal) to more intensive (targeted) supports that frequently require training and adaptation. Thus with DC, the intervention specialist and other members of the team can use their knowledge of the components of evidence-based programs, link these components to the developmental needs of the child & the circumstances of the ecology, and tailor ongoing supports to data from progress monitoring assessments based on the response to intervention and the adaptation of the child. DC research demonstrates the efficacy of a tailored model to fit the community setting and to deliver sustainable outcomes in various states: PA, VA, and AL.

PLAID. **[Positive Learning & Integrated Design]** is a design of the Pace approved private school in Pittsburgh which serves students (K-12th) with significant disabilities (40% of students are diagnosed with Autism and 60% with psychiatric and social-behavioral disorders). Pace, with the assistance of Universities: Pitt, CMU, & Carlow and local foundations, created and implemented a new model-*PLAID (Positive Learning and Integrated Design)* to change the climate of the whole school. **PLAID encompasses the following components: (1) use of a Positive Growth Mindset approach involving staff mentoring on the PGM model; (2) face-face modelling of positive instructional & management strategies, (3) linkages among the PLAID model elements and the lessons plans of teachers, (4) frequent structured observations of teacher/staff practices; (5) mentoring by coaches with teachers to improve and sustain positive practices; and (6) infused program evaluation outcomes research.** PLAID research has documented improvements in teacher practices, teacher beliefs, student academic progress, and student changes in social and self-regulatory behavior. Community internships for students with businesses in inclusive settings have been a major achievement of PLAID.

Include Me (IM). IM is a unique 10-year collaboration among the Pennsylvania Department of Education, the Arc of PA, Pitt and 130 rural and urban school districts in PA. IM emphasizes the development of a direct, insitu mentoring relationship among a parent, student with a disability, and the student's teacher in an general education classroom to ensure the student's full inclusion into all classroom instructional activities. **IM tailors the coaching/mentoring process with each student/parent/teacher triad and constructs and individualized mentoring plan which documents the specific elements of the mentoring process and relationship that accounts for success in inclusion. Such factors include: frequency, duration, and intensity of mentoring; multiple modes of mentoring; focus on specific content areas [i.e., social skills; assistive technology; self-regulatory behavior; and academic goals]. IM research has shown dramatic success with over 1200 students with ASD and other significant disabilities, and in parent engagement with teachers and school administrators; and teachers' use of positive and growth-oriented instructional and management practices in 130 school districts.** Improvements include increases in student academic performance in reading and math and behavior, teacher gains in positive instructional practices, increased attitudes about inclusion by both parents and teachers, and changes in overall school climate.

HealthyCHILD [Collaborative Health Interventions for Learners with Differences] (HC) is a unique collaboration among the University of Pittsburgh, UPMC Children's Hospital of Pittsburgh, Pittsburgh Public Schools, COTRAIC Head Start, the Northern Panhandle of WV Head Start, and Brightside Academy Child Care in Pittsburgh & Philadelphia to mentor parents, teachers, aides, and administrators on promoting healthy social-emotional, self-control, and physical health practices for vulnerable and high-risk infants, toddlers, and preschool children and those with delays and disabilities. HealthyCHILD has operated for 25 years as an integral behavioral health provider to deliver on-site, in-classroom mentoring and support for young children from birth to 8 years of age. Using a tiered and graduated service model to influence changes in classroom climate, teacher practices, and parent engagement, HC

involves a mobile team of interdisciplinary professionals to engage with school and agency staff as mentors to model and to promote quality and efficacy in these childcare settings.
The successful impact and outcomes of HC are underscored by numerous program evaluation research studies and monographs as well as presentations at national research conferences and forums.
The HC model has 6 major dimensions which are evidence-based: (1) mobile interdisciplinary team provides support in-classroom or child care setting; (2) tiered pyramid of graduated promotion-prevention-intervention supports for children, teachers, and parents; (3) individualized modelling of "best practices" for the teaching team and parents via the mentoring by a credentialed early childhood specialist; (4) ongoing consultation and observations of child, parent, and teacher progress in their interactions with children; (5) individualized and group options for parenting education and support; and (6) Community-University Partnerships among university and interagency professionals and parents.

Research strongly supports the efficacy of HC in changing teacher instructional and management practices, parent's responsive engagement with their child and teacher, and children's developmental progress in social-emotional behavior and health, involving over 3,000 children and parents; and 700 classrooms and teaching teams.

