Building Bridges for Our Students!

Emotionally Handicapped & Severely Emotionally Disturbed PROGRAMS

Miami-Dade County Public Schools

Division of Special Education
EH/SED RESOURCE MANUAL

Table of Contents

CHAPTER I: INTRODUCTION
Definitions of EH/SED.......................................................... 1
Eligibility Criteria................................................................. 1
Pre-referral and Referral Procedures................................. 2
Dismissal Criteria for EH/SED Students............................ 4

CHAPTER II: CHARACTERISTICS OF STUDENTS IDENTIFIED AS EH/SED
Disorders Common to EH/SED Students............................. 5
Medications........................................................................ 7
Contributing Factors to Emotional and
Behavioral Disorders..................................................... 9
Expectations....................................................................... 9

CHAPTER III: PROGRAM MODELS
Educational Component................................................. 11
Treatment Component.................................................... 13
Staff Component............................................................ 14
Family Involvement.......................................................... 15
Physical Layout.................................................................. 16
Supplies and Resources.................................................. 17
Team Mediation............................................................... 18
Program Models in M-DCPS............................................. 18

CHAPTER IV: PROGRAM MANAGEMENT AND SUPPORT SYSTEM
Creating a Positive Learning Environment....................... 23
The Principles of Behavior............................................... 24
Preventative Strategies.................................................... 25
Behavior Contracts......................................................... 28
Level System................................................................. 28
Level System and Articulation......................................... 29
Off-Level........................................................................ 29
Self-Management............................................................ 29
Privileges and Reinforcements........................................ 30
Bus Behavior Support System......................................... 30
Six Guidelines for Avoiding and Defusing Confrontations... 31
Guidelines for Dealing with Potential Crises.................... 32

CHAPTER V: ROLES AND RESPONSIBILITIES OF EH/SED STAFF
Roles and Responsibilities of the Classroom Teacher............. 41
Roles and Responsibilities of the Paraprofessional................ 42
Roles and Responsibilities of the Behavior Management
Teacher........................................................................... 43
Roles and Responsibilities of the Clinical Art Therapist.......... 44

November, 2005
Purpose of this Manual

The purpose of this manual is to provide an informational guide for teachers, administrators, counselors, and other clinical staff. The intent is to offer an integral framework for the structure of programs for students identified as emotionally handicapped (EH) and severely emotionally disturbed (SED).

Mission Statement

The Miami-Dade County Public Schools (M-DCPS) programs for students with emotional challenges are dedicated to fostering and developing students’ interpersonal and academic skills. The ultimate goal is to mold citizens who have a sense of achievement and are able to make a positive contribution to their community.

All M-DCPS programs for students with emotional and behavioral difficulties strive to address the diverse needs of the students, utilizing individualized approaches, instructional, therapeutic and behavioral realms into cohesive educational programs.

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Ms. Jennifer Blackmore, Clinical Art Therapist
Ms. Tanya Carey-Henderson, Curriculum Support Specialist
Ms. Michelle Damas-Hernandez, Curriculum Support Specialist
Ms. Leonora Foels, SED Clinician
Dr. Linda Jo Pfeiffer, Clinical Art Therapy Chairperson
Ms. Martine Phanord, Curriculum Support Specialist
Mr. Craig Siegel, Clinical Art Therapist
Dr. Henry C. Sterner, Program Manager, SEDNET
Ms. Isabel Toyos, EH/SED Clinical Services Chairperson

Robin J. Morrison
Instructional Supervisor
Division of Special Education

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CHAPTER I

INTRODUCTION
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I. Definitions

Students identified as EH or SED may be unable to access their education in the general educational setting due to their emotional and behavior difficulties. These students require structure, consistency, small educational settings, behavioral intervention and therapeutic support.

The following definitions of EH and SED as handicapping conditions will serve to help you understand the nature of this exceptionality and their special needs.

A. Emotionally Handicapped

An emotional handicap is defined as a condition resulting in persistent and consistent maladaptive behavior, which exists to a marked degree, interferes with the student’s learning process, and may include, but is not limited to, any of the following characteristics:

- An inability to achieve adequate academic progress which cannot be explained by intellectual, sensory, or health factors
- An inability to build or maintain satisfactory interpersonal relationships
- Inappropriate types of behavior or feelings under normal circumstances
- A general pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears associated with personal or school problems

Students with disruptive behavior shall not be eligible unless they are also determined to be emotionally handicapped.

B. Severely Emotionally Disturbed

A severe emotional disturbance is defined as an emotional handicap, the severity of which results in the need for a program for the full school week and extensive support services.

II. Eligibility Criteria

A. Emotionally Handicapped

A student is eligible for an EH program if there is evidence that:
• The student, after receiving supportive educational assistance and counseling services available to all students, still exhibits an emotional handicap;
• An emotional handicap exists over an extended period of time, and in more than one situation;
• The emotional handicap interferes with the student’s own learning, reading, math or writing skills, social-personal development, language development, or behavioral progress and control; and
• When intellectual, sensory or physical deficits exist, they are addressed by other appropriate interventions or special programs.

Students are eligible for services from their third birthday until they graduate with a standard diploma or general education diploma (GED), or until age 22.

B. Severely Emotionally Disturbed

A student is eligible for an SED program if the student meets the criteria above and there is evidence that the student requires a program which:

• Serves the student for the full school week
• Provides a highly structured academic and affective curriculum, including but not limited to, art, music, and recreation services which are specifically designed for students identified SED
• Provides for a lower adult to pupil ratio than EH programs.
• Provides extensive support services specifically designed for SED students

These services include but are not limited to:

• Individual or group counseling
• Parent counseling or education, and consultation from mental health, medical, or other professionals
• Consultation from mental health, medical, or other professionals
• Cannot be provided in a less restrictive environment (LRE)

Students are eligible for services from their third birthday until they graduate with a standard diploma or GED, or through the school year in which they turn 22.

III. Pre-referral and Referral Procedures

A. Required Procedures

Prior to the referral for student evaluation, the following procedures are required in addition to those in the General Section of the Specific Programs and Procedures for students enrolled in public school programs. If a student is transferring from an agency that provides services to emotionally handicapped students, the requirements in Rule 6A-6.03016(5), FAC, are waived:
• Review of social, psychological, medical, and achievement data in the student’s educational records
• Review of attendance records and, where appropriate, investigation of reasons for excessive absenteeism; and
• Screening for vision, hearing, speech and language functioning.

B. Student Evaluation

The minimum evaluation for determining eligibility for EH or SED shall include all information collected in Rule 6A-6.03016(5), FAC, and the following:

• A medical evaluation when determined by the administrator of the exceptional student program or designee that the behavioral problem may be precipitated by a physical problem;
• A comprehensive psychological evaluation conducted in accordance with Rule 6A-6.0331(1)(a), FAC, or by a psychiatrist which shall include the following information: an individual evaluation of intellectual ability and potential; an evaluation of the student’s personality and attitudes; and behavioral observations and interview data relative to the problems described in the referral;
• An educational evaluation which includes information on the student’s academic strengths and weaknesses; and
• A social or developmental history, which has been compiled directly from the parent or guardian.

For students enrolled in EH programs the minimum evaluation for determining eligibility for SED programs include evidence of the following procedures:

• Conferences concerning the student’s specific problem in the program for emotionally handicapped;
• Anecdotal records or behavioral observations made by more than one person in more than one situation which cite the specific problems causing the need for an SED program;
• Interventions and adjustments that have been tried with the student while enrolled in the EH program;
• An update of the social history required by Rule 6A-6.03016(6)(a)4, FAC; and additional psychological, psychiatric or other evaluations deemed appropriate by the administrator of the exceptional student education programs.

Evaluations or tests administered may include but are not limited to:
• Medical Evaluation
• Comprehensive Psychological Evaluation
• Intellectual Functioning
• Personality and Attitudes
• Behavioral Observations and Interview Data:
• Educational Evaluation
• Social or Developmental History
IV. Dismissal Criteria for EH/SED Students

A. Considerations for Dismissal

Dependent upon the circumstances, dismissal from a special program occurs as a result of either a formal staffing or an Individual Education Plan (IEP) team meeting. A student is considered for dismissal when:

- The student has mastered social/emotional behavioral goals and objectives as stated on the IEP;
- The student has demonstrated socialization skills;
- The student’s performance indicates a need for a program change because the student exhibits willingness, adequate adjustment during the time the student spends in the regular program, interest in academic areas, ability to take responsibility for his/her own learning, and the ability to sustain independent learning activities; and
- The reevaluation results and IEP team findings indicate placement in a regular education program is in the best interest of the student.

CHAPTER II

CHARACTERISTICS OF STUDENTS IDENTIFIED AS EH/SED
CHARACTERISTICS OF STUDENTS IDENTIFIED AS EH/SED

Students placed in special needs programs have exhibited persistent maladaptive behaviors that interfere with their ability to function in the general educational setting. There are numerous contributing factors underlying these behaviors.

The purpose of this chapter is to increase awareness of the etiology of the disorder, behaviors associated with the disorder, common medications for specific mental disorders and possible side effects contributing to classroom behaviors. These factors are critical to understanding the student identified as EH or SED and working effectively with these challenging behaviors.

I. Disorders Common to EH/SED Students

A. Anxiety Disorders

Some of the anxiety disorders diagnosed in these students include the following: Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Social Phobia and Generalized Anxiety Disorder. These students are excessively anxious and fearful. They are often tired because of disturbed sleep patterns and find it difficult to concentrate due to a preoccupation with worrisome thoughts. These children and adolescents may be socially withdrawn as a result of a fear of social situations. Everyday challenges are often overwhelming and exaggerated. They are often overly conforming and perfectionistic, and erase or redo assignments over and over again because of dissatisfaction with less than perfect results. Their emotional distress frequently causes physical problems such as headaches and stomachaches.

B. Mood Disorders

Some of the mood disorders typically diagnosed in these students include the following: Bipolar Disorder, Depression and Dysthymia. The predominant features of these disorders are disturbed, unstable moods, ranging from severe depression to elation. Lack of energy and fatigue are common. They may have difficulty concentrating and show little interest or pleasure in anything. Students with these disorders may have thoughts of death or suicide. Those students with Bipolar Disorder may experience a manic period during which they exhibit an inflated self-esteem, increased agitation and energy. They may have difficulty controlling their thoughts and talk excessively or too loudly.

C. Personality Disorders

Some common diagnoses in these students include the following: Borderline, Narcissistic, Anti-Social and Schizoid Personality Disorders. Students with these disorders exhibit a pattern of behavior, which is out of sync with societal expectations.
Their interpersonal functioning is often impaired and the intensity and range of their emotional responses are inappropriate. These students often lack empathy and have difficulty maintaining relationships. Both adults and peers often dislike them. Students with a schizoid disorder typically show little emotion or interest in others, often preferring solitary activities. They often appear odd because of unusual mannerisms, preoccupations and a lack of social skills.

D. Pervasive Developmental Disorders

Students with Pervasive Developmental Disorders exhibit severe and pervasive impairment in several areas of development, such as social interaction skills, communication skills, interests and activities. These disorders are sometimes accompanied by other medical conditions such as chromosomal abnormalities or abnormalities of the central nervous system. Asperger’s Disorder is commonly diagnosed in these students. They have difficulty making friends their own age and lack social or emotional reciprocity. Their mannerisms are often odd, repetitive and stereotyped. Making eye contact is difficult. They may be preoccupied with parts of objects and have an intense focus on an unusual area of interest.

E. Attention-Deficit Hyperactivity Disorder

The predominant feature of this disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more severe and frequently manifested in individuals their age. The student with this disorder has difficulty attending to details and makes careless mistakes. Their schoolwork is often messy and done quickly and carelessly. They move from one activity to another, rarely following through to completion. Students with this disorder are often disorganized and easily distracted by irrelevant stimuli. Impulsivity is often manifested by impatience, difficulty awaiting one’s turn, or interrupting excessively. They lack social skills and are often unpopular among their peers.

F. Conduct Disorder

This disorder is characterized by a persistent and repetitive pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These children and adolescents are bullies and frequently threaten and intimidate their classmates. Some are physically cruel to animals. Individuals with this disorder have little to no empathy, and show no remorse after violating the rights and feelings of others. They are deceitful and “con” others to obtain material things or avoid obligations. Their peers are often afraid of them. This behavior seriously impairs the student’s social and academic functioning.

G. Psychotic Disorders

Psychotic Disorders include the following: Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder and Brief Psychotic Disorder. The predominant feature of these disorders is the presence of delusions and hallucinations. The duration and severity of the episodes vary with each disorder. Individuals suffering from Psychotic Disorders are often incoherent and appear bizarre. They may experience “command” hallucinations,
such as voices telling them to hit someone. They may see monsters or hear the walls and furniture talking. Their thoughts are disorganized and may be paranoid in nature. They may believe that a classmate or teacher is trying to poison them. The severity of symptoms makes it difficult for the student to function socially and academically.

II. Medications

A. Treatment

The majority of students identified as EH/SED are treated with medication. Psychotropic medications are drugs prescribed to stabilize mood, improve mental status and modify behavior. Some drugs may be used for more than one purpose. Many have unintended side effects such as nausea, dizziness, dry mouth or sleepiness. The following are examples of medications used to treat psychiatric conditions:

<table>
<thead>
<tr>
<th>Therapeutic Action</th>
<th>Effect</th>
<th>Examples of Drugs (Generic &amp; Brand Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>Elevates mood in people who are depressed</td>
<td>fluoxetine (Prozac)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>paroxetine (Paxil)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sertraline (Zoloft)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>imipramine (Tofranil)</td>
</tr>
<tr>
<td>Anti-anxiety</td>
<td>Used to treat anxiety disorders and reduce anxiety symptoms</td>
<td>clonazepam (Klonapin)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lorazepam (Ativan)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>buspirone (BuSpar)</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>Reduces mood swings in individuals with manic-depressive illness</td>
<td>carbamazepine (Tegretol)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lithium (Lithionate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>valproic acid (Depakene, Depakote)</td>
</tr>
<tr>
<td>Anti-Psychotic Drugs, or</td>
<td>Used to treat psychotic disorders such as schizophrenia. Reduces psychotic symptoms such as hallucinations.</td>
<td>haloperidol (Haldol)</td>
</tr>
<tr>
<td>“Neuroleptics”*</td>
<td></td>
<td>risperidone (Risperdal)*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>olanzapine (Zyprexa)*</td>
</tr>
<tr>
<td>Stimulants</td>
<td>Treats Attention-Deficit Hyperactivity Disorder</td>
<td>methyphenidate (Ritalin)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dextroamphetamine (Dexedrine)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pemoline (Cylert)</td>
</tr>
<tr>
<td>Beta Blockers</td>
<td>Treats some forms of severe aggression</td>
<td>propanolol (Indural)</td>
</tr>
<tr>
<td>Opiate Blockers</td>
<td>Treats some forms of self-injurious behavior</td>
<td>naltrexone (RiVe)</td>
</tr>
</tbody>
</table>

*Some newer forms of neuroleptics have recently been developed and are sometimes referred to as the “atypical neuroleptics.” An example is the drug risperidone (Risperdal).
### B. Four Types of Psychotropic Medication and Possible Classroom Effects:

<table>
<thead>
<tr>
<th>Class of Drugs</th>
<th>Examples</th>
<th>Possible Classroom Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stimulants</strong></td>
<td>Ritalin (methylphenidate)</td>
<td>Increased attention and decreased need for teacher control; effects usually evident within the first hour or two after ingestion; effects may last for up to eight hours with time-release capsules; possible side effects include headaches, stomachaches, or increased irritability; too high dosage can decrease learning.</td>
</tr>
<tr>
<td></td>
<td>Dexedrine (dextroamphetamine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cylert (pemoline)</td>
<td></td>
</tr>
<tr>
<td><strong>Neuroleptics or antipsychotics</strong></td>
<td>Mellaril (thioridazine)</td>
<td>Effects usually gradual; decreased aggression or agitation and decreased hallucination within days; increased socialization within three to four weeks; decreased thought disorder within two months; side effects may include tremors, drowsiness, decreased attention.</td>
</tr>
<tr>
<td>(major tranquilizers)</td>
<td>Prolixin (fluphenazine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haldol (haloperidol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Navane (thiothixene)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risperdal (risperidene)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zyprexa (olanzapine)</td>
<td></td>
</tr>
<tr>
<td><strong>Antidepressants or mood stabilizers</strong></td>
<td>Tofranil (imipramine)</td>
<td>Classroom effects not yet extensively studied; may increase communication and attention to tasks, decrease disruptiveness; effects may not be seen for two to three weeks; side effects vary widely with drug.</td>
</tr>
<tr>
<td></td>
<td>Prozac (fluoxetine)</td>
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<tr>
<td></td>
<td>Wellbutrim (bupropion)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lituonate (lithium)</td>
<td></td>
</tr>
<tr>
<td><strong>Anxiolytics</strong></td>
<td>Luminal (phenobarbital)</td>
<td>Effects evident in a day or not for weeks, depending on type of seizure and drug; primary objective is decrease in frequency of seizure; side effects may include drowsiness, irritability, hyperactivity, aggression, and impairment of memory or thinking; these drugs may sometimes also be used as mood stabilizers in some children who do not respond to lithium.</td>
</tr>
<tr>
<td></td>
<td>Tegretol (carbamazepine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zarontin (ethosuximide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Valproate (valporic acid)</td>
<td></td>
</tr>
</tbody>
</table>

For more information about medications, refer to The Physician’s Desk Reference ("PDR") online at [www.pdrhealth.com](http://www.pdrhealth.com).
III. Contributing Factors to Emotional and Behavioral Disorders

A. Biological Factors

Some of the biological factors that may contribute to emotional and behavioral disorders include genetics, brain damage or dysfunction, and temperament. Genetics are known, for example, to be involved in causing schizophrenia. Environmental stressors appear to trigger schizophrenia in students who are genetically vulnerable. Autism is now recognized as a brain disorder, although the exact nature of the dysfunction is not yet understood. Learning disabilities and the associated problems of hyperactivity, impulsivity, and inattention have also been assumed to be caused by brain injury or dysfunction. Temperament is considered to be biological in nature. It is important to note, however, that biological influences do not operate in isolation to cause emotional or behavioral disorders. Although their influences are pervasive, they affect behavior only in complex interaction with environmental factors (Kauffman, 2001).

B. Family/Environmental Factors

Family factors alone do not account for student’s problem behaviors, but they do play an important role. Parental discipline has a significant influence on behavioral development. Conflict and coercion, for example, are known to increase a child’s or adolescent’s risk for developing an emotional or behavioral disorder. Ineffective discipline often involves harshness, laxness or inconsistency. Family structure, by itself, appears to contribute relatively little to a student’s difficulties. Divorce does not usually produce chronic behavior problems in children and adolescents, although temporary negative effects can be expected. Other external factors such as poverty, abuse and malnutrition can have profound long-term effects on a student’s cognitive, physical and emotional development. The popular belief that many emotional and behavioral disorders are caused by diet or allergies has not been supported by current research. Students who are abused are at risk for a full range of emotional and behavioral disorders, including both internalizing problems such as depression, and externalizing problems such as conduct disorder (Kauffman, 2001).

