Direct Treatment Protocol
Frequently Asked Questions

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1. What is a Direct Treatment Protocol?

A Direct Treatment Protocol (DTP) is used to document the specific positive interventions, strategies and supports for students with and without IEPs whose behavior requires systematic treatment from service providers other than the teacher due to the emotionally driven nature of the problem. It specifies how the student will be taught to manage or overcome intense emotional responses to stress provoking stimuli in an educational environment. For example, the student may (a) have intermittent intense rages that have not responded to a function-based behavior plan; (b) refuse to speak in a school environment, yet speak fluently at home; (c) refuse to come to school due to anxieties about what might happen at home or at school; (d) present as highly irritable and make self-harming statements; (e) withdrawal from social interactions and appear depressed; or (f) other exhibit emotionally driven behavior. The student may have specific phobias and other conditions related to traumatic life experiences that are creating an inability to cope with everyday situations which are affecting school behaviors. These are the situations addressed in a DTP.

2. How is the DTP different from a function-based Behavior Intervention Plan (BIP)?

The BIP is a plan that is developed to address a problem behavior based on the purpose or function of the behavior. The problem behavior is unskillful or maladaptive and occurs to get something (i.e., positive reinforcement), or get rid of something (i.e., negative reinforcement). The purpose of the plan is two fold: 1. To outline how to teach a functionally equivalent replacement behavior (FERB) that meets the same need for the student as well as to teach general positive behaviors that we want all students to perform 2. To address environmental conditions that contribute to the behavior and outline changes needed to alter the environment and reduce the need for the problem behavior. The primary implementers of BIPS are education staff (e.g., teachers, paraprofessionals, support staff).

In contrast, the DTP is for an emotionally driven behavior, often beyond the current control of the student. The primary implementers are support staff (e.g., school psychologists, counselors, school social workers, licensed mental health providers) who provide direct therapeutic treatment, often to restructure how children think and regulate or manage their feelings in response to emotion-provoking situations. In some cases, this may include systematically desensitizing (i.e., gradual exposure) the student to the emotion-provoking situations by gradually exposing them to a hierarchical sequence of experiences for which they can practice and use learn cognitive and behavioral skills. Mental health staff often play the primary role in treatment, yet the DTP specifies how instructional staff should manage the emotionally-driven behavior during the treatment period as well.

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3. How are the DTP and the BIP similar?

Both approaches are used to address behaviors that are interfering with the emotional and behavioral health of the student, as well as their academic and social functioning. Both approaches gather progress monitoring data to examine gradual change in behavior over time, use data to make decisions on treatment outcomes and provide reinforcement for skill acquisition, generalization and maintenance over time.

4. Does a student in need of a DTP require an IEP?

DTPs can be for a student with or without an IEP. A DTP may be provided as a school team service, as a behavioral RTI tier III service, as a 504 plan service or as a related service if the student has an IEP. Schools across the nation are in the process of changing practices so that students without IEPs as well as those with IEPs can access higher level behavioral services and supports.

Practice pointer: If the student has an IEP, the related service would be "to benefit from special education" whereas if the student has an IEP and requires a BIP, that would be a "supplementary aid to maintain the least restrictive environment".

5. Who will complete the DTP form?

If the student has an IEP or 504 plan, the team will develop the treatment recommendations, and potential implementers and other members will be present for this process just as they are for a BIP process. If this DTP is being provided as a school team function, or tier III intervention, the school or district method of documentation of interventions will be used.

6. Who will implement the DTP?

There are a number of people who will implement the DTP. In terms of data collection and generalization assistance, the teacher(s) play a role. For the direct treatment, the person with the scope of practice and scope of competence will provide the service. Clinical and school psychologists, school counselors, social workers, marriage and family therapists, speech therapists and occupational therapists often have the scope of practice and competence to address emotionally driven behaviors.

Reinforcement will happen in the classroom for generalization and will also be provided by whoever does the direct treatment portion of the DTP. Parents often play a role in assisting generalization and can be involved in reinforcement. Behavior specialists often play an important role in identifying effective reinforcers in addition to teachers, parents and the students themselves.
Data review and decision making can involve a full range of support personnel.