"ACTIVE AGENTS" FOR EFFECTIVE MODELS

7 Global Components for Successful Human Service System Reform Initiatives
(Salisbury, 2003; Melaville & Blank, 1994; Stroul/SAMSHA, 2002)

1. **Integrated program planning process between parents, professionals & administrators**
2. **Integrated program plan for each child/family**
3. **Collaborative leadership oversight group**
4. **Regular state-local feedback loop for government and interagency partners to address policy-linked challenges to implementation**
5. **Computer or web interface across trans-agencies to share client, program, outcomes data**
6. **Opportunities for structured interdisciplinary cross-training and continuing education**
7. **Ongoing impact evaluation for quality improvements using common transagency measures and outcomes**

9 Core Principles and "Active Agent" Practices of a System of Care for Young Children

1. **Early identification for flexible access to services**
2. **Prevention-intervention continuum**
3. **Family-centered, culturally competent practices**
4. **Evidence-based interventions tailored to community agency capacities and needs**
5. **Community-based, in-vivo supports in natural home and classroom program settings**
6. **Integrated care coordination and transagency care plan to coordinate and synchronize comprehensive health/education supports for entire family irrespective of index client**
7. **Focus on building social-emotional and behavioral foundations for resiliency and early school success**
8. **Mentoring to foster uniform competencies and credentialing of interdisciplinary professionals**
9. **Common and universal standards and outcome indicators and measures across agencies (focus on state/local standards)**

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Poster for the AUCD Conference

Innovative Interventions for Disability Services in Complex Rural & Urban Contexts

Stephen J. Bagnato, Ed.D., NCSP; Tom Farmer, Ph.D.; Miya Asato, M.D.;
Karen Shepherd, M.Ed.; Tracy Larson, Ed.D., NCSP; Sherri Landis; Guy Caruso, Ph.D. ; Jamie Cranmer, BA

Directed Consultation

What is Directed Consultation?

A model for helping teachers tailor strategies to the diverse needs of the students by focusing on what aligns with the resources, strengths, and constraints of the teacher/school.

What is the "active ingredient" of the model?

A "working with what you have" mindset.

What are the essential outcomes of the model?

- **Supportive peer norms for effort & achievement**
- **Peer protection from bullying**
- **Greater sense of school belonging & valuing of school experience**
- **Improved grades & improved standardized achievement scores**

•Observations
•Interviews
•Data Use Consultation
Data Collection
•Workshops
•Training Institutes
•Relationship Building
Tailored General Training
Implementation Control
•Team
•Individual
•Real World Use & Adaptation
Ongoing Training
•Online Modules
•Implementation Data
•Clarification

HealthyCHILD

What is HealthyCHILD?

Community-University partnership to mentor parents, teachers, aides, and administrators on promoting healthy social-emotional, self-control, and physical health practices for vulnerable young children.

What are the "active ingredients" of the model?

- **Mobile developmental healthcare team**
- **Weekly classroom teaching team mentoring**
- **Modelling "best practices"**
- **Tiered supports approach**
- **Technology aids: snap videos, texting**

What are the essential outcomes of the model?

- **Improved teacher's classroom instructional and management practices**
- **Improved parent engagement with their child and teacher**
- **Improved childrens' social-emotional and behavioral progress for Pre-K & K**

HEALTHY CHILD MODEL
Developmental Healthcare Support Model
COLT
Collaborative Leadership Team

Include Me

What is Include Me?

On-site, direct, weekly teacher mentoring relationship among a parent, student with a disability, and teacher in a general education classroom to ensure the student's full inclusion into all classroom instructional activities (K-12).

What are the "active ingredients" of the model?

- **IM inclusion mentoring model for severe disabilities**
- **Parent-school engagement efforts**

What are the essential outcomes of the model?

- **Increased performance in reading, math & behavior**
- **Gains in teacher inclusion practices**
- **Positive attitudes about inclusion**
- **Changes in overall school climate**

Insert Exhibit 25. Extent of Progress Made Across FOCAL Domains here

Percentage
100%
80%
60%
40%
20%
0%
Social Emotional
Knowledge
Effective Actions
Self Regulation
Academics
Technology
Little or No Progress Observed
Made Observable Progress
At or above peers

PLAID

What is PLAID?

Positive Growth Mindset approach & positive instructional methods to improve and sustain practices among the teachers for students with complex disabilities in special classrooms (K-12).

What are the "active ingredients" of the model?

- **PGM training**
- **PLAID elements infused into lesson plans**
- **Observations of teaching interactions**
- **Mentoring & feedback with teachers**
- **Teacher-directed professional development**

What are the essential outcomes of the model?

- **Improvements in teacher practices and beliefs**
- **Improved student academic progress**
- **Improved student changes in social & self-regulatory behavior**
- **Community internships for students with businesses in real-life settings**

Growth Mindset Measure
(Pace Staff Beliefs, N=86)

	Growth	Neutral	Fixed
TOTAL	48%	43%	9%
INTELLIGENCE	55%	26%	19%
PERSONALITY	48%	30%	22%
KIND OF PERSON	47%	32%	21%
OTHERS' MORALITY	50%	29%	22%
WORLD	45%	29%	26%