IV. Expectations

An important task of those working with students identified as EH/SED is to develop realistic expectations. A realistic approach involves consideration of those contributing factors, which account for the student’s behavior and an awareness of those factors which can be altered by environment and experience. It is the educator’s responsibility to ensure that no further disservice is inflicted upon the student by expecting too little or too much. Finding a level of expectation for oneself and others that fosters personal growth and facilitates change is essential to achieving success when working with behavior disordered students. Those whose expectations are either self-serving or self-sacrificing will more than likely fail, and do little to contribute to positive change. Behavior is predictable and manageable, and enough controlled factors can be developed in the classroom to produce therapeutic results. Experiences can be enhanced and supplemented to improve the student’s competencies and to foster the development of more appropriate behaviors in spite of unalterable past and present circumstances.

CHAPTER III

PROGRAM MODELS
PROGRAM MODELS

The purpose of this chapter is to describe the organizational structure of EH and SED program models in M-DCPS. Programs vary in size, setting, and the services provided. Components included in all programs are individualized curriculum, a comprehensive treatment program, instructional and clinical staff, parent education/support programs, and supplies and resources.

Each student with a disability is entitled to receive a free appropriate public education in the least restrictive environment (LRE) and to access the general curriculum to the maximum extent appropriate. Special education and related services are designed to meet the unique needs of the student. They include specially designed instruction, supportive services, and accommodations and modifications as needed by the student. A range of service delivery options is available to meet the student’s special needs. Teachers are trained to provide the unique services identified for each student and are provided with administrative support to assure reasonable class size, adequate funds for materials, and in-service training.

The program models for students identified as EH and SED are designed to establish an effective learning environment for students whose emotional challenges interfere with learning in the general education classroom setting. Students are provided with a highly structured and supportive environment to assist them in reaching their academic goals.

I. Educational Component

A. Academic Curriculum

The curriculum for each student with a disability is determined by the IEP team and initiated with the assumption of access to the general curriculum (Sunshine State Standards) with appropriate accommodations. The Sunshine State Standards for Special Diplomas provide curriculum direction for the modification of the Sunshine State Standards and other educational needs that are needed by most students with disabilities.

The Competency-Based Curriculum (CBC) takes into consideration the student’s learning characteristics and individual needs. The teacher utilizes the curriculum to help students improve, strengthen, and attain competencies that will facilitate the ability of students to think, analyze, solve problems, and do independent and creative work. Curriculum adaptations focusing on the affective domain, career awareness, and vocational skills shall be developed and implemented as a part of the curriculum. Affective education covers social skills that are taught to students to help develop successful relationships with peers, parents, and teachers.

Students will work on the following skill areas: cooperation, assertion, communication, empathy, and self-control.

The curriculum in EH and SED programs is individualized to assist each student in accessing his education. Each student is evaluated using a standardized test such as the Woodcock-Johnson or the Kauffman Test of Educational Achievement to establish
academic levels or grade equivalencies. Teacher observation is a large component in designing the student’s academic needs. Lesson plans are based on the goals and benchmarks listed on the IEP which are derived from the student’s Priority Educational Needs (PENS). Instructional goals reference the CBC. Lesson plans include goals, activities, evaluation techniques and home learning.

B. High School Diploma Options

Students with disabilities have the option of pursuing either a standard high school diploma or a special diploma. If unable to meet the requirements of either diploma, the student may be eligible to receive a certificate of completion or special certificate of completion. Students with disabilities awarded a special diploma, certificate of completion, or special certificate of completion may elect to continue participating in school and receive services until they earn a standard diploma, or through the end of the school year during which they reach 22 years of age. A student may switch from a standard diploma to a special diploma and receive credit towards a special diploma for passing general education courses. Students may switch from a special diploma to a standard diploma and receive elective credit towards a standard diploma for passing exceptional student educational courses. The various diploma options are outlined below.

- **Standard Diploma**

  Graduation requirements for a standard diploma include: earning a passing score on the Florida Comprehensive Assessment Test (FCAT), demonstrating computer literacy, completing a community service project, and earning a cumulative grade point average of 2.0. All students with disabilities may be given the opportunity to meet the requirements for a standard diploma. Under special circumstances, the IEP team may waive the FCAT requirement.

  Students pursuing a standard diploma have three options: 1) the 18 credit college preparatory accelerated option; 2) the 18 credit career preparatory accelerated option; and 3) the traditional 24 credit option.

  The standard diploma offers the most advantages following graduation. This diploma is recognized by employers, accepted by vocational schools and colleges, and recognized by military recruiters.

- **Special Diploma**

  A special diploma certifies that the student has mastered the student performance standards for exceptional students (Sunshine State Standards for Special Diploma) and specified district course/credit requirements. A 2.0 grade point average will determine mastery of standards. Students cannot attain a special diploma through either of the 18 credit options. This diploma is accepted by community colleges for most vocational/technical programs. Military recruiters may not accept it. Students awarded a special diploma may continue to work towards a standard diploma.
• **Certificate of Completion**

A certificate of completion certifies that the student passed the required courses in high school but failed to pass the FCAT or achieve the required grade point average. This certificate is not a high school diploma. It is accepted by community colleges for most vocational/technical programs. It is not accepted by some military recruiters and not recognized by employers. Students awarded a certificate of completion may continue to work towards a standard diploma.

• **Special Certificate of Completion**

A special certificate of completion certifies that the student passed the required ESE courses in high school, but failed to master the Student Performance Standards or Sunshine State Standards for a special diploma. It is not a high school diploma and not accepted by community colleges (provisional enrollment may be allowed). This certificate is not accepted by the military, is not recognized by employers, and may not be accepted by vocational schools. Students awarded this special certificate may continue to work towards a standard diploma.

C. **Inclusion**

The reauthorization of the Individuals with Disabilities Education Act (IDEA) in 1997 focused on the requirement that students with disabilities be involved and progress in the general curriculum. To achieve this goal, students with disabilities must receive needed supplementary aids, services and supports within the general education class “to enable children with disabilities to be educated with non-disabled children to the maximum extent appropriate.”

Supports may include providing accommodations and/or modifications, the use of instructional and assistive technology, or offering individual assistance from other people including peers and staff. The IEP team determines the individual student support needs and the least restrictive environment in which students can meet their IEP goals. Documented communication between the EH/SED staff and the general education teacher is essential for success. The challenge is to find a balance between creating a stimulating learning environment and providing the necessary support needs for the students.

II. **Treatment Component**

A. **Behavioral, Social and Emotional PENS, Goals and Benchmarks**

Behavioral, social and emotional goals and benchmarks are part of the student’s IEP and are recorded on Insert B of the IEP. They are derived from the student’s PENS. Once the student’s PENS have been identified, the clinical staff collaborates with the teacher(s) to design goals and benchmarks, which address both the student's behaviors and therapeutic needs that interfere with learning. Individualized target behaviors along with social and emotional goals and benchmarks are documented on the student's IEP (Insert B and/or Insert C) using behavioral language that is quantifiable and measurable. As the student
masters these goals and benchmarks, the clinical staff and classroom teacher reassess them and document the student's progress and mastery.

B. Staff Meetings

Staff meetings are scheduled weekly or bi-weekly and consist of the following:

- Student case conferences on selected students
- Discussion of teacher/parent contacts and parent concerns
- Review of issues related to behavior management techniques
- Reinforcement strategies
- Discussion of program’s extra-curricular activities
- Review of teachers’ and clinicians’ concerns
- Review of inclusion activities and student’s progress
- Review and update of targeted behaviors

C. Case Conferences and Functional Assessments of Behavior (FAB)

Student case conferences are an integral part of the educational/treatment plan for students identified as EH/SED. They are to take place regularly to plan and facilitate strategies and interventions for students. The progress and needs of each student as well as the immediacy of their needs and/or changes in their progress are factors to consider when scheduling case conferences. Students must have a Functional Assessment of Behavior (FAB) and a Behavioral Intervention Plan (BIP). The case conference schedule should be developed with sufficient advance notice to allow the counselor, social worker, psychologist, art therapist and teacher to be prepared to give input on the relevant sections of the Student Case Conference/Review form prior to the meeting.

D. Crisis Plan

EH/SED programs may encounter crisis situations, which require efficient, effective action by staff members. In order to facilitate the appropriate action during a crisis, EH/SED program personnel are to develop a crisis plan. The crisis plan should include a description of possible crisis situations, the specific steps to follow, and the roles of each staff member in following the plan. A periodic review of the crisis plan should take place each school year during the weekly case conference or team meeting. (See Chapter IX, Appendix, for a sample Crisis Plan).

III. Staff Component

The staff in EH/SED programs are comprised of clinical and instructional components. Woven into the learning environment is an affective approach to instruction that addresses students’ social, emotional and behavioral needs that impact their ability to access their education.
A. **Instructional Staff**

There are several different models for students housed in self-contained EH/SED classrooms. Some models adopt a teacher-teacher format wherein two teachers work together in a single classroom. Other models use a teacher-paraprofessional format that utilizes a single teacher per classroom and the assistance of a paraprofessional. Some programs also have a Behavior Management Teacher (BMT) who coordinates the program and offers daily support to both students and staff.

B. **Clinical Staff**

Programs for students identified as SED have a full-time clinical social worker or school psychologist/clinical psychologist based at the school site and a consulting psychiatrist. Programs for students identified as EH have counseling services provided on a contractual basis by outside agencies, or services provided by M-DCPS personnel. Some programs may have a part-time or a full-time clinical art therapist servicing select students who meet criteria for this non-traditional approach to therapy. Whereas social workers, counselors and psychologists provide a traditional modality of intervention, art therapists use the creative process to help individuals reconcile emotional conflicts and foster self-awareness. Family involvement is an integral part of the treatment planning. Monthly parent education sessions are offered to parents of students identified as SED.

All staff members have roles that complement the learning environment of the students. Working together as a team is crucial to a well functioning program. Although roles are diverse and specialized, the staff functions as a whole with a unified purpose.

IV. **Family Involvement**

A. **Parent Support**

The staff at each site integrates parent education/support into their program. A formal needs assessment may be conducted to determine the most appropriate delivery model for services. In addition, consultation with parents is provided on an as-needed basis. Social workers, psychologists or counselors working with an elementary or secondary population may find certain topics such as normal child/adolescent development, limit setting, community agencies, and drug education important subjects to cover during parent support/education groups. Schedules may need to be adjusted to provide hours outside of the school day to meet the needs of parents and families.

B. **Parent Participation**

Coordination between the home and school is an important part of a student’s success in the program. A student’s progress is greatly enhanced by the involvement and support of his/her family. Ways that parents can participate in the educational environment of their child include:
• Meeting with the staff as requested or as needed
• Conferencing with staff either via telephone or in person as needed
• Attending Open House each school year
• Attending parent/child counseling sessions
• Supporting the program objectives at home
• Ensuring consistent student attendance/participation in the program
• Signing any behavior contracts necessary to address specific behaviors
• Supporting the staff with the behavior modification program
• Following through with staff/therapist recommendations regarding crisis intervention strategies, medication management, and notifying staff of any changes in medication
• Contacting therapist/staff regarding community resources, funding and services that may be available to your family

C. Community Resources

Referrals to outside community agencies are often needed to enhance the student’s educational program. A list of services providing community family support, assistance and/or resources for specific needs may provide families with the information they need to increase their effectiveness as parents. Parents will often need the assistance of clinical personnel or the BMT to intervene on their behalf with community agencies. (See Chapter VII, Community Resources, for a complete list).

V. Physical Layout

A. Classroom area

Each classroom should have at least two exits and provide privacy with minimal distractions. Shared space is not recommended. The square footage of the classroom must meet the requirements of the number of students as well as the specific needs of the EH/SED student. Classroom structure for elementary, middle and high school may differ depending upon the needs of the students. A suggested classroom design may include:

• A central work area consisting of teacher and student desks facing a blackboard designed for group and individual instruction
• Additional bulletin boards placed in other areas of the room as needed
• Adequate storage space in each classroom
• Learning centers for individual and small group activities
• Activity center for hands-on experiences relating to subject matter
• Quiet study center that provides students with an area for individual time with minimal distractions
• Library center for individual use
• Time-out area
• Communication center with display space on walls designated for classroom schedule, expectations, rules and point system
B. Social Worker/Counselor/Psychologist’s Space

A private, well lit office with adequate space for individual and group counseling is required. The office must include locking file cabinets to secure confidential records.

C. Art Therapist’s Space

A private, well-lit office with adequate space for individual and small group art therapy sessions is required. Also needed is a locked filing cabinet to secure confidential records as well as a locked storage cabinet for supplies.

VI. Supplies and Resources

A. Textbooks/Materials

Each individual student is provided with course textbooks and any needed supplementary materials. Textbooks used reflect the subject matter and correspond with the individual school’s textbooks and curriculum. State adopted textbooks are required, as well as any supplementary materials needed for individual instruction. Each teacher is provided with a teacher’s edition for any text used, and any necessary resource materials. The school provides textbooks and materials. Internet resources are available.

B. Support Staff Supplies

Materials and supplies for the counselors, social workers, psychologists and art therapists are needed to support EH/SED programs. Clinical staff members assigned to schools throughout the District are to order needed materials through their respective chairpersons on a yearly basis. EH counselors and BMTs are to contact their schools directly for supplies and materials.

C. Equipment

Equipment is necessary for successful individual instruction and to meet the multiple needs of the classroom teacher. The following program equipment is recommended:

- Computers, printers and software
- CD player and headphones
- TV and VCR/DVD player
- Student and teacher desks (adequate number per room)
- Table and chairs (one set per room)
- Chalkboard and whiteboard (one each per room)
- Geographical maps (one set per classroom), and a globe
- Flag (one per classroom)
- Clock (one per classroom)
- Secure file cabinet (at least one per classroom/office)
- Telephones and/or two-way radios for emergency communication
VII. Team Mediation

Programs for students identified, as EH/SED are multidisciplinary in nature and involve a team approach. Professionalism, mutual trust and interdependence are vital to maintaining a strong and well functioning program. Periodic team building activities are recommended. At times, however, a member of the team may experience personal or professional problems that affect job performance. This may have long-term effects if it becomes a divisive element.

Students are often aware of the friction and may respond with acting out behaviors, anxiety or staff splitting. It is at this time that action needs to be taken. The place to address concerns should proceed in the following order until the problem is resolved:

- Individual staff members attempt to resolve differences.
- Issues are discussed at the weekly staff meeting.
- The group meets with the ESE Department Head and/or ESE Program Specialist.
- The individuals meet with the appropriate supervisor.
- All concerned individuals meet with administrators from the school.

VIII. Program Models in M-DCPS

A. M-DCPS Elementary, Middle and Senior High School Models

There are several EH/SED programs housed in elementary, middle and senior high schools throughout M-DCPS, which share common structures and program philosophies. The goal of these selected programs is to help students with emotional/behavior problems achieve academic success and transition back into the general education setting. Program components include:

- Highly structured behavior support system
- A teacher with support from another source such as another teacher or paraprofessional
- Individual and group therapy provided by either a contracted or M-DCPS clinical or school psychologist, clinical social worker, EH counselor and M-DCPS clinical art therapist
- BMTs (selected programs only)
- Parent support programs
- Inclusion options
- Psychiatric consultation (SED only)

B. Bertha Abess Children’s Center Model

The Bertha Abess Children’s Center (BACC) provides comprehensive day treatment programs for EH and SED students, ages three through 22. A cooperative agreement with
the University of Miami School of Medicine provides training opportunities for psychiatric fellows, and faculty members provide regularly scheduled consultation to BACC programs. A cooperative agreement with M-DCPS provides teaching staff, curricular materials, transportation, and facilities. All students are staffed through the M-DCPS ESE Department.

Clinicians are hired by BACC and provide affective education through group and individual therapies. At selected sites M-DCPS clinical art therapists offer individual and small group art therapy services. A program of Parent Education and Training (PET) is provided, with follow-up parent support groups and family therapy.

C. Center Schools

Ruth Owens Kruse Educational Center and Robert Renick Educational Center are specialized schools designed to provide a structured, therapeutic educational setting for middle and senior high students identified as EH and SED. The goals of the programs are to enable students to increase self-control, develop more appropriate social skills and progress to a less restrictive learning environment. The overall structure of the schools includes:

- Two teachers for 10-12 students
- School-wide behavior management plan
- Block scheduling
- Clinical services infused throughout the school day
- Psychiatric consultation and medication management

D. ESE Outreach Programs

The Miami-Dade Department of Human Services, Psychological Services Division entered into a cooperative agreement with M-DCPS in 1982 to provide day treatment services to children and adolescents identified as SED. There are currently four programs in operation.

There are significant similarities between the programs, although differences are keyed to the specific population needs and developmental issues unique to the nature and degree of the exceptionality. The goals of the programs overlap and are aimed at improving family functioning while increasing the social, psychological and academic functioning of the student. The Miami-Dade Department of Human Services provides administrative components, clinical psychologists, clinical social workers, interns and physical facilities. M-DCPS provides clinical art therapists, special education teachers and paraprofessionals. Each program offers family therapy, weekly and individual group therapy and art therapy. A behavior modification substrate is integrated into the daily activities.

The four Day Treatment Programs are:

- Early intervention Development Center (EIDC)
  Provides services to children from age five to 12 of average intellectual
ability.

- Family and Children’s Development Center (FCDC)
  Serves SED children of average intelligence, ages five to 12.
- Specialized Development Center-North (SDC-N)
- Specialized Development Center-South (SDC-S)

Both SDC programs serve SED children, adolescents and young adults, ages five to 22, who are also diagnosed as Educable Mentally Handicapped (EMH) (IQ’s from 40-75).

E. TOPS Program Model

Teaching Outreach, Parent Support (TOPS) is a program serving elementary-aged SED students through a school/mental health agency collaborative model. There are currently two programs: one at Ludlam Elementary School and the other at Howard Drive Elementary School. The program structure includes:

- A highly structured behavior management system
- Multi-Disciplinary Team including psychologists, agency therapists, clinical art therapists, educational support staff and teachers
- Diagnostic and psycho-educational evaluations
- Individual and group therapy
- Family consultation and support
- Agency therapists who provide day and evening services
- Psychiatric consultation

F. Vocational School Program Model

There are currently five vocational school programs available to high school students with emotional and behavioral problems to help them negotiate a successful transition from school to work. The programs are as follows:

- Robert Morgan Educational Center (STEPS TO SUCCESS)-Offers therapeutic services, curriculum focusing on workplace and independent living skills, school to work transitional planning and community outreach activities.
- BACC STARTEC Program-Provides treatment-oriented, individualized transition and support services such as life coaching, employment supports to assist them in completing high school, budgeting and maintaining a residence, and gaining and establishing positive relationships at work and in the community.
- Barbara Goleman Vocational Program-This joint program with Florida International University offers Domestic Wiring training. Upon completion of 180 hours students receive 3 college credits and a Certificate as an Electrical Engineer Apprentice. A Computer Design class is also available.
- Lindsey Hopkins Technical Center-A dual enrollment program with currently 120 students from 13 high school participating. Students are bussed from their home schools to Lindsey Hopkins in the morning and return to their home school for the remainder of the day. Upon completion of selected courses students receive high school and adult education credits.
G. Alternative Education Programs

The following programs for students identified as EH/SED whose inappropriate behavior and lack of interest in education interfere with their ability to function in the traditional school setting:

- Jan Mann Opportunity School
- JRE Lee Opportunity School
- Miami Douglas MacArthur Senior High School North
- Miami Douglas MacArthur Senior High School South

A student must exhibit the following characteristics in order to be eligible for these programs:

- The student displays behavior that interferes with the student’s own learning or the educational process of others, and requires attention and assistance beyond that which the traditional program can provide as evidenced by five or more referrals.
- The student has a history of disruptive behavior in school, either in or out of class, which warrants suspension as evidenced by three or more documented infractions.