7. Who will monitor the DTP?

Monitoring is embedded throughout the plan and can often involve a variety of personnel. Weekly data should be gathered and graphed so that efficient decisions on whether DTP is working or whether adjustments to the plan need to be made.

8. Who makes the decision on whether to use a BIP or a DTP?

A team decision is always the best decision in determining best approaches. Typically a Pathway Chart is helpful and will have been completed before an approach is selected. This Pathway Chart is a helpful

tool to summarize the team's hypothesis of why the behavior is occurring. See: http://www.pent.ca.gov/frm/forms.html. If the student has an IEP or 504 plan, the team will determine which approach should be tried. Similarly, the school team or RTI team can make the decision if no IEP or 504 plan is presently in place.

Sometimes we immediately know that finding a functionally equivalent replacement behavior (FERB) will not solve the problem. For example, selective mutism, in which the student refuses to speak in school, yet speaks fluently at home, does not change with a function-driven BIP because it is an anxiety based disorder. Rather, there are evidence based, step by step protocols available to systematically address the problem effectively.

9. Who may be involved in the data collection process to select either a BIP or a DTP? Will a mental health provider be a part of the assessment process?

Students with IEPs

If the student has an IEP, an assessment plan will be developed to gather data as to the nature of the variables supporting the problem behavior. This may involve school psychologists, clinical psychologists, Board Certified Behavior Analysts and other behavior specialists, speech pathologists, MFTs, social workers, occupational therapists (typically for emotionally driven escape behaviors in students with autism and/or moderate to severe disabilities) and others. The parent/guardian must agree in order for assessment to proceed. The data collection and analysis should be performed as a transdisciplinary process in which all supporters weigh in as to the nature of the problem and develop a treatment approach. For some students, behavior problems will require BOTH a BIP and a DTP. When the related service of mental health treatment is potentially a need which will be described in the DTP, then those individuals with the scope of practice and competence will be selected.

Students with no IEPs

If the student does not have an IEP and the team wishes to provide either a BIP or a DTP to address a problem behavior, the team may review existing data, such as incident reports, school records (attendance/discipline/medical) for the purpose of developing a BIP or DTP, and no assessment plan is required. However, it is important to be cognizant of when an assessment for special education services is triggered. That is, districts must develop clear "Child Find" procedures to avoid failure to provide special education in a timely manner.

It is possible and appropriate to address many students' behavior problems with either a BIP or a DTP or both but at any point, non-responsiveness to the intervention may be the data that suggests a comprehensive assessment for special education services is needed.

Examples

1. A kindergarten student may have intense school refusal behaviors. If the student is not demonstrating a gradual response to the DTP that employs evidence based treatment for this problem, at some point a Child Find obligation to examine the need for special education services will be triggered.
2. A first grade student refuses to speak in school. The Speech-Language Pathologist must determine that there is no underlying language disorder that is causing or contributing to the reticence. Typically, it will be discovered that the speech refusal is an anxiety based disorder, and assessment will be necessary to satisfy a Child Find obligation. (Often audio recording in the home will be analyzed to evaluate the possible language disorder contribution, if any.)

3. A highly traumatized 5th grader with multiple foster home placements exhibits rage behaviors not associated or rarely/infrequently associated with environmental stimuli. BIP and DTP may be used with careful data analysis prior to consideration for special education services. However, non-responsiveness may trigger a Child Find obligation.

Avoiding delay in assessment for special education services

By collecting data daily, graphing weekly and meeting at the 4 week decision point, delays in special education assessment can be avoided. Also, it is very important to remember that at any point, parents or others can request full special education assessment. When a parent requests special education assessment, the district is obligated to either assess or provide the parent with a Prior Written Notice outlining the reasons for not conducting an assessment.

Avoiding over identification

When there has been a lack of response to behavioral (BIP) or cognitive behavioral (often DTP) interventions, the most likely suspected disability is Emotional Disturbance. This requires a condition, to a marked degree over a long period of time, that meets additional criteria. Careful data analysis will be especially helpful in avoiding false positive findings, a critical issue to remember as schools face disproportionality issues in their identification processes. In some districts, a disproportionate percentage of students of specific ethnicities or races have been identified as emotionally disturbed. Increasingly, schools are experiencing more students with trauma in their lives and school must be careful in determining whether or not the behavior is disability related.