ESE students who meet the program eligibility criteria may be considered for placement. An IEP team, which includes a representative from the Office of Alternative Education must meet to review the student’s records prior to placement in an alternative education program.

The Office of Alternative Education also offers Teenage Parent Programs to students identified as EH/SED students who are expecting or parenting. Academic classes and auxiliary services are provided to meet the special needs of the students so that they can continue their educational program. These services include health care, social services, childcare and transportation. The curriculum includes instruction in topics such as prenatal and postnatal care, parenting skills, benefits of sexual abstinence, and consequences of subsequent pregnancies. The following programs are offered to EH/SED students:

- C.O.P.E. Center North (Continuing Opportunities for Purposeful Education)
- Dorothy M. Wallace Center C.O.P.E. Center South

The student must meet the following eligibility criteria to be eligible for these programs:

- An expectant youth or school-age parent,
- A school-age parent requesting initial enrollment, continued enrollment, or re-enrollment due to child care problems, or specialized curriculum needs, and
- Children of teen parents enrolled or who have been enrolled in a teen parent program are eligible to receive childcare, health care, social services, and transportation as long as the parent is enrolled in school.
ESE students who meet the program eligibility criteria will be considered for placement. An IEP team, which includes a representative from the Office of Alternative Education, must meet to review the student’s records prior to placement.
CHAPTER IV

PROGRAM MANAGEMENT AND SUPPORT SYSTEM
Most students with emotional and behavioral challenges have a history of negative school experiences. They lack the motivation to learn and skills to actively engage in the learning process. In order for them to develop a positive perception about school they need to have positive school experiences associated with social and academic success. Only then is it likely that their negative thoughts and feelings about school will be replaced with positive ones. This will enhance the development of an intrinsic motivation to positively engage in the learning process, which will result in improved behavior. (Center for Mental Health in Schools, 2004).

The behavior support system is designed to help students with this process. The goal is to reduce behavior problems that interfere with a student’s ability to maximize his educational experience. Staff and students work within a structured framework to implement strategies that focus on reinforcing positive behaviors and teaching social skills to replace the negative, problem behaviors. A positive classroom environment that establishes clear expectations, a sense of safety, fair and consistent consequences and mutual respect is critical to the success of a behavior support system. Teachers and paraprofessionals must understand the system and implement it consistently throughout the school day. An effective behavior support system is measured by the success of its students.

I. Creating a Positive Learning Environment

A positive learning environment is essential to facilitating behavioral change in students with emotional difficulties. Each teacher is responsible for setting a tone in the classroom that fosters personal growth and enhances the educational experience of each student in order to bring about positive behavioral change. The physical environment, daily routine and quality of the interaction between staff and students all play an important role in determining the effectiveness of the program. The following are key components to a positive learning environment:

- Teachers and paraprofessionals must maintain a positive, professional and respectful relationship with students at all times. Boundaries and limits should be clearly established.

- The classroom should be organized in a manner that provides safety, open access and visibility to all areas. The physical structure should facilitate instruction as well as classroom management and behavioral control.

- A stimulating, well organized and inviting classroom environment will foster a sense of well being and belonging while enhancing the educational experience for students.

- Classroom rules, expectations and consequences should be posted in a clear and concise manner and understood by all students. A running chart of positive student behaviors may serve as reinforcement.
A schedule of daily and weekly activities aids in fostering a predictable classroom routine.

Providing opportunities for students to share in classroom responsibilities will encourage pride and ownership in the learning environment.

Ongoing displays of the students’ successes will reinforce their sense of accomplishment and self-worth.

II. The Principles of Behavior

Educators need to understand that challenging behaviors are not always entirely attributed to a student’s disability or a deliberate attempt to behave badly. These students have learned inappropriate ways to get the same things other students are able to get in more appropriate ways. This behavior serves a function: to either get something or to escape or avoid something.

Understanding the principles of behavior and determining its function is essential to changing it. The following will help to define the principles of behavior (Florida’s Positive Behavior Support Project, University of South Florida, 2005, p. 3)

1. Understand the function (WHY) of behavior
2. Understanding comes from observations of ABCs
3. Behaviors are the result of antecedents and consequences
4. Behaviors tend to be repeated or discontinued because of their outcomes
5. Antecedents precede and increase the likelihood of behavior
6. Behavior is affected by its consequences
7. Behavior is strengthened by reinforcement
8. Behavior may be weakened by withholding consequences
9. Consequences should be consistent and immediate
10. Modeling can strengthen or weaken behavior

The Functional Assessment of Behavior (FAB)

The Functional Assessment of Behavior is a tool to help teachers and staff identify the function of the problem behavior. Once this is determined they can develop an intervention plan to teach the student appropriate replacement skills that serve the same function. This approach is instructional and addresses the skill deficits that often exist in students with challenging behavior. The process of conducting a FAB involves those individuals who know the student best. Each team member will have some responsibility for implementing, monitoring and, when necessary, revising the plan.

Behavior Intervention Plan (BIP)

The Behavior Intervention Plan (BIP) is designed to directly address the problem behavior. The intervention should match the function identified during the assessment process. Interventions
are separated into three categories: Proactive, Educative and Functional. Proactive interventions involve making simple environmental changes that make the problem behavior unnecessary. Educative interventions teach behaviors and/or skills that replace problem behaviors. Functional interventions establish how consequences are to be managed to ensure the student is reinforced for positive rather than problem behavior.

Defining Problem Behaviors

Each program is responsible for developing appropriate definitions of problem behaviors. What one teacher may view as a problem behavior, another may consider acceptable. For this reason, behaviors need to be operationally defined and categorized into major and minor problem behaviors and those incidents that would be considered a crisis. It is important that each team agrees on the definitions and is properly trained. Once this is established a distinction must be made between those problem behaviors that are to be managed in-house (minor) by program staff, those that are referred to administration (major), and crisis situations that would warrant an immediate response from administration and/or a crisis response team. (University of South Florida, Florida’s Positive Behavior Support Project, 2005, p. 26).

Discipline Referral Process

Once the team has defined and categorized problem behaviors, the next step is to design a discipline plan that clearly establishes consequences for specific behaviors. It is important that the consequences are appropriate to the behavior. The program staff should manage minor problems. In order for the plan to be effective, all staff must understand the discipline referral process and follow it consistently. (University of South Florida, Florida’s Positive Behavior Support Project, 2005, p. 29).

III. Preventative Strategies

Teachers are responsible for managing minor behavior problems within the classroom setting. The following strategies are useful in preventing behaviors from escalating. When used in a timely and consistent manner, these preventative strategies are effective tools to maintaining control over the classroom environment. The following material was taken from “Managing Surface Behaviors of Children in School,” written by Nicholas Long and Ruth G. Neuman.

A. Planned Ignoring

The staff member ignores the inappropriate behavior of a student while simultaneously reinforcing the appropriate behavior of other children. With planned ignoring, the child is monitored and reinforced when the first appropriate behavior occurs. Ignored behaviors will often exhaust themselves and the frequency of occurrence will diminish.

B. Proximity Control

The physical proximity of a non-threatening adult can lend support to a student who is having difficulty controlling problem behaviors. Staff members position themselves in
such a way to encourage appropriate behaviors. Contacts such as a hand on the shoulder or standing in close proximity to the student are ways to encourage appropriate behavior.

C. Signal Interference

This intervention involves the use of non-verbal techniques to communicate expectations to the student. These may include eye contact, hand gestures, snapping fingers, clearing one’s throat, frowns, and body postures. These signals serve to interrupt and remind the child that the behavior is inappropriate. This technique is most effective at the beginning stages of misbehavior.

D. Removing Distractions

Objects that distract the students should be removed from work areas. Certain objects have a magnetic appeal and, if visible, the student will be unable to resist the impulse to pick them up and play with them.

VERBAL INTERVENTIONS

Research has demonstrated that approximately 80% of the interactions that occur between teachers and students in classrooms are negative. Most frequently, these interactions are characterized by comments such as, “Stop that!” or “Don’t do that!” This constant barrage of negative comments produces a climate that interferes with the development of positive relationships between teachers and students. Teachers can create a more positive classroom environment by consciously employing the following strategies:

A. Peer Reinforcement

Praising other children for the behavior that you want the off-task student to exhibit uses peer reinforcement to socially reinforce on-task behavior.

B. Modeling

Modeling is another way of demonstrating to the off-task student the expected behavior. This can be accomplished either verbally or non-verbally, and involves showing or telling a student the behavior you expect. Modeling gives the student an alternative way to regain the teacher’s attention appropriately and receiving reinforcement. Either the teacher or another student may model the desired behavior.
C. Interest Boosting

A student can be motivated when the teacher demonstrates a genuine interest in the task. This intervention can also be used to tap a child’s knowledge base (such as sports, cars, etc.) when assigning tasks or redirecting him back to the activity at hand.

D. Hurdle Help (verbal clarification)

This intervention is used when the inappropriate behavior is the result of frustration with the task or activity at hand. The student does not understand what to do and rather than asking for help, chooses to engage in inappropriate behavior. By assisting the student with the assignment, or providing clarification of the assignment, the teacher can prevent problem behaviors.

E. Restructuring

At times it is helpful to change either the activity the student is assigned, or the location where he is working. Modifying the task often helps the student to continue to work successfully.

F. Changing the Scheduled Activity

Scheduled activities are sometimes inappropriate for the activity level of the group. Delaying or modifying the activity can facilitate successful completion.

G. Support from Routine

Students feel more secure and comfortable in a structured setting. A daily schedule that is routine and predictable is essential for preventing misbehavior.

H. Antiseptic Bouncing

Antiseptic bouncing involves the teacher removing the child for a short period of time from the potentially disruptive situation. The intent is not to punish the child but to prevent problem behaviors from occurring by giving him an errand to run or suggesting that he gets a drink of water.

I. Problem Solving

Problem solving is a way to avoid off-task behavior by identifying a solution to a particular problem. The teacher meets individually with the student to discuss the problem that is interfering with his work.

J. Time-out from the Activity

Time-out may be utilized to assist in de-escalation to student behavior. The student can use this time to regroup or refocus before returning to the activity in the classroom. A teacher or paraprofessional should monitor the time-out area. A student should never be left unattended during time-out. The time to be served should be short and should not
begin until the student has complied with the staff member’s instruction. (See Chapter 9, Forms and Sample Documentation, for a sample Time-out Log).

The Behavior Checklist is a useful tool to document problem behaviors and interventions attempted in the classroom to manage these behaviors. (See Chapter 9, Forms and Sample Documentation, for a sample Behavior Checklist).

IV. Behavior Contracts

An alternative for chronic behavior problems is a behavior contract between student, school staff, and/or parents. The purpose of the behavior contract is to identify behaviors and assist the student in focusing on those behaviors. Reinforcers and consequences for specified behaviors are clearly stated and agreed upon by all parties. Both contracting and off-level procedures are designed to promote self-control for the student and to supplement the behavior support system. (See Chapter 9, Forms and Sample Documentation, for a sample contract).

V. Level System

A major facet of the behavior management system is the Level System. The Level System requires the application of shaping behavior, where the goal is self-management. This system also provides a structure throughout the day where interventions that are used depend on student needs and program expectations.

Each level has replacement behaviors from the student’s BIP and IEP and is written on the student’s point sheet. Level 1 may have one to two classroom rules in addition to the student’s replacement behaviors. The remaining levels must have behaviors taken from the student’s BIP and IEP. Specified criterion levels must be built into the system based on the student’s individual needs, which are stated on the student’s IEP.

Earning points generates movement through the Level System. To be effective, points must be given consistently by all staff and accompanied by social reinforcement. Pairing the delivery of verbal praise with a description of the behavior increases the potency of the points and ensures that the student knows what he/she has done correctly. This also facilitates movement towards naturally occurring reinforcement and self-monitoring behavior.

Students can earn points from the moment they start school to the end of the day. Behaviors listed on the point sheet in addition to the student’s progress must be reviewed daily with the student by program staff. Staff and/or student monitoring procedures must be developed to ensure behavioral interventions are working. Point sheets should be collected at the end of each day and recorded on a Tracking Chart. (See Chapter 9, Forms and Sample Documentation, for a sample Tracking Chart).

Reinforcers or privileges for each level must also be determined. For reinforcers to be effective, they must function as a reinforcer for the individual students. What reinforces one student may not reinforce another. It is important to survey students to find out what
they like. These privileges may be individualized activities or material and social reinforcers.

A communication system to be used among special education and general education staff and parents must be developed. When students are included in general education classes, progress notes must be created by the program staff and given to general education teachers to monitor student behavior and completion of academic assignments. Student behavior and academic growth should also be reported to parents through daily or weekly progress notes.

VI. Level System and Articulation

When a student returns to a full-time EH or SED program following the end of the school year, they maintain their level status achieved during the year.

When a student moves from an elementary program to a middle school program or from a middle school program to a high school program, that student retains level status achieved during the previous school attended. The first nine weeks in the program will be considered a probationary period during which time the program staff will meet with each student to evaluate success within the system. If the student shows lack of progress on the level system, program staff must review and revise the student’s BIP, IEP, and replacement behaviors listed on the level system.

VII. Off-Level

Students enrolled in EH and SED classes often require consequences for inappropriate behavior. The Code of Student Conduct is the guideline for all student violations of behavior. Being placed off-level should not be viewed as punitive, but rather as an intervention that helps the student reflect on the severity of the behavior and regain self-control. The student is required to make the number of points needed for daily advancement and must do so for three consecutive days in order to be reinstated. The student is not eligible to earn reinforcers related to the Level System during the time he or she is “off-level”. When a student returns to the Level System, the student returns to the level and day that he or she was on prior to removal.

VIII. Self-Management

Self-management strategies involve teaching students how to manage their own behaviors. Students actively participate in the selection of the target behavior for improvement and behavioral goals. Furthermore, self-management leads to generalized behavior in all situations. Teacher control is minimal.
IX. Privileges and Reinforcements

The following privileges and reinforcements can be utilized with EH/SED students to increase probability of desirable behaviors.

### SUGGESTIONS FOR BEHAVIORAL REINFORCERS

<table>
<thead>
<tr>
<th>Elementary</th>
<th>Secondary</th>
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</thead>
<tbody>
<tr>
<td><strong>Social/Activity Reinforcers</strong></td>
<td><strong>Social/Activity Reinforcers</strong></td>
</tr>
<tr>
<td>• Play board or computer games</td>
<td>• Earn extra credit points</td>
</tr>
<tr>
<td>• Classroom jobs (line leader, chalkboard eraser)</td>
<td>• Earn coupons to be excused from an in-class or home-work assignment</td>
</tr>
<tr>
<td>• Teacher helper (pass out papers, take attendance to the office)</td>
<td>• Time to listen to music</td>
</tr>
<tr>
<td>• Choose preferred seating</td>
<td>• Time to read a book or magazine</td>
</tr>
<tr>
<td>• Extra recess or activity time</td>
<td>• Time to draw</td>
</tr>
<tr>
<td>• Drawing time at desk</td>
<td>• Be a coach’s assistant</td>
</tr>
<tr>
<td>• Coupons to excuse student from a homework assignment</td>
<td>• Read to or tutor younger students</td>
</tr>
<tr>
<td>• “Good News Note” to take home</td>
<td>• Be a teacher’s “assistant” to an elementary class</td>
</tr>
<tr>
<td>• Call parents to report a good day</td>
<td>• Be an office helper</td>
</tr>
<tr>
<td>• Use preferred equipment or materials in the classroom</td>
<td>• Be a library assistant</td>
</tr>
<tr>
<td>• Make a bulletin board</td>
<td>• Leave for lunch a few minutes early</td>
</tr>
<tr>
<td>• Extra library time</td>
<td>• Leave a few minutes early at the end of the day</td>
</tr>
<tr>
<td>• Office helper</td>
<td>• Leave for lunch a few minutes early</td>
</tr>
<tr>
<td>• Eat lunch with teacher</td>
<td>• Gym Time</td>
</tr>
<tr>
<td>• Visit the principal or counselor</td>
<td>• Play computer games</td>
</tr>
<tr>
<td>• Leave for lunch a few minutes early</td>
<td>• Field Trip(s)</td>
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<tr>
<td>• Blow Bubbles</td>
<td>• Field Trip(s)</td>
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<tr>
<td>• Play with friends</td>
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<tr>
<td>• Field Trip(s)</td>
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<table>
<thead>
<tr>
<th>Elementary Material Reinforcers</th>
<th>Secondary Material Reinforcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• School supplies</td>
<td>• School supplies</td>
</tr>
<tr>
<td>• Stickers</td>
<td>• Posters</td>
</tr>
<tr>
<td>• Small toy</td>
<td>• Books</td>
</tr>
<tr>
<td>• Posters</td>
<td>• Magazines</td>
</tr>
<tr>
<td>• Books</td>
<td>• Food Coupons</td>
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X. Bus Behavior Support System

Each EH and SED program should incorporate a Bus Behavior Support System into their program. This system should monitor behavior and reinforce self-control. A bus behavior management mini-workshop will enhance communication between the school program and transportation personnel.
XI. Six Guidelines for Avoiding and Defusing Confrontations

The following material was adapted from “A Teachers Guide to Cooperative Discipline” by Linda Albert. These guidelines are helpful intervention strategies that can be applied when the goal of the misbehavior is power and/or revenge.

1. **Focus on the behavior, NOT the student**
   a. Describe the behavior instead of evaluating it.
   b. Deal with the moment (forget what happened in the past.)
   c. Be firm and friendly.

2. **Take Charge of Negative Emotions**
   a. Control negative emotions.
   b. Release negative emotions.

3. **Avoid Escalating the Situation**
   a. This list of teacher behavior negatively affects the student’s sense of belonging and reduces self-esteem. Some encourage a more difficult student/teacher interaction that regresses from attention-seeking behaviors into power struggles; power issues to revenge behavior.

   - raising voice
   - yelling
   - saying “I’m the boss here”
   - having the last word
   - using tense body language
   - using “put downs”
   - using sarcasm
   - nagging
   - acting superior
   - using physical force
   - comparing student with others
   - having a double standard
   - rewarding the student
   - preaching
   - making assumptions
   - backing student into a corner
   - pleading or bribing
   - bringing up unrelated events
   - making generalized statements
   - unsubstantiated accusations
   - holding a grudge
   - attacking student’s character
   - throwing temper tantrums
   - mimicking the student
   - drawing unrelated parties into the conflict
   - command, demand, dominate
   - insisting that you’re right

4. **Discuss Misbehavior Later**
   a. Be direct, firm and friendly when applying appropriate interventions on misbehavior.
   b. Refrain from discussing the misbehavior or negotiating solutions.
5. **Allow Students to Save Face**
   a. Be flexible. Rigid expectations provoke confrontations that are more unpleasant than the original.

6. **Model Non-Aggressive Behaviors**
   a. When experiencing strong emotions and displaying aggressive behavior, postpone taking any disciplinary actions that are likely to be handled poorly.

XII. **Guidelines for Dealing with Potential Crises**

The following articles are from JKM Training, Inc. 2001 Safe Crisis Management Instructor’ Manual. These articles offer guidelines for defusing potential crises in the classroom. Included are strategies to manage emotionally charged situations, dealing with oppositional; and defiant behavior, and ways to avoid common traps set by emotionally challenging students.

**Formula for De-escalation**

Below are generic guidelines for dealing with youth during crisis. These suggestions are consistent with the literature and are generally agreed upon by recognized experts in the field. In application, the unique circumstances of each situation will shape actual intervention, as will the interaction style of the intervening adult.

**Assume a Calm Demeanor – You are in Charge!**
Your non-verbal and para-verbal communications are critical. Look calm. Be deliberate and confident (*not threatening or threatened*) in your movement. Assume a posture that is relaxed and open (*breath deeply*). Speak slowly and make eye contact.

**Listen**
Listen actively to what is being said. Pay attention to the youth’s non-verbal and para-verbal communication as they often contain the clues that will allow you to respond to the emotional content. Try to give legitimacy to the emotions that are being expressed. Allow time for some of the “emotion to drain off”. As the youth vents their anger, listen for hints about the central issue. Problem identification is one of your goals, but remember the present problem may not be the central issue. Attempt to get the youth to engage with you in problem solving by reflecting what they are saying. Have them verify your understanding of the problem.

**DO’S & DON’TS**
DON’T lead with the rules.
DON’T lead with the consequences.
DON’T begin statements with the words “You” or “Why”.

DO use positive expectations.
- “I know we can resolve this”.

DO use “I” statements.
- “I think we can…”
- “I am concerned about your behavior and I need you to slow down…”
- “I see you are mad, if you can calm down I think I can help…”

DO reflect the emotion you hear.
- “It’s obvious that you are really angry…”

DO try to direct the youth into a problem-solving mode.
- “I would like to understand, but the words are coming so fast, maybe you could slow down a little…”

Honestly attempt to assist the youth in solving their problem. If you get some cooperation in the moment, assume that you are administering “emotional first aid”. While your overall goal is to deal with the central issue, it is usually not discovered without some time consuming dialog. To get at the latter you may have to arrange another time during which you can talk at length. In the present, you may have to settle for minimal cooperation to ensure that everyone involved remains safe.

**Remain Alert**
Sometimes our best efforts at de-escalation will not be successful and the youth will move to a full explosion. The best indicators of this behavior are found in the youth’s non-verbal and para-verbal communication.

**Beware of:**
- Escalating volume and sarcastic tones.
- Dilating pupils and direct stares.
- Clenched fists and muscle constriction.
- Flushed appearance and angry looks.
- Crouched posture and the invasion of personal space.
- Rapid and deep breathing.

Should a physical explosion occur, you must be ready to flee, employ self-defense and/or use physical techniques. Your judgment regarding what to do will be based upon the circumstances. If your choice is physical restraint, it should be based upon the youth’s behavior. Physical restraint is appropriate when the youth is harming self/others, and/or under certain circumstances that are sanctioned by policy (the policy must be based on legal standard).

**Non-Compliance – The Ultimate Threat to Power & Control**
When a youth decides to willfully break the well-established operational rules, or to openly defy some direction that they have been given by the adult in charge, a line is drawn in the sand. These are the occasions when adult authority (power and control) is challenged. These are the situations that most intimidate adults because they threaten our status as the “In Charge” person. Immediately, these become win/lose predicaments.

November, 2005
The degree of win/lose that is involved in these situations is defined by a number of variables (status of the individuals involved, the seriousness of the rule breaking etc.). It is critical to establish the non-negotiable rules of the program or school before any such incident occurs. When these are clear for both the youth and adults, the scope of winning and losing narrows.

In these situations, the self-perceived risk for the adult is the possibility that they will lose face and will no longer have the respect of any youth in their charge. The youth who instigates the situation usually has nothing to lose. If the adult ends up looking foolish, the youth wins. If the adult retains the position of authority, the youth still wins, because they have risked challenging the adult.

**The Following Suggestions are Offered:**

1. Remember who drew the line in the sand. The youth owns the problem. The youth is responsible for their behavioral choice. Too often in these circumstances, the adult falls for the trap of making their own authority the problem. This is not a question of “Who’s in Charge”. We are not the problem – we are in charge. The problem is the behavioral choice made by the youth. (Note: in situations where the adult’s behavior has stimulated the youth’s misbehavior, it may be necessary for the adult to eat crow and back off).

2. Defiance is almost always done in front of a crowd. The classmates, peer group and others in the vicinity are immediately defined as the audience who are about to witness a dramatic presentation. If possible, take the action off stage by removing the audience. (Note: in a situation where the audience is a very positive group the adult may be able to use positive peer pressure to redirect the defiant youth; on the other hand, if the peer group is negative, the adult must be very cautious as the defiance of one individual can easily become the defiance of many.)

3. While we do not recommend that the intervention start with the “Rules”, a simple restatement of our expectations/rules may be in order. (This assumes legitimate and reasonable expectations/rules. Unreasonable expectations will be challenged.) Restating the expectations allows the youth to reconsider the choice they are making. Obviously, the restatement must be devoid of denigrating tone, inflection, etc. Controlling our para-verbal communication is not easy when defiance is encountered because we have a natural inclination for counter aggression. This is most typically seen in “either/or” statements (“either you comply, or I’ll impose a consequence you won’t like…”) that are an attempt to put the defiant youth in their place and to reaffirm the adult’s status of being in charge. When you give an “either/or” statement to a defiant youth, you are inviting escalation. The youth will almost always take the “or” and present the adult with the dilemma of following through on the threatened consequence. Rather than fall for the counter aggressive instinct that uses “either/or” and messages that are contaminated by non-verbal and para-verbal cues, a benign statement of expectation is best.

4. Once the choice of defiance is made, the youth has very limited options. In a real sense, the youth position themselves in a corner. With the lack of options comes the sense of powerlessness. When this occurs, the youth is likely to use the same “either/or” proposition described about. That is, they will face the adult with “either/or” statements
in an attempt to salvage the situation. The “or” in “either/or” is usually threatening. Here, the adult must resist the instinct for counter aggression (responding to the threatening “or”). For the adult, the trick is to help the youth get out of the corner without losing face. Our ability to help the youth find some reasonable alternative is critical. Doing this is very connected to our own sense of personal confidence and our ability to not define the moment in “power and control” terms. Here, mediation (use of third party, peer support, etc.) may be best. Our use of time can also be critical. Unless there is imminent danger or significant program disruption, we may not have to solve the issue right now. Allowing a little time and space may reduce the tension enough for negotiation to be successful.

5. Defiance or deliberate rule breaking occurs in a moment of time in the life of a program or during a school year. On some occasions, the program or school may be at a point of development where negotiation is not practical. This is a point of time when decisive action is necessary to ensure the integrity of the program or school. Here, the adult may need to be confrontational and direct. It is suggested that the rules and expectations be restated. If compliance is not forthcoming, there should be immediate action. Usually, this means removal of the youth from the immediate area to a place designated for restriction (office, time out room, etc.). This requires a performance capacity that assumes adequate and trained manpower.

Dealing with Smart Mouth and Defiant Behaviors

Youth in crisis often transfer the angry feelings they are experiencing to the nearest available target. All youth service professionals have experienced this transfer phenomenon. Even when intervention staff are using the best possible approaches, crisis youth will treat their effort similar to the way a wounded animal will bite the hand that is trying to help them. This occurs because youth in crisis feel vulnerable, sometimes hurt and often powerless. To compensate for these feelings they often engage in verbal attacks on the adults who are attempting to assist them. These attacks provide the youth with a sense of psychological advantage. For the intervening adult, they are a personal insult.

Verbal attacks by youth have power when they target something the adult values. Youth have an uncanny ability to identify these things. They have radar like capacity to know exactly how to get under the adult’s skin. Some have called this the ability to “push buttons.” When they push our buttons, we will react.

Mary Beth Hewett, in her article “Smart Mouth Kids: Taking the Sting Out of Verbal Aggression” (1998), suggest that there are three levels on which verbal “button pushing” occurs.

These levels are:

1. Physical Characteristics: Size, weight, body parts, etc.
2. Home and Hearth: Family, race, personal possessions, etc.
3. Personal Values: Fairness, dedication, professionalism, etc.
It is also noted that these insults are frequently verbalized in a progression that begins with remarks on physical characteristics, then targets home and hearth and thereafter attacking our values. Button pushing is an attempt by the youth to gain psychological advantage over the adult. Too, they are an attempt to entice the adult to lose control and engage in a verbal battle.

The inexperienced caretaker may react to such insults by firing back in kind. For example, statements like, “Boy you got a big nose”, might be responded to by, “If you think my nose is ‘big’ you should see yours, half pint.” The verbal tennis ball is now back in the youth’s court and it is likely to be returned to the adult with velocity. Such a reaction opens the door for escalation. When the next insult crosses the net, the caretaker will be primed to react. This trading of insults can lead to a serious incident. Research on Middle School Violence (1999) clearly indicates that most incidents of violent behavior between youth begin with an “opening move” that is relatively slight. Youth engage in fights on a regular basis because one has verbally insulted the other.

The experience caretaker will let these verbal insults role off their back. While this is more productive than responding in kind, it may be missing a golden opportunity to connect with a troubled youth. Safe Crisis Management suggests that the behavior that we describe as “button pushing” might better be called “an invitation.”

An “Invitation” to Engage in Professional Intervention. How do we do this?

First, caretakers must recognize that the Smart Mouth behavior described above is going to occur. The reason it occurs is that the youth in care is experiencing pain, anxiety, etc. They compensate for these feelings by verbally attacking the adult. The target of the attack is something that they know will trigger a reaction in the adult.

Second, based on recognition of the above, the adult must identify their “soft spots”. If you are sensitive about (level one) the size of your nose, shape of your head, lack of hair, need of glasses, etc., (level two) your family, tribe, car, house etc., (level three) dedication to the job, fairness with youth, etc., you need to know that these areas are likely targets. Once identified, the adult needs to plan their response to a verbal attack.

Third, using the identified soft spots the adult can script a professional response to the expected verbal insult. For example, “you know, you’re right, I am overweight and I should do something about that,” or “yes, I wish I didn’t have to wear glasses to see”. Such a response takes the sting out of the attack and deflates the attacker. Another example would be, “you know when you say things about my family it hurts me, is that what you mean to do?” Or, “You know I really try to treat everyone fair and I’m sorry you feel that way about me”. Such responses expose the insult for what it is without entering into the argument game. Responses similar to the above provide an opening for discussion about the youth’s need to attack. This approach views the attack as an invitation to engage the youth, rather than as a disrespectful comment.

Finally, the behavior described above is not relegated to the youth/adult relationship only. Youth insult each other on a routine basis in the same manner. Teaching youth about the tree levels of insults and helping them to script responses that will move in positive rather than negative directions can be a valuable life skill instruction. When adults view the insults as invitations, the teaching moments that follow may be the rare opportunity to connect with a troubled youth.
Dealing with Oppositional Behavior “An Invitation to Power and Control Games”

For all human beings the issue of personal control in the living experience is significant. Our self-esteem, status and sense of well-being are contingent on our belief that we are in control. When circumstances occur in which our sense of control is threatened or significantly decreased, a personal power vacuum is experienced. This feeling of powerlessness often results in compensating behavior that is directed at regaining our sense of personal control.

The experience of “power loss” most often occurs during times of transition when life is uncertain. Sometimes these feelings occur when the living environment changes such as when we change living locations – relocate. This feeling also occurs when the people most immediate in our life experience change – death divorce- etc. Some people become adept at living with the uncertainty of transition and some do not. For children and adolescents times of transition can be traumatic. Some adapt and some do not. Those who are unable to adjust often engage in compensating behavior patterns that can be classified as oppositional and defiant. This pattern is very much related to their felt sense of powerlessness. It is a compensation by which they seek to relieve their uneasy feelings.

Children and adolescents who exhibit this pattern of oppositional and defiant behavior present a most difficult challenge to educators and adult caretakers. The difficulty presented by such behavior has to do with the adult’s perception that their personal authority is being challenged. In fact, this perception is often correct.

How the adult reacts to oppositional and defiant behaviors is a critical issue for both the immediate and the long-range situation. These non-compliant behaviors must be perceived as “invitations” to engage in professional response. When the adult accepts the behavior as a professional response issue, the outcome can be positive. Too often, adults feel the ding in their authority armor and respond with power asserting behavior that can quickly become fuel for a conflict. In the latter response, the adult is joining the youth in a power and control game in which there are no winners.

Oppositional and defiant behaviors are poorly camouflaged relationship traps set by youth that are caught in a struggle with themselves and their life experience. Because they are feeling impotent in dealing with their perceived trouble they invite connected adults to join them by attempting to assert some type of control over the adult. Avoiding these traps can be significant for adults. In the article “The control game: Exploring oppositional behavior”, author, Mary Beth Hewett, identifies several examples of oppositional behavior commonly seen in youth care and education. They are: (1) Loopholes, (2) Making deals, (3) Blatant rule breaking, (4) Having the last word, (5) Questioning, “Why”, (6) Splitting staff, and (7) Outright refusal to comply (Hewett, 1999).
Every youth worker and educator have, at some time, run into the above-indicated behaviors when dealing with youth. Responding professionally to these behaviors is more or less challenging depending upon the circumstances and our relationship with the youth in question. Some suggested responses are as follows:

1. **Loopholes:** This refers to the youth who follows the letter of the law but not the spirit of the law. For example when told to “remove their head band”, the youth responds by removing the headband and then immediately putting it back on their head. Sometimes more specific language can resolve the loophole but more often than not the youth will simply opt for another loophole. The problem here, as with many of the examples that follow, is that the youth is asserting personal power by crossing the line in the sand that has been drawn by the establishment of a rule of behavioral expectation. Sometimes attending to the process of rules and expectations is an initiation for rule violation. When adults do not involve the youth in question in the process of expectation setting they are asking to spend significant time chasing violators. Achieving some consensus around rules and behavioral expectations up front makes more sense. As we engage the youth in this process it is well to explain the difference between the “letter” and the “spirit” of the rules.

2. **Making deals:** This is behavior that is a soft “either/or”. For example, the adult makes a statement of behavioral expectation – “you need to clean up before going out – and the youth responds with “I’ll clean up twice as good later if I can go out now”. What they are really saying is, “If you don’t, you risk having a conflict over it”. In short, “Either let me have my wish, or I’ll force you into a situation that you don’t want”.

Fundamentally, the deal seeking youth wants to have a sense of control in the situation. Staff can sometimes achieve compliance by pointing out the control issues at stake. For example, “I know that you want to feel like you have options and control over what occurs with you. No one can force you to do what you don’t want to do. It’s your choice, don’t do your chores and don’t go out. It’s up to you”. For other youth it may simply be an issue of not wanting to be told what they can or cannot do. Adults can lessen this feeling by asking rather than telling the individual what to do. Making deals around rules and expectations can undermine personal and program authority. When adults find themselves giving in to such requests they should examine the rationale for the rule and their commitment to the rule. When rules don’t make sense they cause frequent problems.

3. **Need to have the last word:** This oppositional behavior is motivated by the need to keep the present conversation going so that a sense of control is maintained. In short, as long as the discussion is open, I have a chance to win. Unfortunately, most human beings are very susceptible to this need to have the last word. As such, staff very often fall for this trap and respond with their own “last word”, which of course only continues to fuel the conversation. If staff can simply decide to allow the youth to have the last word they can end the situation on a positive note. Even the “parting shot” can be ignored in the immediate moment and reaction is given at a later time. It we think about it, last word conversations are simply one person saying “…and remember I’m in charge”, and the other person saying, “No you’re not, I am”. And so on, and so on. Success here requires
staff to engage in an internal conversation that reaffirms their own sense of being in control.

4. **Blatant rule violation:** When a youth breaks a known rule right in front of your nose, they are saying “come and get me”. This is an invitation to engage in a power struggle over the rule. Again, they are challenging authority. When rule violation is blatant, it is usually an attempt by the youth to gain a sense of control. “Look what I can do, you can’t stop me”. The decision to deal with the rule violation is contingent on a variety of issues. When the violation is not a threat to safety the option of ignoring it is available to staff. It is sometimes better to ignore minor rule violations in order to avoid a large-scale confrontation or power struggle. Staff can react to the violation with consequences at a later time. This planned ignoring technique should only be used with low-level behaviors.

Another reaction might be the use of positive correction where the staff reminds the youth of previous correct behavior prior to correcting the existing violation. This technique when properly applied can be very successful. Too, the use of consequence reminders is another option.

5. **Constantly questioning “why?”** Oppositional youth always want to know the rationale for rules and directions. They will question “why” to almost any directive. This need is a way of challenging authority and of controlling discussions. When adults are questioned this way they experience an authority challenge and the frustration of questions being raised to matters in which the answers are obvious. The instinctive inclination of the adult to reaffirm their own authority can lead to less than professional responses.

6. **Play one staff against another:** “Mrs. Smith doesn’t do it that way”, is often heard from youth who have as their purpose attacking staff inconsistencies to avoid being responsible to a rule or directive. Youth in care have an uncanny ability to spot inconsistencies with adults. They often use this as an excuse for avoiding behavioral expectations. They rationalize that if adults are not consistent with their expectations then it is ok for them to act irresponsibly around those expectations. The truth is that adults are not always consistent – but that has little to do with their choice to avoid their responsibility. A simple confrontation of this manipulation is usually the most efficient response. It is, of course, better for staff to be consistent in their expectations, but inconsistencies occur.

7. **Refusal to comply:** This is the “you can’t make me” response to staff directives. The answer is that they are right, “we can’t make them”, only they can decide. Adults can respond by agreeing and pointing out how they hope the youth makes a good decision and why. Remember, asking a youth for compliance is different than directing them to comply. The former provides an opportunity for choice and often results in less opposition because it allows the youth to experience the power of choice.

Finally, staff must remember that oppositional behavior is age appropriate for the pre-adolescent and adolescent age group. These life stages are times for testing and difference as youth struggle to define themselves. When we are working with these two groups, opposition and defiance must be expected.
CHAPTER V

ROLES AND RESPONSIBILITIES OF EH/SED STAFF
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OF
EH/SED STAFF

The purpose of this chapter is to delineate the roles and responsibilities of staff members comprising programs for students identified as EH and SED. The job descriptions include the following: classroom teacher; paraprofessional; behavior management teacher (BMT); counselor; clinician; and clinical art therapist. Although each staff member has different roles and responsibilities within the program, all work together collaboratively to ensure that a structured, supportive and comprehensive learning environment is implemented to assist students in reaching their academic goals.