10. If the student has an IEP, at what developmental level may a student benefit from the related service specified on the DTP?

Not all treatment outlined in a DTP requires a cognitive behavioral approach with a need for insight, i.e., the ability to "think about your thinking" which Piaget described as beginning at approximately age 7, when beginning logical reasoning to think about past, current and future are present. http://www.pent.ca.gov/beh/dev/dev.html Other treatment approaches, such as relaxation training taught by a Autism Specialist, or Occupational therapist or others could be outlined in the DTP to deal with high emotionality when presented with a trigger.

In general, when in doubt, the best way to determine if a student will benefit is to begin treatment and carefully monitor response.

11. Will there be a subjective type of baseline data measured by the student prior to intervention?

It is recommended that in general all data measurement is designed BEFORE the intervention has begun. Data collection should be measured against changes from baseline. Typically, multiple data providers will give the best measure of change. This includes parents, teachers, support staff and the students themselves. Much work surrounding Subjective Units of Distress Scales (SUDS) has shown it to be a good student perspective measure on whether skills are being developed that are alleviating distress. The Incredible 5 Point Scale has been used successfully with students with autism and other scales are available on websites. For example, on the PENT website under progress monitoring, many tools are available for use for these purposes.

12. Should we consider more than one evidence-based practice to be included on Line 9?

The correct answer to this question is that it depends. Typically, there is one evidence-based treatment or protocol that should be selected and followed faithfully to address a particular issue of concern (e.g., school refusal, conduct problems, depression). On a few occasions, more than one protocol will be followed because the student has comorbid conditions. Each treatment protocol will have within it multiple evidence-based components. For example, if following the evidence based protocol designed by Dr. Christopher Kearney at UNLV for school refusal, that would be described. Within that protocol many components are in and of themselves evidence based as well. A DTP follows a step by step treatment for a specific disorder or condition. If we are "eclectic" we end up with a non-evidence based protocol, which should be avoided much as we have learned to avoid "eclectic" approaches to teaching reading.

13. Can we attach other documents that outline in detail the treatment protocol?

Yes. Often attaching a preexisting step by step treatment or other guidance sheet can streamline the writing process and avoid lengthy rewriting of documents.

14. How does a service provider establish the expertise to provide the treatment?

Step one is to examine the training and background of the credential or license to practice. This provides evidence of "scope of practice." For example, a staff person who is BCBA credentialed may have no background or training to provide direct cognitive behavioral therapy for individuals with bipolar disorder and other conditions. However, the individual may be both a BCBA and a school psychologist. It is within the scope of practice of a school psychologist to provide direct one on one counseling using a cognitive behavioral therapy approach. An occupational therapist, BCBA or other behavior specialist or autism specialist may have credentialing that includes teaching relaxation and coping to this population, therefore the scope of practice provision is met.

Step two, if step one is established, then the potential provider should establish scope of competence. This can be done through university preparation, reading, completing on-line training, taking extension courses, being mentored by a competent practitioner and supervised by a specialist in the methodology.

15. Does this plan allow for the generalization of coping skills into the classroom setting?

Yes. Goals will be established on the plan that specifically report on changes on the progress monitoring measure selected that are inclusive of school environments. This always includes classroom and school grounds, but may also include changes reported in the home environment. Again, progress monitoring tools for this purpose are located at http://www.pent.ca.gov/frm/forms.html.

16. How frequently would we progress monitor the generalization of skills in the natural environment?

Typically somewhere between once per day and once per week the staff will complete the simple form mentioned in question 14 above. This typically requires 1 to 2 minutes of staff time and

approximately 3-5 minutes to train staff on how to use the selected form. The plan will specify who collects and graphs data. Typically, the direct treatment staff will aggregate the data and input it into a graph, but this can vary and be determined by the team.

17. Why does the DTP emphasize data collection, reporting and communication between stakeholders?

Often in the past, related services were provided with no ongoing communication or progress monitoring other than summative assessment of progress at the end of an IEP period based on subjective hunches. The new educational emphasis on formative assessment, DURING the treatment results in better ability to determine when the service is working, and to what extent. Multiple informant exchanges allow stakeholders to determine the degree to which changes in student performance are actually occurring and observable outside of a therapy room.
In the past, for example, mental health therapy often occurred for years on end with no discernable, measurable data collected or analyzed in defense of terminating, maintaining or increasing intensity, changing approaches or changing service providers. The DTP increases accountability in related services, much as increases in accountability are occurring in academics.