I. Roles and Responsibilities of the Classroom Teacher

In addition to the M-DCPS description of the classroom teachers’ responsibilities, the classroom teacher in specialized programs is primarily responsible for providing appropriate and effective educational and behavioral programming for the students placed in the program. Included in these broad responsibilities are the following:

- Prepares an annual IEP for each student as well as updates at mid-year and at the end of the year, including academic testing as needed
- Prepares and implements detailed daily lessons plans that reflect the goals and benchmarks listed on the student’s IEP, in addition to the preparation of daily task/point sheets for each student
- Implements a specific model for classroom design, academic programming, affective curriculum, behavior support and the provision of related services
- When necessary, assists program staff in physically controlling students who present a danger to self or others using School Board approved Safe Crisis Management (SCM) procedures
- Participates in faculty and professional meetings, IEP conferences and in-service classes
- Cooperates and communicates with other staff members at the school site including administrative staff, paraprofessionals, and other teachers
- Adheres to the policies and procedures established by the school where the teacher is based
- Provides supervision and direction for behavioral paraprofessionals
- Supervises students at all times
• Consults with the administration, the BMT, the counselor and families in the development and support of a consistent behavioral support plan for the school site

• Participates in individual parent conferences to provide updates on academic and behavioral progress

• Contacts parents regarding issues related to their child when designated

• Participates in the development, implementation and monitoring of the Functional Assessments of Behavior (FAB) and Behavior Intervention Plans (BIP)

II. Roles and Responsibilities of the Paraprofessional

In addition to the M-DCPS description of a behavioral paraprofessional’s responsibilities, the primary responsibility of the classroom paraprofessional is to assist the classroom teacher with the implementation of programs and services for the students. They are administratively responsible to the on-site administrator, but are under the direct supervision of the classroom teacher. When a paraprofessional is absent, a substitute should be provided to assist the classroom teacher in program implementation.

Included in these responsibilities are the following:

• Monitors students during lunch period, and escorts students to and from their special areas when needed

• Monitors the loading and unloading of the school buses at the beginning and end of a school day while under the supervision of the on-site administrator or designee

• Supervises Physical Education (PE) activities under the direct supervision of the PE teacher

• Assists the teacher in the supervision of playground activities

• Assists the classroom teacher with the implementation and maintenance of the behavior support level system by monitoring and recording student behavior, and assigning and calculating students’ points, etc. (These activities are conducted using guidelines established by the teacher)

• Under the guidance of the classroom teacher, reinforces academic skills

• When necessary, assists program staff in physically controlling students who present a danger to self or others using School Board approved SCM procedures

• Assists the teacher in creating a positive and supportive learning environment
• Performs, when needed, routine clerical tasks related to classroom instruction, such as duplicating materials, typing, filing tests and other instructional materials

• Performs various support tasks, and utilizes professional practices, methods and instructional aids, appliances and apparatus associated with the area of assignments

• Participates in the implementation and monitoring of FABs and BIPs

III. Roles and Responsibilities of the Behavior Management Teacher

The primary role of the BMT is to directly support the classroom teachers by assisting in the planning of individual academic and affective programs, and devising appropriate strategies to deliver curriculum to the students. They should also assist each teacher in developing and implementing an effective behavior support system.

The responsibilities of the BMT are as follows:

• Facilitates the development of EH/SED yearly program performance plan in collaboration with the program staff

• Supports classroom teachers in the development and implementation of appropriate academic curriculum designed to meet the individual needs of students, considering such factors as physical, social, emotional, behavioral and educational levels of development

• Supports classroom teachers in determining the most effective learning strategies for individual students in class

• Supports classroom teachers in the selection of a variety of appropriate multimedia materials for delivery of the academic program

• Supports classroom teachers in obtaining accurate academic assessments of individual students to ensure proper levels of instruction

• Supports classroom teachers in developing and implementing a classroom behavior management system

• When necessary, assists program staff in physically controlling students who present a danger to self or others, using School Board approved SCM procedures

• Supports classroom teachers in selecting and implementing appropriate affective curriculum

• Supports classroom teachers in developing and implementing consistent prescriptive consequences appropriate to the individual needs of each student
• Assists classroom teachers in maintaining classroom order by supporting the teacher in enforcing student discipline

• Observes, monitors, and modifies student academic and behavioral plans as needed in consultation with teachers

• Assists administrators and other school staff in understanding the possible causes of a student’s behavioral problems and suggests methods of decreasing inappropriate behaviors

• Assists teacher, students, and parents with the inclusion process to ensure that it is implemented in a positive, successful manner

• Meets with the parents of the students to inform them of their children’s needs and issues, as well as their progress and accomplishments

• Assists the students in exploring and investigating various careers during their school experience

• Participates in school, Region or District staffing/placement conferences, requested by the supervising administrator. The BMT will come to the conference prepared to discuss the student and will have written documentation regarding the academic, communication and/or social/emotional progress of the student

• Supports and provides in-services to parents and program staff in developing strategies to facilitate home/school communication to maximize generalization and increase awareness of community resources

• Provides and facilitates training to school staff on various topics relating to the achievement of students with disabilities

• Attends and/or presents at professional development in-services

• Participates in the development, implementation and monitoring of FABs and BIPs

IV. Roles and Responsibilities of the Clinical Art Therapist

In M-DCPS, art therapy is an adjunctive service. The clinical art therapist plans, organizes and develops an ongoing art therapy plan designed to meet the individually assessed special needs of exceptional student education students. Duties include but are not limited to the following:

• Creates and maintains a therapeutic environment that is psychologically safe (e.g., provides structure and behavioral management, ensures privacy and confidentiality)

• Administers and prepares a written, approved M-DCPS art therapy assessment within required time lines and shares pertinent information about art therapy with team members
• Maintains a copy of the assessment in student’s art therapy file with the original art work

• Prepares and records on the student’s annual IEP an individualized treatment plan with measurable goals and benchmarks for students who meet the criteria for art therapy

• Adheres to the guidelines established by the art therapy department for ordering materials and equipment, requisitioning supplies and organizing the art therapy room

• Makes quarterly evaluations of student’s progress and records this information on the student’s IEP

• Conducts an annual re-assessment of the student’s progress in written form and files a copy of the report in the student’s cumulative folder

• Provides individual and small group art therapy for ESE students based on the annual art therapy goals listed on the IEP

• Uses art processes to facilitate expression and the exploration of feelings, thoughts, perceptions, and to increase self-perception, enhance self-worth, develop ego strength, and promote growth and healing

• Maintains a weekly written record of student’s treatment using the Session Treatment Plan form based on the student’s goals and benchmarks

• Participates in school staff meetings, faculty meetings, student case conferences and progress reviews

• Promotes the use of art therapy with students, conducts required in-service lectures, workshops and presentations and serves as a resource person to staff regarding therapeutic interventions

• Conforms to instructional staff personnel working hours, procedures for reporting absences and/or any leave from campus both at the school(s) and at the district level

• Participates in the FAB and BIP process

• Maintains an individual folder for student records that contains the following: Eligibility Criteria form; Insert B of IEP signed by parent/guardian; a current, approved M-DCPS Clinical Art Therapy Assessment; current Progress Report; Parent Permission Form; Parent Contact Log; Completed M-DCPS Clinical Art Therapy Session Notes; M-Team Report or Psychological Report; and SCMs

• Provides art therapy services in accordance with the American Art Therapy Association (AATA) Code of Ethics for Art Therapists, the AATA General Standards of Practice Document, and the policies and procedures of the M-DCPS

• Documents provision of art therapy services on SCM form 4 times/year and, if student attends summer school, once during the summer

• Performs other assigned duties as required by the M-DCPS Office of ESE, Clinical Art
Therapy Department

See Chapter 8, Forms, and the Clinical Art Therapy Procedures manual for art therapy documentation forms.

V. Roles and Responsibilities of the Clinician

School psychologists and clinical social workers assigned to the M-DCPS EH/SED programs are responsible for offering clinical and other support services, which include, but are not limited to, the following areas:

- Provides individual and/or group therapy to each student

- Provides family counseling, education, and support and adjusts schedule to meet with families on an as-needed basis

- Conducts weekly staff meetings with planned agendas, including student case conferences, progress reviews, FABs and BIPs

- Develops therapeutic and behavioral goals on the student’s IEP and BIP, and arranges the provision of services for all students (this plan is developed in conjunction with the determination of needs defined through classroom and clinical observations and conferences); develops behavioral and therapeutic goals that are consistent with the behavior management system, IEP and BIP

- Maintains up-to-date documentation, i.e. Student Contact Logs to document weekly progress in individual therapy, Progress Report used consistently on a monthly basis, and Crisis Notes used appropriately as needed

- Performs comprehensive psychological reevaluations of SED students within the required time lines (social workers meet with the psychologist assigned to their schools and provide information essential to the completion of the CSTR, including psychological and behavioral information.)

- Coordinates psychiatric consultation services and prepares records and referral questions in advance

- Consults with school, Region, and District staff and participates in committee meetings and activities related to students and programming, as well as monthly clinician meetings

- Consults with administration, staff, and families in the development and support of a consistent behavioral management plan and crisis intervention for the school site

- Retains a list of community resources to meet the student’s needs and maintains communication with other professionals serving students, as appropriate
• Provides case management services and parent contact information on each student, as needed

• Consults with the Region, school, and district administrative and support staff to ensure the implementation and maintenance of a quality program which conforms to district standards

• Posts time sheet and conforms to teacher working hours with the exception of region and district meetings

• When appropriate, assists program staff in physically controlling students who present a danger to self or others using School Board approved SCM procedures

• Maintains clinical records for each student in an individual file, including but not limited to, contact logs, progress notes, crisis notes, case conferences, FABs, BIPs, psychological and psychiatric evaluations and the current IEP

• Documents provision of clinical services on SCM form 4 times/year and, if student attends summer school, once during the summer

See Chapter 8, Forms, for EH/SED clinical documentation forms.

IV. Roles and Responsibilities of the EH Counselor

The Division of Student Services, in cooperation with the Office of Special Education, Alternative Outreach, and Psychological Services, is responsible for the overall program development, implementation, and monitoring of the counselors working with emotionally handicapped students. The counselor facilitates the acquisition of competencies by students in personal/social, educational, and career development. Job tasks/responsibilities are as follows:

• Implements affective education curriculum

• Conducts learning activities planned in conjunction with administrators and teachers

• Consults with teachers to facilitate the infusion of learning activities into regular education curriculum

• Guides and counsels students in groups or individually

• Assesses students and develops educational and career plans

• Collaborates with others to assist students in making transitions

• Applies test results to educational and career planning and provides resources and information to assist in career exploration
• Consults with teachers, staff and parents regarding meeting the developmental needs of students

• Conducts in-service programs for faculty

• Assists families with school related problems

• Participates in IEP team meetings and FAB and BIP process

• Refers students with severe problems to appropriate community resources

• Assists other school staff in placing students in appropriate programs

• When appropriate, uses physical restraint techniques to control students who present a danger to self or others using School Board approved SCM procedures

• Coordinates and participates in school activities

• Interprets test results for faculty and staff

• Assists other school staff in placing students with special needs in appropriate programs

• Facilitates articulation activities

• Cooperates in activities which support the effective delivery of the student services program

• Evaluates the program’s processes and outcomes

• Attends staff development programs

• Updates skills and knowledge

• Performs related work as required or as assigned by the supervising administrator or his/her designee

• Documents provision of clinical services on SCM form 4 times/year and, if student attends summer school, once during the summer

See Chapter 8, Forms, for counseling documentation forms.
CHAPTER VI

STATE AND DISTRICT PROCEDURES
STATE AND DISTRICT PROCEDURES

The purpose of this chapter is to provide information about the proper procedures to follow in different situations that may arise involving EH/SED students. These guidelines are mandated by Florida Statutes, State Board of Education Rules, Miami-Dade County School Board Rules and the Office of Special Education, Alternative Outreach, and Psychological Services, and are to be adhered to at all times.

For a complete listing of Florida Statutes and State Board of Education Rules refer to the following website: www.firn.edu/doe/commhome/pub-home.htm. Click “Exceptional Education and Student Services Home Page/Resources/Florida Statutes.”

For a complete guide to M-DCPS School Board procedures refer to the following website: http://ehandbooks.dadeschools.net/ehome.asp?policymanuals=Yes. Click “View” under “Procedures for Promoting/Maintaining Safe Learning.”

I. Articulation

Relationships should be developed with feeder pattern school program personnel to facilitate the articulation process for elementary and middle school students. Planning for articulation should occur in the spring of each year to prepare for the following school year. Schools must hold an IEP team meeting to address a student’s educational needs prior to assigning the student to the new school site. For secondary students, particular attention must be given to the selection of the diploma option. Unless there are mitigating circumstances such as recent deterioration of skills, incoming ninth graders who have skills below the fifth grade level in both reading and math should be seriously considered for the special diploma option.

II. Referral Procedures for Center Schools and SPED Outreach Programs

Contact persons and staffing specialists from referring schools need to prepare referral packets and forward them to the designated Region staffing specialist whenever a placement is being considered. The referral package must include the information:

A. Contents of Referral Package

- FAB/BIP including the current and previous BIP, if available
- Psychological (no more than 2 years old) with IQ and projective tests, including adaptive behavior scales, if appropriate
- Current psychiatric evaluation, if available
- Current IEP
- Student Case Management forms (SCMS) for previous 6 months
- Anecdotal records

November, 2005

49
• Attendance information (printout for the past year)
• Current academic evaluation with grade levels
• Academic grades (printout for the past 2 years)
• Release of information forms signed by parent for any programs to be considered, with contact information completed
• Consent for Evaluation form signed by parent with “other” checked, and a completed observation(s) informal assessment by ESE Outreach and/or M-DCPS Staff
• A completed Mutual Exchange of Information form for any outside agencies or individual service providers signed by parent/guardian, as appropriate

B. Processing the Referral Package

After receiving the referral packet, the Region Center staffing specialist (EH/SED) will forward the information to the programs being considered and schedule an IEP team meeting, allowing two weeks, whenever possible, for staff observations and site visits by the parent/guardian (if desired). In consultation with the referring program and the school-based staffing specialist, the Region Center staffing specialist will identify possible program options. The IEP team meeting should be scheduled when the Region Center staffing specialist receives the completed packet.

C. Referral Procedures for Region Center Staffing Specialists (EH/SED)

• The sending school completes packet and forwards it to the Region Center staffing specialist (EH/SED).

• The Region Center staffing specialist reviews packet to ensure that the packet is complete and the required information is up-to-date.

• The Region Center staffing specialist will forward the packet to the appropriate programs so that program staff can schedule observations and/or parent visits.

• The Region Center staffing specialist, in consultation with the school-site staffing specialist, will identify appropriate alternatives to be considered. At least one school-based program, in addition to the sending school, should be invited to participate (even if this must be facilitated across Region Center boundaries).

• The Region Center staffing specialist will contact the appropriate programs and parent/guardian to schedule the IEP team meeting.

• The Region Center staffing specialist should call the parent/guardian to explain the process to them and to inform the parent/guardian of the programs
being considered. The parent/guardian should also be encouraged to visit the programs before the scheduled meeting.

- The Region Center staffing specialist, when possible, is responsible for chairing the meeting.

### III. Limited English Proficient Students

#### A. Determining Eligibility

Students who meet the following criteria shall be evaluated by a bilingual evaluation specialist (e.g. school psychologist) with the assistance of a trained translator unless it is not feasible to do so:

- Students from kindergarten through twelfth grade who come from language backgrounds other than English who test below English for Students of Other Languages (ESOL) level 5

- Students in grades four through twelve who are at ESOL level 5 and at or below the 32nd percentile on the Reading and Language Mechanics Subparts of the Stanford Achievement Test (SAT)

A bilingual assessor may administer a language proficient/dominance assessment for ESOL students at ESOL Levels 3, 4 and 5 who have been exited from the ESOL Program and are going through post program monitoring.

#### B. Individual Educational Plan (IEP)

The IEP of ESE students who are limited English proficient (LEP) (ESOL) levels 1-4 must have a PEN indicated on their IEP. Elementary and secondary LEP ESE students shall be involved in the ESOL program and in the Basic Subject Area instruction, Curriculum Content in English Using ESOL Strategies, Curriculum Content in the Home Language (CCHL) and Bilingual Curriculum Content (CCE/ESOL) (BCC) as indicated on their IEP. The student's instructional goals and benchmarks must reflect the student's ESOL level. Instructional methodology shall be appropriate to the student's level of language proficiency and disability.

#### C. Exiting the ESOL Program

Through the annual review of the IEP, ESE students in grades kindergarten-third grade, and ESOL ESE students (all grades) who (1) do not participate in the FCAT; (2) obtain an ESOL Level V on one of the ESOL placement tests of the Continuum of ESOL Placement Tests for Exceptional Students; and (3) no longer need ESOL instruction will be exited from the ESOL program. ESE students in fourth-twelfth grades who obtain an ESOL Level V shall be
administered the Reading and Language Mechanics Subparts of the Metropolitan Achievement Test-7 (MAT) (the Reading NRT of the FCAT can be substituted for the MAT) and if they are between 32% on the MAT or 51% on the Reading NRT of the FCAT, they shall be exited from the ESOL Program. Students who obtain an ESOL level 5 on the Oral Language Proficiency Scale-Revised (OLPS-R) or the Relative Language Dominance checklist-Revised (RLDC-R) and participate in the SAT are exited from ESOL after a review of the SAT results.

IV. IEP Procedures

The purpose of this section is to provide a brief overview of certain procedural requirements and helpful guidelines. For additional information, please utilize resources within your school, i.e., the ESE department chair, program specialist, school administration, access center staffing specialist, or district office.

A. The Purpose of the IEP

The overall purpose of the IEP is to identify the needs of the student (academic, behavioral, social, and emotional) and to coordinate the most appropriate services to address these needs. The IEP team must consider supports for these identified needs, including the establishment of behavioral goals, the development of behavioral intervention plans, and the provision of clinical or counseling services. The IEP must include documentation of these considerations in the conference notes.

B. The Goal of the IEP Team

The goal of the team is to provide an appropriate education to all students. It is the obligation of every school employee to utilize professional courage in identifying and recommending interventions in order to keep focus upon what is in the best interest of the student. At times, there may be a disagreement between what is recommended by the team and the parent’s desires. In such cases, the team should meet and decide what is in the best interest of the student. If a disagreement persists, the team must inform the parent of their due process rights while following what is documented on the IEP. For example, the parent of a student may insist that her child be excluded from counseling. After careful consideration of the student’s present level of functioning, the IEP team may decide that it is in the student’s best interest to continue with counseling. In this situation, the IEP team should clarify to the parent the reasons that counseling is recommended and in the best interest of the child and, if possible, explore why the parent is resistant. Counseling should not be removed from the IEP. The parent’s comments should be recorded in the conference notes, and he/she must be informed of due process rights and mediation.

C. Accountability and the IEP
The issue of accountability is a strong component of IEP reviews. Whatever criteria are used as an evaluative measure of a goal need to be completed and collected for review by parents or other appropriate staff. For example, if the evaluation criteria on Insert B of the IEP include a teacher questionnaire, this questionnaire needs to be available for review. If a behavioral goal has a progress note as the evaluation criteria, it also must be made available to the parent should it be requested. Placing a clinical progress note as the evaluation criteria may potentially create a multitude of confidentiality issues. Therapeutic notes, in this case, are seen as part of the educational record and the confidentiality of the child, adolescent, and family may be endangered.

D. Procedural Safeguards/Due Process

The ESE administrator or designee is responsible for ensuring that parents are informed and receive a full explanation of all procedural safeguards. A copy of the procedural notice is provided to parents whenever prior notice or written consent is required before the district takes any action regarding a student’s receiving of special education services. Due process hearings may be initiated by a parent or a school district on the proposal or refusal to initiate or change the identification, evaluation, or educational assignment of the student or the provision of a free appropriate public education to the student. The student involved in the complaint must remain in the present educational assignment during the time that an administrative or judicial proceeding regarding a complaint is pending, unless the district and parent of the student agree otherwise.

V. Promoting and Maintaining a Safe Learning Environment

Students who participate in ESE programs are required to adhere to the same school rules that apply to the whole population of M-DCPS. The school environment must allow for students to develop the skills necessary to achieve academic excellence. This purpose is best achieved in a learning climate in which the rights and responsibilities of every person are known, respected and upheld. The following violations are to be dealt with according to Florida Statutes, the Florida Board of Education, and Miami-Dade County School Board Rules.

For a complete listing of Florida Statutes and State Board of Education Rules refer to the following website: www.firm.edu/commhome/pub-home.htm. Click “Exceptional Education and Student Services Home Page/Resources/Florida Statutes.”

For a complete guide to M-DCPS School Board procedures refer to the following website: http://ehandbooks.dadeschools.net/ehome.asp?policymanuals=Yes.
A. Zero Tolerance for School-Related Violent Crime

The Florida Board of Education has established a zero tolerance policy on school violence, crime, and the use of weapons as a part of a comprehensive approach to reducing school violence. This policy requires school districts to invoke the most severe consequences provided for in the Code of Student Conduct in dealing with students who engage in violent criminal acts. Section 230.235, Florida Statutes (F.S.)

B. Reporting Crime and Disruptive Behavior

All employees of Miami-Dade County Public Schools are required to report any criminal act or other disruptive behavior occurring on Miami-Dade County School Board property to the responsible administrator or designee. The responsible administrator will conduct an immediate investigation of the allegation and, upon verification of a criminal act, report the incident for investigation to the Miami-Dade Schools Police Department at 305-757-0514.

Students are responsible for reporting any criminal act or other disruptive behavior occurring on school premises to the teacher or principal; all students are to be notified annually of this responsibility.

The principal or designee is to report any criminal act occurring on school premises or at any school-related function such as athletic events, field trips or dances to the Miami-Dade School Police Department. A case number will be issued by the School Police Department to the reporting individual. There are specific violations that the principal or designee MUST report if they occur.

There are specific incidents that need to be reported to SESIR (School Environmental Safety Incident Reporting). Some incidents may or may not need to be reported to law enforcement. School Board Rule 6Gx13-4A-1.21

C. Reporting Child Abuse

All School Board employees are REQUIRED by law to report known or suspected child abuse, abandonment or neglect by a custodial caregiver to the Florida Department of Children and Families Central Abuse toll-free Hotline at 1-800-96-ABUSE. Any person who knowingly and willfully fails to do so, or who knowingly and willfully prevents another person from doing so, is guilty of a misdemeanor of the second degree, punishable as provided in Section 775.082, Section 775.083 or Section 775.084, F.S.

The following procedures are to be followed:

- The person who suspects the abuse is to contact the Central Abuse Hotline at 1-800-96-ABUSE.
• Report the abuse to a school-site administrator.

• Report the abuse to the Miami-Dade Schools Police Department.

• **NO SCHOOL-SITE EMPLOYEE SHALL CONTACT THE CHILD’S PARENT OR GUARDIAN.** The representative from the Department of Children and Families or a law enforcement agency will contact the parent/guardian.

Florida Statute requires school employees to provide their names to the hotline staff. The names are recorded with the report, but will be held confidential. The intent of this legislation was to end the practice of taking anonymous reports from professionals who are mandated to report. **It is not the responsibility of any school employee to investigate the suspected or confirmed child abuse. The Department of Children and Families and/or the appropriate law enforcement agency are responsible for the investigation.**

The person who reports the alleged abuse shall remain at the school and an appropriate School Board employee shall remain with the child until either the Department of Children and Families or law enforcement arrives on campus. At that point questioning of the child may resume, but only at the direction of either the Department of Children and Families or a law enforcement agency.

Should a citizen report a suspected case of child abuse to a School Board employee, it becomes the responsibility of the employee to follow the above reporting procedures. In the event a report of suspected child abuse is made after regular school hours, the School Board employee must follow the above reporting procedures.

Any School Board Employee who is aware of suspected or confirmed child abuse committed by another School Board Employee shall immediately complete the following procedures:

• Report the abuse to the Central Abuse Hotline at 1-800-96-ABUSE.

• Report the abuse to the principal or designee.

• Report the abuse to the Miami-Dade Schools Police Department.

• **NO SCHOOL-SITE EMPLOYEE SHALL CONTACT THE CHILD’S PARENT OR GUARDIAN.** The representative from the Department of Children and Families or law enforcement will contact the parent/guardian.
A written confirmation no longer needs to be sent to the Department of Children and Families following a call to the Child Abuse Hotline. No written record is to be made by school personnel, as such information is confidential and not to be placed in the student’s cumulative file. Additionally, the individual who reported the alleged abuse shall not be identified as the reporter except to those authorized representatives from the Department of Children and Families or the appropriate state attorney or law enforcement agency. Section 39.201(2)(a), F.S.

D. Reporting Possession, Use, Distribution, and/or Sale of Mood Modifiers or Controlled Substances

All School Board employees are required to report to the principal or principal’s designee any suspected unlawful use, possession, or sale by a student of any controlled substance, any counterfeit controlled substance, or any alcoholic beverage. All School Board employees shall be exempt from civil liability when reporting in good faith to the proper school authority such suspected unlawful use, possession, or sale by a student. Only a principal or designee shall contact the parent(s)/guardian(s) of a student regarding this situation. Section 831.31 and Section 561.01(4), F.S.

E. Discipline of Students with Disabilities

The following procedures are defined by Guideline #19 from the Procedures for Promoting and Maintaining a Safe Learning Environment manual.

The M-DCPS Code of Student Conduct defines distinct violations, identified by principals, administrators, teachers, students, and community members, which are representative of those acts frequently causing disruption of the orderly educational process. Occasionally, regular, disabled and/or gifted students may engage in behavior which, under normal circumstances, could warrant disciplinary actions.

Prior to the suspension of a student with a disability, the administrator should consider various less restrictive alternatives. These alternatives should include, but are not limited to, the following:

- Daily progress note
- Work assignment
- Behavioral contract
- Parent conference
- Detention/after school assignment

Other options that may be explored through the convening of a staffing placement committee meeting are:
- Providing additional related services (e.g., counseling)
- Increasing time in current special program
- Changing the student’s educational placement

The discipline of students with disabilities is covered by Federal Law, Florida Statutes, Florida Board of Education Rules, and Miami-Dade County School Board Rules. The Individuals with Disabilities Act (IDEA) authorizes schools to remove a student with disabilities for up to ten school days for minor disciplinary infractions and for up to 45 days for dangerous behavior involving weapons and drugs through the administrative review process.

Parents/guardians of student(s) with a disability must be provided with a notice of disciplinary action and a copy of the Summary of Procedural Safeguards no later than the date the decision was made to take action.

If a child has behavior problems that interfere with his/her learning or the learning of others, the IEP team must consider all possible strategies to address the behavior. Consistent misbehavior which violates the Codes of Student Conduct and for which usual disciplinary actions have failed to produce positive results, should be addressed in an IEP team meeting for the purpose of reviewing the student’s placement and obtaining further evaluative data.

If a student is assigned to the School Center for Special Instruction (SCSI), ESE services and/or consultation must continue during that assignment.

A FAB and BIP should be initiated by the sixth day of suspension in order to be reviewed by the IEP team following the tenth day of suspension. Once the FAB is conducted, the IEP team must reconvene and develop a BIP. This BIP must be reviewed by the IEP team during any additional suspensions. Removal of a student with a disability for more than ten cumulative days requires an IEP team meeting to determine if the student’s behavior is a manifestation of his/her handicapping condition. A Manifestation Determination process must be completed prior to any additional suspensions after the initial ten days of suspension and initiated no later than ten business days after the tenth day of suspension, or upon recommendation of expulsion.

A principal may request that the Superintendent recommend to the School Board that a student with a disability be expelled if the IEP team determines that the student’s behavior is not a manifestation of his/her disability. This may deny the student attendance in any of the M-DCPS schools for a designated period; however, this action must not result in a complete cessation of educational services.

The following steps must be taken following a recommendation for expulsion of a student with a disability:
M-Team Staffing Committee meets within five days to determine if the student’s act is a manifestation of the disability.

If the act is determined to be a **manifestation of the disability**, the student **cannot be expelled**.

The IEP is reviewed and changed in program and placement are considered.

If the Region does not have an appropriate placement, a district staffing should be requested.

If it is determined that the act **was not a manifestation of the student’s disability, expulsion may be recommended**. Placement in an opportunity school or another alternative program with a work-back component should be recommended.

If the staffing committee determines that placement in an opportunity school or another alternative program with a work-back component is not appropriate, a district staffing should be requested.

The following is a sequence of events following a request for a **Waiver of Expulsion** of a student with a disability:

- Principal recommends Expulsion Waiver
- Region approval
- District approval
- Waiver is granted (student remains in present placement)

If a waiver is requested and granted and a change in the student’s program or placement is requested, a region staffing committee must be convened prior to the change in program or placement.

A FAB must be initiated within ten business days of the recommendation for expulsion. The IEP team must determine the degree of services and modifications necessary to prevent the behaviors from recurring. Gun and drug violations may result in an expedited removal/change of placement. Students recommended for expulsion are placed either at an opportunity school or in another alternative educational placement and are allowed to participate, when appropriate, in the Work Back Program. Expulsion is withheld.

**F. Confidentiality**

1. **Student Disclosure During Counseling Sessions**

All School Board employees are REQUIRED by law to report to administrators a situation involving a student who may be violating federal, state, or local laws. The principal or designee shall involve the Miami-Dade Schools Police, and the parent(s)/guardian(s) of the student involved, if appropriate. Clinical personnel should caution or remind students receiving counseling services that there are confidentiality guidelines which must be followed in the event the student...
discloses information that involves a violation of federal, state, or local laws. The same procedures must be followed when the student’s situation indicates that there is a clear and imminent danger to self or others, such as a suicide threat, danger to others, or a threat of bodily harm. The counselor must take direct, personal action and inform the responsible administrator. The parent(s)/guardian(s) shall be informed, as well as the Miami-Dade Schools Police Department, if warranted. The same procedure must be followed in the event the student informs the counselor of a situation that involves another student and possible violation of federal, state, or local laws. In this situation, the identity of the student should be protected as much as possible.

2. Release of Information

Professionals who work with students in EH/SED programs are required to adhere to a standard of professional ethics regarding the confidentiality of information relating to students and their families. Many students with emotional challenges receive mental health services outside the school system, i.e., a psychiatrist or a community mental health agency. Collaboration of mental health services is essential. The need often arises for staff to share educational information with other professionals. This should be documented in accordance with the Family Educational Rights and Privacy Act (Public Law 93-380) and Board Rule 6Gx 13-5B-1.07. Access to any student information or the release of any personally identifiable information is only granted with the written consent of the parent or eligible student. The consent must contain the reason for the release, the specific records to be released, and to whom the records are being released. (See Ch. VIII, Forms, for the “Consent for Mutual Exchange of Information” form).

G. Suicide Prevention and Intervention

EH/SED programs have an inherent responsibility to promote awareness of suicide and establish procedures to manage all crises appropriately. The crisis plan is a written procedure dispatched to all teachers and approved by all administrators. It takes into account the resources of the school and systematically defines what actions are to be taken in particular situations. Every crisis plan prioritizes student safety and emphasizes the importance of supervising students at all times, especially during a crisis. All crisis plans specify who conducts assessments under what circumstances, how interventions must include a parent and administrator, and the importance of appropriate documentation of events. The crisis plan is distributed to appropriate staff (teachers of the student, BMT, EH/SED clinical staff, resource officer, administration, TRUST counselor, and other appropriate student services personnel. The M-DCPS crisis line is (305-995-CARE/2273). See Chapter IX, Appendix, for sample Crisis Plan.

1. Increase Parent Awareness of Suicide/Crisis Events
Parents should be made aware of the possible warning signs of decompensation and/or suicidal/homicidal ideations. Clinical staff should make immediate contact in the beginning of the school year to introduce staff members to parents. The purpose of this initial contact is to ascertain appropriate assessment information for crisis events. Important questions to gather from parents and/or guardians are:

- Has your child ever been hospitalized for emotional reasons resulting in an attempt to hurt him/herself or others?
- Has your child ever purposefully hurt him/herself or others?
- Has your child ever become violent at home and lost control? How so?
- Has your child ever told you that he/she saw things others cannot?
- Has he/she reported hearing voices?
- Has your child experienced any traumatic event?
- Is he/she seeing a psychiatrist/other therapist?
- Is he/she on any type of medication or has he/she been on any type of medication in the past? Which ones?
- Request information from the parent/guardian regarding previous psychiatric diagnoses, the child’s medical issues as well as family members.

Parents should be urged to come to the school so the site clinician or counselor may conduct a psychosocial assessment. Parents/guardians should be made aware of the warning signs of suicide and the need to notify the child’s counselor/clinician if their child becomes depressed or suicidal at home, or exhibits bizarre or self-injurious behaviors.

2. **Promote Awareness of the Warning Signs Associated With Suicidal Behavior**

Students may exhibit behaviors that indicate an increased risk of suicide. Counselors should review with the administration, faculty and staff the following warning signs for a potential suicidal risk:

- Changes in eating or sleeping habits
- Increased isolation from friends and family
- Tendency to become more active and aggressive than usual
- Decrease in academic achievement
- Giving away a valued possession or increased interest in getting his/her “life in order”
- Thinking/talking about or threatening suicide
- Sudden and intense interest in religious beliefs and the afterlife
- Recent loss, such as a divorce or death in the family, death of a role model or idol, or a close friend dying or moving away, or a breakup of a romantic relationship
- Abusing drugs or alcohol
• Intense focus on death and/or dying
• Hopelessness
• Evidence of bizarre behavior or thoughts
• Presence of auditory/visual/tactile hallucinations
• Discontinuation or initiation of psychiatric medications

3. Refer Students Experiencing Emotional Stress

Many students who attempt suicide exhibit some of the above-stated symptomatology. Any person who has reason to believe that a student is experiencing emotional stress should refer the student to his/her EH/SED clinical staff. The clinical staff shall implement the procedures listed below:

• Assess student
• Gather additional information from parents/staff if necessary
• Mobilize necessary resources accounting for level of need and urgency
• Counsel the student, and, if possible, resolve the problem or reduce the level of stress experienced
• Notify the parents/ or pertinent staff if clinically appropriate
• Consult with additional student services professionals if necessary
• Continue to meet with the student regularly to provide ongoing support and/or increase level of contact in order to stabilize situation
• Continue to provide individual counseling as well as group counseling
• Collaborate and coordinate with existing mental health services and provide the family with a selection of community agencies/providers if additional mental health services are needed

4. Respond to Student’s Suicidal Threat

When a student makes a suicide gesture (threatens to harm him/herself), a suicide threat, or a suicidal ideation, the crisis plan should be followed. The crisis plan should include the following actions that should be taken:

• Inform the appropriate administrator of the threat
• Escort the student to the primary therapist (SED clinician or EH Counselor)
• Assess level of suicidal risk
• Mobilize resources
• Call 911 and the M-DCPS Police Department (305-757-2677) in a life-threatening emergency – if after assessment suicidal risk deems this to be a necessary action
• Provide and maintain constant professional supervision of the student until supervision is assumed by the police/fire department, the parents/guardians, or the emergency contact person
• Notify the parents/guardians immediately unless there is suspected or confirmed child abuse. If the parents/guardians cannot be contacted, appropriate authorities i.e., the police and/or the Florida Department of Children and Families must be contacted.
• Provide the student and his/her parents/guardians with a list of community mental health agencies/providers if necessary.
• Request that the parents/guardians sign a release-of-information form with the community agency or private therapist so that the school and the provider can work together to assist the student.
• Notify M-DCPS Department of Crisis Management (305-995-2273) of all suicidal behavior.
• Input the appropriate Student Service codes into ISIS (i.e., RS-Risk Assessment; RI-Risk Intervention; RP-Post-Vention).

5. **Respond to Student’s Suicide Attempt**

When a student makes a **suicide attempt** on school grounds, the crisis plan must include a section discussing this particular action. The crisis plan must include the following actions which should be taken:

• Assess injury or condition
• Apply emergency first aid/CPR, if necessary
• Call 911 and M-DCPS Police (305-757-2677) if emergency medical services are required
• Inform appropriate administrator
• Secure and stabilize the site of the event
• Isolate the victim from others
• Escort or bring site clinician to the student
• Do not tamper with any evidence, or clean the area, until police have completed their investigation
• If weapon must be carried or relocated, wrap in heavy cloth and point down at all times
• Baker Act assessment should take place
• Involuntary examination at the hospital should be considered
• Intervention by the hospital crisis center is strongly encouraged
• Transportation issues arise when dealing with a suicidal individual, especially one who has recently made an attempt. Appropriate interventions must take into account these dangers, especially when parents choose to voluntarily take students to the hospital. For example, student may jump out of the car in transport or become violent in the backseat causing the parent to have an accident.
• A counselor and/or other appropriate staff members should remain with the student until a parent/guardian arrives at the hospital
• Notify School Operations (305-995-2913)
• Notify Region Center *
6. Return of Student to School Following Suicide Attempt

When the student returns to school following a suicide attempt, clinical staff must follow up with student and the student’s family by taking the following actions:

- Meet with or call the student prior to his/her return to school and offer support
- Provide the student with direct access to clinical staff
- Consider whether level of clinical service or supervision needs to increase
- Confer with only the staff members who will be responsible for the student during the school day to sensitize them to the student’s need for support, and to familiarize them with appropriate ways to provide that support
- Ascertain level of services provided at the hospital or clinic
- Consult with the student’s current therapist for guidance, if written parental permission has been obtained, to ensure the student’s readjustment to the school environment
- Consult with other student service professionals

7. When a Student Commits Suicide

Implement suicide completion response procedures following the suicide of a student or staff member. Refer to the M-DCPS Critical Incident Response Plan for further information on this topic.