18. Who are the stakeholders for communication during this plan and how often should communication occur?

The communication plan will be highly individualized. A team will wish to designate who exchanges valid data (not impressions), at what time interval and for what purpose. This is a team effort, and each stakeholder should weigh in on what data will be helpful. Stakeholders may include: parents, outside therapists, site administrators, program managers and specialists, support personnel serving the student in other capacities, probation officers, teachers and others concerned with the emotional and behavioral health of the student. The ultimate goal of an effective DTP is to support the student's generalization and maintenance of learned skills across multiple environments. This requires true two-way communication between the therapeutic provider and all stakeholders.

19. How long will a plan like this be implemented?

Protocols for specific disorders and conditions typically describe a range of implementation time to achieve success. CBT approaches typically require 12-16 weeks, depending on the issue in question. Many other issues resolve much more quickly. That being said, it depends on how quickly rapport or a therapeutic relationship can be established. In situations in which rapport takes longer periods of time to be established, the therapy may take slightly longer. The data collection, aggregation and summarizing the generalization outcomes inherent in this approach prevents discontinuing the DTP too soon, or keeping it in place too long.

20. Is a DTP required by law?

A Direct Treatment Protocol is not mentioned in federal or state law. However, there are legal requirements inherent in IEPs when students have behavior that needs to be addressed.

If the student has an IEP, it is necessary to determine if any related services are required to benefit from special education services. Additionally, if the student with an IEP has behavior that impedes the student's learning or peers learning, we must consider strategies, including positive behavioral interventions strategies and supports. If we consider strategies, we are required to write what

strategies are selected. Since this is student "need", we must have a goal for every need we discuss in an IEP.

The DTP form provides a record of how we will address the emotionally driven behavior, how staff should reinforce changes in behavior and use of effective skills, how staff should manage the problem behavior if it occurs again, what goals will be monitored over time and how stakeholders should communicate progress with each other.

Increasingly, mental health services are being delivered within the school setting in California, and many SELPAs and districts have hired their own additional clinical staff, in addition to the school psychologists and others who have addressed mental health needs in schools. The DTP provides a monitoring system to improve delivery of service from school-based providers.

21. What assessments should be conducted to justify a DTP rather than a behavior plan and must a diagnosis of mental disorder be given following an assessment and prior to the DTP?

The transdisciplinary team, either an IEP team, a 504 team or a school team will frequently present behavioral observations as data suggesting that an emotional response is occurring. Often the parent will report via an interview that the child has difficulty managing emotions in the context of specific situations at home and/or in school. Other times, the team will have data gathered from an FBA observation, a universal screening measure, or from a standardized behavior rating scale (e.g., BASC, BIMAS, Achenbach, SSRS) that indicates emotional dysregulation and unhelpful thinking patterns are connected to certain problem behaviors.

This is a needs-driven intervention plan and no specific assessment tool exists, nor is a specific one required, to indicate that the child's identified problem is more of an emotionally-driven than a purposeful behavior. Often a Pathway Chart will demonstrate that teaching a functionally equivalent replacement behavior is insufficient to address the underlying unhelpful thinking patterns and emotional problems associated with the child's response to triggering situations. If a mental health provider is seeking reimbursement for services, such as MediCal, then a specific assessment and diagnostic label may be required. But there is no legal mandate that requires a mental diagnosis to provide school-based counseling services.

We do not place a mental health diagnosis on the DTP as this is confidential and should remain in assessment reports, if one was conducted. On the DTP we might say, (1) the student has emotional distress separating from the caregiver rather than Separation Anxiety, (2) the student shows intense anxiety during social interactions with peers rather than Social Phobia, or (3) the student has withdrawn behavior with flat affect and takes no pleasure in previously enjoyed activities instead of Depression. The DTP is a school-based plan designed to coordinate multiple stakeholders in supporting the implementation of therapeutic supports focusing on improving the emotional regulation skills, helpful thinking patterns and problem-solving skills of students with emotional needs.