In the event that the suicide occurred on campus, the response procedures are as follows:

- Call 911 and M-DCPS Police (305-757-2677)
- Inform appropriate administrator
- Maintain and model a sense of calm and control
- Assess situation
- Mobilize school/work site Critical Incident Response Team
• Notify School Operations (305) 995-2513*
• Notify Region Center*
• Notify the Public Information Officer (305) 995-4638*
• Contact the Department of Crisis Management (305) 995-2273*
• Secure/contain incident site and affected area, and/or commence building/campus evacuation procedure
• Do not tamper with any evidence, or clean area, until police have completed their investigation
• Prioritize student and staff safety
• Assign campus security liaison to meet and direct emergency personnel to incident site
• Obtain all relevant information regarding the incident, including those involved
• Accompany police officer to personally inform parent/guardian/spouse of the deceased student/staff member
• Provide an opportunity for students and staff to process their reactions regarding the suicide
• Site clinical staff should increase services to students, especially those students highly impacted by this event
• Discourage any “glorification” of a suicide; suicide death should not be announced over the public address system nor are school-sponsored memorial activities recommended
• Convene faculty and staff at the end of the day to review the day’s events and make additional plans*
• Maintain ongoing contact with students/parents/guardians, and staff, as necessary

8. For a Suicide Occurring Off-Campus

For a suicide occurring off campus, the response procedures are as follows:

• Confirm that the incident has occurred
• Designate staff to respond to incident site and/or hospital, if deemed appropriate*
• Make a home visit to offer condolences*
• Mobilize school/work site Critical Incident Response Team*
• Notify School Operations (305) 995-2513*
• Notify Region Center*
• Notify the Public Information Officer (305) 995-4638*
• Contact the Department of Crisis Management (305) 995-2273
• Provide an opportunity for students and staff to process their reactions regarding the suicide
• Site clinical staff should increase services to students, especially to those students highly impacted by the event
• Discourage any “glorification” of a suicide; suicide death should not be announced over the public address system nor are school-sponsored memorial activities recommended.
• Convene faculty and staff at the end of the day to review the day’s events and make additional plans.*

9. Suicide Postvention

Mourning the death of a loved one or friend is one of life’s most difficult challenges. When a death occurs as a result of suicide, the psychological and emotional impact can be devastating. Confusion and questions surrounding such a traumatic loss serve to compound and complicate the grieving process. Further, the risk of a single suicide event influencing others to attempt or complete the act (contagion effect) presents a special concern for the school community.

Responding appropriately to a suicide death of a student or staff member is critical (see Procedures for Promoting and Maintaining a Safe Learning Environment, Guideline #34: Suicide Prevention and Intervention Procedures and the M-DCPS Critical Incident Response Plan Suicide Completion, section II-53). Ultimately, the goals of suicide postvention for schools are to prevent future suicides and suicidal behavior; to effectively respond to those grieving the loss of the deceased; to identify and support those most at risk of self-harm; and to promote the healthy readjustment to the school community.

10. Post-Suicide Guidelines: Do’s and Don’ts

In the aftermath of a suicide completion:

• **Do** verify the facts and treat the death as a suicide
• **Do** give the facts to the students (while downplaying the method)
• **Do** emphasize prevention and everyone’s role in preventing suicides
• **Do** provide individual and group counseling
• **Do** emphasize that no one else is to blame for the suicide
• **Do** emphasize that help is available, that suicides can be prevented, and that everyone has a role to play in prevention
• **Do** contact the family of the deceased
• **Do** consider the wishes and concerns of family members
• **Do** identify and support those who were friends or teachers of the deceased, or others who may be at risk for suicide themselves
• **Don’t** dismiss school or encourage funeral attendance during school hours
• **Don’t** dedicate a memorial to the deceased
• **Don’t** hold a large assembly to notify students of the suicide

American Association of Suicidology (as cited in Poland and McCormick, 1999)
11. Recommendations for Discussing a Suicide Death with Students

- Avoid trying to determine why the deceased took his/her life. Most likely, we will never be able to determine why the individual chose to complete suicide.
- Emphasize that no one except the deceased should be blamed for the suicide. Communicate that the deceased made a choice, a bad and avoidable choice to end his/her life.
- Confront any attempts to glorify or romanticize the suicide.
- Empower students to believe that they can play a major role in preventing future suicides by communicating awareness of any threatening statements or writings shared by peers.
- Inform students of the numerous mental health resources, which are available in the school and community.

12. Complicated Grief Following Suicide

- The act itself is accompanied by social stigma and shame.
- The intense search for “why?” or reasons for the suicide can lead to scapegoat or blaming.
- The suddenness of the event allows no time for anticipatory mourning which may temper the initial shock.
- Investigations by police, etc., can heighten guilt and stigma.
- Guilt is exacerbated by the fact that the death might have been prevented.
- Feelings of rejection and desertion affect survivor’s self-esteem.
- Survivors may fear their own self-destructive impulses.
- Questions about the inheritability of suicide are raised by family members.

13. High Risk Students Following a Suicide Completion

- Any student who participated in any way with the completed suicide; helped write the suicide note, provided the means, was involved in a suicide pact, etc.
- Any student who knew of the suicide plans and kept it a secret.
- Siblings, other relatives or best friends.
- Any students who were self-appointed “therapists” to the deceased student and who had made it their responsibility to keep the student alive.
- Any student with a history of suicidal threats and attempts.
- Any student who identified with the victim’s situation.
- Any student who had a prior reason to feel guilty about things they had said or done to the student prior to the student’s death.
- Other students desperate for any reason, who now see suicide as a viable alternative.
- Any student who observed signs or behaviors which they later learned were indicative of the victim’s suicidal intent.

14. Probable High Risk Times
• Anniversary of the suicidal death
• Birthday of the deceased
• For the family members of the deceased: birthdays, holidays, expected graduation date, etc.

15. Value of Consultation

We strongly encourage full utilization of the resources available within our EH/SED programs. The following clinical staff are available for consultation: SED clinicians, clinical art therapists, and EH counselors as well as the school’s TRUST counselor. When possible, it is a best practice to consult with other clinicians when determining level of risk and level of interventions needed during a crisis. Consultation by another on site clinician is invaluable and strongly encouraged, as it reduces clinician liability and increases the quality of services delivered to our students.

H. Baker Act

A student may exhibit self-injurious behavior, suicidal/homicidal ideation, intent or plan which requires immediate action. Involuntary Examination (Chapter 394, F.S.), the Baker Act, states that an individual may be taken to a receiving facility for involuntary examination if:

• He/she has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination.

• The person is unable to determine for him or herself whether an examination is necessary.

• Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services.

• There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to him/herself or others in the near future, as evidenced by recent behavior.

It is important for clinicians to be aware that a child or adolescent may not be able to provide consent to receive a voluntary examination due to age and/or mental status. Students who exhibit the above-cited behaviors may agree during the school evaluation to voluntarily go to a crisis unit, but oftentimes later recant or become defiant. Additionally, parents may state that they are willing to transport the student to a crisis center, but this may not be a safe or reliable alternative. The
child may jump out of the car, refuse to follow parent directives, or the parent may choose not to take the child to the crisis center. It is imperative that the clinician consider all of these factors when determining whether a Baker Act should be initiated.

There are only three ways to initiate the Baker Act:

- An ex parte order (court order where a family member or adult petitions the court
- Police officer
- Professional certificate completed by a physician, clinical psychologist, clinical social worker, licensed mental health counselor, or psychiatric nurse

The statute utilizes specific language when detailing these methods: “the court may issue an ex parte order,” “a physician, clinical psychologist, psychiatric nurse, or clinical social worker may execute a certificate,” but “a police officer shall take a person who appears to meet the criteria, shall execute a written report detailing the circumstances under which the person was taken into custody.” The law does not indicate the police officer must observe the individual – it requires the police officer to report on the circumstances which led to the Baker Act. The law specifies that the criteria are based on recent behavior; a police officer can utilize credible witnesses as the basis of the Baker Act. The professional certificate requires clinicians to report on what specifically they observed; police officers only have to report on the circumstances which led them to Baker Act.

It is important for law enforcement and clinicians to note the following. Section 394.459(10) F.S. states “any person who acts in good faith in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section does not relieve any person from liability if such person commits negligence.” As long as an individual acts in “good faith” they are immune “from civil or criminal liability”, but negligence, failure to act, is not covered under this immunity.

**VI. Physical Restraint Procedures**

Students enrolled in EH and SED programs, because of the nature of the disability, may on occasion experience impaired impulse control of such severity that the use of physical restraint is necessary to prevent such students from inflicting harm to himself/herself or others, or from causing damage to property. It is not to be used to “teach the child a lesson” or as punishment. Students enrolled in other exceptional student programs may also display behaviors that may require the use of physical restraint.

Strategies for the prevention of aggressive behavior shall be utilized on an ongoing basis. However, when an explosive event occurs without warning and is of such a degree that
there is imminent risk to person or property, the use of physical restraint techniques is authorized.

Physical restraint refers to the use of physical intervention techniques designed to restrict the movement of a student in an effort to de-escalate aggressive behavior. In order to promote a safe learning environment, the district has authorized the implementation of specific physical restraint procedures to be used in EH, SED, and autistic programs. These specific procedures may also be used with other exceptional education students, when it is indicated on the student’s IEP. These procedures include, but are not limited to, holding and escape techniques which, when implemented, prevent injury to students and staff or prevent serious damage to property. Specific physical restraint procedures may also be approved for use with other specific student populations upon mutual agreement of the parties and would be reviewed on an annual basis.

The School Board shall provide for the training of instructional and support staff in Physical restraint techniques, as well as strategies for prevention of aggressive behavior. Training materials developed for this purpose are available at school sites.

Physical restraint techniques provided in training programs approved by the Board are authorized and, when utilized in accordance with the training provided, these guidelines shall not constitute grounds for disciplinary actions. If a teacher is not trained in the use of approved physical restraint procedures and is faced with an emergency, the teacher is authorized to employ the moderate use of physical force or physical contact as may be necessary to maintain discipline or to enforce School Board rules. The appropriate use of these procedures shall not constitute a violation of the corporal punishment policy.

The use of physical restraint techniques shall be discussed as part of the IEP development and review process. A recommendation for the use of Board–approved safe crisis management must be made by the Multi-Disciplinary Team (M-Team) and shall be documented on the student’s IEP form before the use of such procedures may be authorized. The Local Educational Agency (LEA) representative, at the initial IEP meeting and/or annual review, shall provide notification to parents of physical restraint procedures. When parents or surrogates are not present at the meeting, written notification to them regarding the use of safe crisis management will be provided.

The use of physical restraint must be documented as part of the Student Case Management System. Instructional or support staff who utilize physical restraint techniques shall complete the Student Case Management Services form to record student case information regarding each incident. Directions shall be provided to instructional and support staff to assist them in completing the appropriate form.

VII. Media Release

Parental/guardian permission must be obtained in order to photograph or videotape for publication or distribution of any kind. (See Ch. 8, Forms, for a Media Release form).
VIII. Clinical Documentation

Clinical staff work within a school setting. Session notes are considered part of the school record. Therefore, parents as well as other school personnel have the right to review these session notes for their review in addition to the clinical records/notebook itself. Special consideration should be made when documenting sensitive information due to this potential risk. Keeping personal notes is up to the discretion of the clinician and art therapist.

IX. Medication Administration

Many students in special programs are on medication. The following are guidelines, which must be followed in the administration of medication to students during school hours:

A. Every attempt must be made by the student’s parent and physician to have medications administered at home during non-school hours. When this is not possible a completed Medication Authorization Form must be provided for each medication during the school hours. School personnel may administer no medication unless the parent presents the school with a completed Medication Authorization Form, signed by the physician and parent.

B. The Medication Authorization Form must be renewed each school year and placed in the student’s cumulative folder. A copy should also be kept with the person administering the medication.

C. Any changes in the type, dosage or frequency of medication administered will require a new Medication Authorization Form to be completed.

D. The Medication Authorization Form must be current. Place expiration date in red at the top or bottom of the Authorization Form. This makes a quick reference.

E. For medications that are terminated, draw a line through the authorization slip. The Medication Authorization Form should be filed in the student’s Cumulative Health Record (HRS-H Form 3041).

F. In an emergency situation a Medication Authorization Form can be faxed to the physician and returned by fax to the school. A copy should be made of the form, as fax copies fade. An original must be obtained from the physician and include parent/guardian signatures.

G. Every time a medication is given, all School Board employees will use the universal medications safety precautions, known as the five Rights of Medication
Administration: The right drug, the right dose, the right time, the right route (mouth, inhaler, suppository, etc.), and the right student.

H. Always wash hands before administering medications.

I. If there is any question concerning the medication, contact the parent, physician, or pharmacy before administration.

J. Medications are to be brought to school by the student’s parents or guardians.

K. Medications are not to be transported on a school bus, unless student is accompanied by a trained personnel.

L. Non-prescription (over the counter) medication must be received in its original container and labeled with the student’s name. A completed and signed Medication Authorization Form must accompany each over the counter medication.

M. Prescription medication must be received in a pharmacy labeled container with the following information:
   - Student’s name
   - Physician’s/nurse practitioner’s name
   - Pharmacy name and phone number
   - Name of medication
   - Directions concerning dosage and administration
   - Expiration date

STORAGE AND LABELING AND DISPOSAL OF MEDICATIONS

A. Medications must be stored in a locked cabinet in the health room clinic. If medication must be refrigerated, it should be stored in a sealed box in a locked refrigerator in the health room clinic.

B. Medication must be kept in the prescription container in which it was dispensed with date, dosage, name of drug, student’s name, physician’s name, pharmacy name and phone number clearly marked.

C. The cap of the container should always be replaced tightly to prevent exposure to air and bacterial growth.

D. Medication that changes color, appearance, or has an odor, should not be given. Notify the parent(s) immediately.

E. Refrigerated medications should not be kept in the refrigerator door.
F. Food should not be stored in the same refrigerator as medications.

G. For medication that is no longer being given, a note must be sent home to parents to pick up unused medications.

H. Unused medications should not be disposed of at school.

I. No medication should be disposed of at school.

J. No medication should remain in the school’s locked medicine cabinet at the end of each school year except for year round schools.

ADMINISTRATIVE TECHNIQUES:

A. Always wash hands carefully before and after giving medications.

B. Follow the label directions carefully including any precaution stickers.

C. Record all medications immediately on the Student Medication Log (see Chapter VIII, Forms, for Medication Log). Date and initial each entry, with the time given. The Student Medication Log and the Medication Authorization Form are to be kept together in a medication binder or folder.
CHAPTER VII

COMMUNITY RESOURCES
COMMUNITY RESOURCES

The following is a list of Miami-Dade County community resources, which may be of assistance to students identified as EH/SED and their families:

Refer to the following websites for additional community resources:

- **Miami-Dade County Public Schools**
  [http://sednet.dadeschools.net](http://sednet.dadeschools.net)
  [http://ese.dadeschools.net](http://ese.dadeschools.net)
  Click Emotional Handicapped Programs /Clinical Services

- **FDLRS-Community Resource Guide 2004**
  [http://fdlrs-south.dadeschools.net](http://fdlrs-south.dadeschools.net)

- **Switchboard of Miami**
  [www.switchboardmiami.org](http://www.switchboardmiami.org)

- **Florida Department of Education**
  [www.firm.edu/doe/commhome/pub-home.htm](http://www.firm.edu/doe/commhome/pub-home.htm)
  Click Instructional Support and Community Services Publications

**Abuse Registry**
1-800- 96-ABUSE
1-800-962-2873

**Alcoholics Anonymous**
305-371-7784

**Al-Anon**
305-663-0029

**Alliance for Human Services**
3250 S.W. 3rd Ave.
Miami, FL 33129
305-646-7134

**Baker Act**
Click Involuntary Petition Handbook

**BayView Center for Mental Health, Inc.**
12550 Biscayne Blvd., #919
Miami, FL 33150
305-892-4646

**Bertha Abess Children’s Center**
5801 Biscayne Blvd.
Miami, FL 33137
305-756-7116
305-893-7400

**Center for Family & Child Enrichment**
1825 N.W. 167th St., #102
Miami, FL 33056
305-624-7450

**CHARLEE of South Dade County Inc.**
5915 Ponce De Leon Blvd., Suite 26
Coral Gables, Fl. 33146
305-665-7365

**CHI (South)**
10300 S.W. 216th St.
Miami, FL 33190
305-253-5100

**Children’s Home Society**
17501 S.W. 117th Ave.
Miami, FL 33157
305-254-9759

**Children’s Psychiatric Center, Inc.**
- **North Dade Office**
  15490 N.W. 7th Ave., Suite 101
  Miami, FL 33169
  305-685-0381
- **South Office**
  9380 Sunset Dr., Suite B-120
  Miami, FL 33173
  305-274-0841
- **Hialeah Office**
  430 W. 66th St.
  Hialeah, FL 33012
  305-558-2480

**The Children’s Trust**
1900 Biscayne Blvd., Suite 200
Miami, FL 33132
305-571-5700
www.thechildrenstrust.org

Citrus Health Network
4175 W. 20th Ave.
Hialeah, FL 33012
305-825-0300

Department of Children and Families
401 N.W. 2nd Ave.
Miami, FL 33128
305-377-5006
305-377-7582

Department of Juvenile Justice
11430 N. Kendall Dr. Suite101
Miami, FL 33176
305-598-6998

Douglas Gardens CMHC
701 Lincoln Rd., 2nd Floor
Miami Beach, Fl 33139
305-531-5341

Family Violence Shelters
305-758-2546

Fellowship House
5711 S. Dixie Highway
South Miami, FL 33143
305-667-1036

The Human Services Coalition
260 N.E. 17th Terr.
Miami, FL 33132
305-576-5001

Jackson Memorial Hospital
1611 N.W. 12th Ave.
Miami, Fl 33136

  • Emergency Mental Health Hotline
    305-324-4357

Jackson North CMHC
20201 N. W. 37th Ave.
Miami Fl 33056
305-628-8984
  • Crisis Stabilization Unit
    305-681-2631
  • Adult Outpatient Services
    305-681-2095

Jackson South Community Hospital
9333 S.W. 152nd St.
Miami, Fl 33157
305-251-2500
www.um-jmh.org/body.cfm?id=49

Jewish Community Services of South Florida
305-933-9820

Jewish Family Services
  • Aventura
    305-933-9820
  • Coral Gables
    305-445-0555
  • Kendall
    305-670-1911
  • Homestead
    305-248-2522

Marchman Act
www.MyFlorida.com
Substance Abuse Handbook

MENTOR
7700 N. Kendall Dr., Suite 607
Miami, FL 33156
305-598-0242

Miami Behavioral Health Center
3580 W. Flagler St.
Miami, Fl 33134
305-774-3300
  • Coconut Grove Office
    305-442-0748
  • Westchester Office
    305-553-4322

Miami Bridge
  • Central Unit
    305-635-8953
• Homestead Unit  
  305-636-3526

Miami Children’s Hospital  
6125 S.W. 31st St.  
Miami, Fl 33155  
305-666-6511  
www.mch.com

Missing Children Information Clearinghouse  
1-888-Fi-MISSING  
1-888-356-4774

Multi-Agency Network for Students with Emotional Disturbance (SEDNET)  
11001 S.W. 76th St., #63  
Miami, FL 33173  
305-598-2436  
http://sednet.dadeschools.net

NA & Al-Anon  
• North  
  305-620-3875  
• South  
  305-265-9555

National Runaway Switchboard  
1-800-621-4000

New Horizons Community Mental Health Center  
1313 N.W. 36th St.  
Miami, FL 33142  
305-635-7444  
• Day Treatment  
  305-759-5262

Parent Hotline  
1-888-41-FAMILY  
1-888-413-2645

Runaway Hotline (Florida)  
1-800-RUNAWAY  
1-800-786-2929

South Florida Mental Health Association, Inc.  
2140 South Dixie Highway  
Miami, FL 33133
305-854-5827

Switchboard of Miami Crisis Hotline
1-800-358 HELP
1-800-358-4357
www.switchboardmiami.org
Referral Information

University of Miami Child Protection Team
1150 N.W. 14th St., Suite B-212
Miami, FL 33136
305-243-7550

Women in Distress-Crisis Line
954-761-1133
CHAPTER VIII

FORMS
FORMS

The Office of Special Education, Alternative Outreach and Psychological Services has completed a review of all Special Education forms. Some of the forms, identified by FM#’s, are only available on the M-DCPS website. This change in policy is due to the continuous need to update forms in order to meet state and federal requirements. This new procedure ensures that the most current form is being used.

Forms used by EH/SED staff that are not available on the M-DCPS website can be found on the following pages. Some forms have been completed as sample documentation.

To access forms with FM#’s, go to www.dadeschools.net. Click on “Records and Forms” under “Resources.” Under “Search by Form Number,” type in the FM# from the list at the end of this chapter. In order to access forms you need Adobe Acrobat Reader 5.05.

“ESH” following the title of any form indicates the form is available in English, Spanish and Haitian-Creole. In order to access the Spanish and Creole version of the form click on the appropriate bookmark on the left side of the form.
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<tr>
<th>Form #</th>
<th>Form Title</th>
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<tr>
<td>6747</td>
<td>Parent and Teacher Guide to Section 504: Frequently Asked Questions</td>
<td>May-04</td>
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<td>5319</td>
<td>Section 504 Eligibility Determination (ESH)</td>
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<td>5320</td>
<td>Section 504 Accommodation Plan</td>
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**Art Therapy**

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<td>Clinical Art Therapy- Group Parent Contact Log</td>
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<td>6786</td>
<td>Clinical Art Therapy- Individual Parent Contact Log</td>
<td>Jun-04</td>
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<td>6787</td>
<td>Parent Permission for Clinical Art Therapy Activities</td>
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<td>Criteria for Determining Eligibility for Clinical Art Therapy</td>
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<td>Clinical Art Therapy Session Treatment Notes</td>
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**Assistive Technology**

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**Child Study Team / CST**

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<td>CST Request for Evaluation</td>
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<td>3040</td>
<td>Child Study Team Plan</td>
<td>May-03</td>
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<td>5239</td>
<td>Alternative Strategies and Follow-Up Form</td>
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# Child Study Team - Reevaluations (CST-R)

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<td>CST-R Documentation Form</td>
<td>Nov-03</td>
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<td>4958</td>
<td>Informed Notice of Reevaluation Review Meeting and/or Consent for Reevaluation (ESH)</td>
<td>Aug-04</td>
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[Return to Forms Category Listing](#)

# Emotionally Handicapped and Severely Emotionally Disturbed Related Forms / EH and SED

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<td>Counseling Services Record Sheet</td>
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<td>6497</td>
<td>Parental Permission to Photograph Students</td>
<td>July-03</td>
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<td>6579</td>
<td>Counseling Services Record Sheet for EH Counselors</td>
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<td>Clinical Services for the Programs for EH and SED-Student Contact Log</td>
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<td>6596</td>
<td>Clinical Services for the Programs for EH and SED-Crisis Notes</td>
<td>Sept-03</td>
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<td>6599</td>
<td>Clinical Services for the Programs for EH and SED-Clinical Progress Report</td>
<td>Jan-05</td>
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<td>6632</td>
<td>Clinical Services for the Programs for EH and SED-Clinician Schedule</td>
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<td>5351</td>
<td>Program Performance Plan for EH/SED Behavior Management Teachers</td>
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<td>Emotionally Handicapped Case Summary Form</td>
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[Return to Forms Category Listing](#)

# ESOL

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<td>Modified Oral Language Proficiency Scale, grades 3-5</td>
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<td>Modified Oral Language Proficiency Scale, grades K-2</td>
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<td>Modified Oral Language Proficiency Scale, grades 6-12</td>
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## Bilingual/ESOL ESE Program Monitoring

**Form #** 6639  
**Form Title** Bilingual/ESOL ESE Program Monitoring  
**Revision Date** Oct-03

[Return to Forms Category Listing](#)

## Extended School Year (ESY)

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<td>School Based Extended School Year (ESY) Services Log: Summer 2005</td>
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[Return to Forms Category Listing](#)

## FCAT

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<td>Waiver of FCAT Graduation Requirements for Students with Disabilities</td>
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[Return to Forms Category Listing](#)

## Functional Assessment of Behavior / FAB

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<td>Functional Assessment of Behavior Screening Worksheet</td>
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<td>FAB Data Collection: Latency</td>
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<td>Functional Assessment of Behavior Antecedent-Behavior - Consequence Analysis</td>
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<td>FAB Data Collection Scatter Plot</td>
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<td>Functional Assessment Observation Form</td>
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## Individual Educational Plan (IEP)

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<td>Parent Resources (ESH)</td>
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<td>Procedural Safeguards (ESH)</td>
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<td>Individual Educational Plan</td>
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<td>Additional Conference Notes</td>
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<td>Special Diploma: Sunshine State Standards, Insert A (IEP)</td>
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<td>Measurable Annual Goals and Benchmarks, Insert B (IEP)</td>
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<td>Individual Transition Plan, Insert C (IEP)</td>
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<td>Educational Setting-Adaptations, Insert D (IEP)</td>
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<td>Changes in Educational Services (IEP insert)</td>
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<td>School Level ESE Staff Student Observation Form</td>
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<td>Extended School Year (ESY) Services Form</td>
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<td>Parent and Student Notification, Transfer of Rights at Age of Majority (ESH)</td>
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<td>Parent Notification Physical Restraint Procedures (ESH)</td>
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<td>Informed Notice of Proposal or Refusal... (ESH)</td>
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<td>Status Report Letter of IEP Goals (ESH)</td>
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<td>Student Services / ESE Services Data Input Sheet</td>
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<td>Consent Form for Mutual Exchange of Information (ESH)</td>
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<td>IEP Instructional Goals and Objectives-Oral Motor</td>
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<td>Exceptional Student Records (folder)</td>
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<td>Factors for Consideration of Equipment Release/Transfer from M-DCPS</td>
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### Matrix

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### Miscellaneous

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<td>Parent Notification Physical Restraint Procedures (ESH)</td>
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<td>Travel Request Form</td>
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<td>9731/9615 Payroll and Travel Review</td>
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<td>9731/9615 Payroll Leave/Documentation Recommendation/Approval Form</td>
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### Nursing and/or Respiratory Therapy

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<td>Physician’s Request for In School Nursing and/or Respiratory Therapy Services</td>
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### Psychological Services

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<td>Review of Psychological Reports Originating Outside MDCPS</td>
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<td>Psychological Services School Case Log</td>
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<td>Standards for Psychological Services</td>
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<td>Psychological Progress Report</td>
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### School Support Team / SST

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<td>6278</td>
<td>School Support Team, Request for Assistance Form</td>
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<td>6285</td>
<td>School Support Team - Mathematics Data</td>
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<td>6290</td>
<td>School Support Team Intervention Plan</td>
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<td>School Support Team Secondary Reading/Writing Data</td>
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<td>6493</td>
<td>SST Monitoring System</td>
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<td>Parent/Guardian Student Support Plan (Optional Form) (ESH)</td>
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<td>SST Liaison Activity Log</td>
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### Student Development Team (SDT)

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<td>SDT Monitoring System</td>
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<td>Student Development Team Intervention Plan</td>
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<td>SDT Request for Evaluation</td>
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<td>Student Development Team Request for Assistance</td>
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### Surrogate Parent

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<td>Request for A Surrogate Parent</td>
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<td>Surrogate Parent Student Assignment</td>
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<td>Request for Special Transportation Services Due to Medical Needs</td>
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<td>6546</td>
<td>Request for Review of Medical Documentation for Specialized Transportation</td>
<td>May-03</td>
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Miami-Dade County Public Schools

Sample Behavior Management Teacher Schedule

Name: _____________________________   Date: ___________________

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**Explanation of Number Codes**

1. Review of Student Records
2. Student Academic Assessment
3. Classroom Observation
4. Student Observation
5. Classroom Support
6. Student Supervision
7. Teacher Consultation/Planning
8. Affective Activity
9. Demonstration Lesson
10. Conference with Administrators
11. Parent Conference
12. Flexible Time
13. Staffing/IEP Conference
14. Reinforcement Time
Programs for the Severely Emotionally Disturbed
and Emotionally Handicapped

SAMPLE COUNSELOR REQUEST FORM

Centennial Middle
Ms. Samuel
BMT Request Form

Teachers/Students: Please Place in My Box

Name: ________________________   Date: _______________

Teacher/Room Number: ______________________________

Reason:

___________ Personal

___________ Academic concern

___________ Conflict with another student
                   Name of the other student________________________

___________ Referral/Behavior Consultation

___________ Other

Please describe the situation in detail:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
## Miami-Dade County Public Schools
### Sample Baseline

Date: 

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<th>Name/Target Behavior</th>
<th>Level</th>
<th>Beh. Report</th>
<th>Supp.</th>
<th>1st per.</th>
<th>2nd per.</th>
<th>3rd per.</th>
<th>4th per.</th>
<th>Lunch</th>
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**Miami-Dade County Public Schools**

**Sample Medication Log**

Student’s name: _______________________      Medication: _______________

Address: _____________________________      Dosage: _______________

Home/Telephone Contact: _______________      Time: _______________

Classroom/Homeroom Teacher: ___________________________________________

Doctor’s Name and Phone Number: ________________________________________

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<th>Signature of Person Administering</th>
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List of any side effects:

_____________________________________________________________

_____________________________________________________________

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</table>
Sample Behavior Management Teacher
Parent Conference Form

Student Name: _____________________________  Date: ____________

Parent Name: __________________________________________

Phone Number: _______________________

Teacher Name: _______________________________

Purpose of Conference:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Summary of Conference/ Results
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Additional Notes:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Miami-Dade County Public Schools
Sample Daily Behavior Report

Date________________
___________________
___________________

____________ % of his/her points today.

1. Following directions/participation
2. Staying in seat and on task
3. Ignoring inappropriate behavior
4. Respecting self, others and learning environment
5. Target Behavior____________________________________
6. Target Behavior____________________________________

____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

There is Homework tonight in:

Learning Strategies______    Science___________
History___________    Math___________
Language Arts_______    Extra Activities_______

No Homework Tonight______

__________________________
Parent/Guardian Signature

Parent/Guardians Comments:
____________________________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

November, 2005
Miami-Dade County Public Schools

Sample Daily Inclusion Slips

Name: __________________________   Date: ________________

Conduct: Satisfactory: ____________  Unsatisfactory: ___________

Teacher Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Miami-Dade County Public Schools

Sample Daily Inclusion Slips

Name: __________________________   Date: ________________

Conduct: Satisfactory: ____________  Unsatisfactory: ___________

Teacher Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Programs for the Severely Emotionally Disturbed and Emotionally Handicapped

Centennial Middle School
Sample Weekly Inclusion Report

To:_____________________     Date:_______________

From:__________________

Student’s Name:_________________________    Period:______

The student above is currently included into your class and is enrolled in ESE for part of the school day. In order to make educational decisions, your input is important. Please complete this form and return to my mailbox. Thank you ☺

Academic Performance (Check one)

_____ Above Average    _____ Attendance

_____ Average       _____ Absences

_____ Below Average  _____ Tardies

Behavior/Attitude (Please check all that apply)

_____ Attentive       _____ Uncooperative

_____ Cooperative   _____ Unmotivated

_____ Motivated     _____ Inattentive

_____ Works independently  _____ Works only under direct supervision

_____ Interacts favorably with teacher  _____ Appears isolated from peers

_____ Interacts favorably with peers   _____ Openly rejected by peers

_____ Completes homework   _____ Participates in class activities

Additional Comments:____________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Do you recommend this student to remain in your class? _______
Off-Level Form

Name: ________________________            Date: ____________

I, _______________________, have been benched due to my behavior. I understand that I have lost my privileges for 3 days and I will not move up in days in my team while being benched.

The behavior that caused me to be benched was

____________________________________________________________________________________

____________________________________________________________________________________

The reason I chose to behave this way was

____________________________________________________________________________________

____________________________________________________________________________________

Next time, instead of behaving this way, I will

____________________________________________________________________________________

____________________________________________________________________________________

This is my ____________ time being benched.

Student Signature: ______________________________________

Staff Signature: ________________________________________

Parent Signature:
CHAPTER IX

APPENDIX
M-DCPS Acronyms

1. AP  Assistant Principal  
2. AATA  American Art Therapy Association  
3. ATCB  Art Therapy Credentials Board  
4. AEP  Alternative Education Program  
5. ATR  Art Therapist Registered  
6. BD  Behavior Disorder  
7. BC  Board Certified  
8. BIP  Behavior Intervention Plan  
9. CD  Communication Disorder  
10. CEC  Council of Exceptional Children  
11. CSPD  Comprehensive System of Personal Development  
12. CST  Child Study Team  
13. DAE  Division of Alternative Education  
14. DCF  Division of Children and Families  
15. DD  Developmentally Delayed  
16. DJJ  Department of Juvenile Justice  
17. DOB  Date of Birth  
18. EC  Established Conditions  
19. EH  Emotionally Handicapped  
20. EMH  Educable Mentally Handicapped  
21. ESE  Exceptional Student Education  
22. EESAC  Educational Excellence School Advisory Council
<table>
<thead>
<tr>
<th></th>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>23</td>
<td>ESOL</td>
<td>English for Speakers of Other Languages</td>
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<td>24</td>
<td>FAB</td>
<td>Functional Assessment of Behavior</td>
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<td>25</td>
<td>FAPE</td>
<td>Free Appropriate Public Education</td>
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<td>26</td>
<td>FBE</td>
<td>Florida Board of Education</td>
</tr>
<tr>
<td>27</td>
<td>FDLE</td>
<td>Florida Department of Law Enforcement</td>
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<td>28</td>
<td>FDOE</td>
<td>Florida Department of Education</td>
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<td>29</td>
<td>FPC</td>
<td>Facilities Planning and Construction</td>
</tr>
<tr>
<td>30</td>
<td>FT</td>
<td>Full-time (more than 12 hours)</td>
</tr>
<tr>
<td>31</td>
<td>F.S.</td>
<td>Florida Statues</td>
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<tr>
<td>32</td>
<td>FTE</td>
<td>Full-time equivalency</td>
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<tr>
<td>33</td>
<td>HI</td>
<td>Hearing Impaired</td>
</tr>
<tr>
<td>34</td>
<td>IDEA</td>
<td>Individual with Disabilities Act</td>
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<td>35</td>
<td>IEP</td>
<td>Individual Education Program</td>
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<td>36</td>
<td>ISIS</td>
<td>Integrated Student Information System</td>
</tr>
<tr>
<td>37</td>
<td>JJSP</td>
<td>Juvenile Justice Support System</td>
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<td>38</td>
<td>LA</td>
<td>Language Age</td>
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<tr>
<td>39</td>
<td>LD</td>
<td>Learning Disabilities</td>
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<tr>
<td>40</td>
<td>LD/INT</td>
<td>Learning Disability/Intensive Speech</td>
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<tr>
<td>41</td>
<td>LECATA</td>
<td>Levick Emotional and Cognitive Art Therapy Assessment</td>
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<td>42</td>
<td>LEP</td>
<td>Limited English Proficiency</td>
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<td>43</td>
<td>L/LD</td>
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<td>44</td>
<td>LEA</td>
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<td>45</td>
<td>M-DCPS</td>
<td>Miami-Dade County Public Schools</td>
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<td>46.</td>
<td>MLR</td>
<td>Mean Length of Response</td>
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<td>47.</td>
<td>MLU</td>
<td>Mean Length of Utterance</td>
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<td>48.</td>
<td>MPP</td>
<td>Master Plan Points</td>
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<td>49.</td>
<td>MSPS</td>
<td>Minimum Student Performance Standards</td>
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<td>OIT</td>
<td>Office of Information Technology</td>
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<td>51.</td>
<td>OLPS</td>
<td>Oral Language Proficiency Scale</td>
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<td>52.</td>
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<td>53.</td>
<td>OT</td>
<td>Occupational Therapy</td>
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<tr>
<td>54.</td>
<td>PARIS</td>
<td>Pupil Ad Hoc Response Information</td>
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<td>55.</td>
<td>PEN</td>
<td>Priority Educational Needs</td>
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<td>56.</td>
<td>PI</td>
<td>Physically Impaired</td>
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<td>57.</td>
<td>PMH</td>
<td>Profoundly Mentally Handicapped</td>
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<td>58.</td>
<td>PPP</td>
<td>Pupil progression Plan</td>
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<td>59.</td>
<td>PREP</td>
<td>Primary Educational Program</td>
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<td>60.</td>
<td>PT</td>
<td>Physically Therapy</td>
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<td>61.</td>
<td>PTO</td>
<td>Parent Teacher Organization</td>
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<td>62.</td>
<td>PTS/PTA</td>
<td>Parent/Teacher/Students- Parent/Teacher Association</td>
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<td>63.</td>
<td>SBE</td>
<td>State Board Education</td>
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<td>SCMS</td>
<td>Student Case Management System</td>
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<td>School Center for Special Education</td>
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<td>66.</td>
<td>SDT</td>
<td>Silver Drawing Test</td>
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<td>67.</td>
<td>SEA</td>
<td>State Education Agency</td>
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<td>68.</td>
<td>SED</td>
<td>Severely Emotionally Disturbed</td>
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<td>Description</td>
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<td>69</td>
<td>SESIR</td>
<td>Schools Environmental Safety Incident Reporting</td>
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<td>70</td>
<td>SLD</td>
<td>Specific Learning Disabled</td>
</tr>
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<td>71</td>
<td>SPP</td>
<td>Student Performance Plan</td>
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<td>72</td>
<td>SST</td>
<td>Student Support Team</td>
</tr>
<tr>
<td>73</td>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>74</td>
<td>TP</td>
<td>Therapeutic Plan</td>
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<tr>
<td>75</td>
<td>UTD</td>
<td>United Teachers of Dade</td>
</tr>
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<td>76</td>
<td>VE</td>
<td>Varying Exceptionality</td>
</tr>
<tr>
<td>77</td>
<td>VI</td>
<td>Visually Impaired</td>
</tr>
<tr>
<td>78</td>
<td>VT</td>
<td>Visiting Teacher</td>
</tr>
<tr>
<td>79</td>
<td>WNL</td>
<td>Within Normal Limits</td>
</tr>
<tr>
<td>80</td>
<td>WL</td>
<td>Work Location</td>
</tr>
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</table>
Affective Materials

Kits
1. ART (Aggression Replacement Training)
2. AWARE
3. DEAL (DLM) Daily Experiences and Activities for Living Series
4. Children are People
5. Coping with Series
6. Learning Tree Series
7. MARC (Model Affective Resources Curriculum)
8. Problem Solving
9. Project Self-Esteem
10. TAD (Toward Affective Development)
11. Transition
12. TRUST
13. EQUIP
14. Stop-n-Think
15. Teen Sense
16. Bullying Game

Reproducibles
1. Communicating to Make Friends
2. Contracts
3. Decision Making
4. Feeling About Friends
5. Getting Along With Others
6. Good Apple Books (Caring, loving, Sharing, Coping Etc.)
7. Skill Streaming for the Adolescent
8. Think Aloud
9. Thinking publications (SSS- Social Skills Strategies, Scripting, Social Communication for Adolescents , Study Smart)
10. Resource Book- Counseling Activities for Children at Risk by: Sue Dennison
11. SEAL

Adventure Curriculum
1. Adventure in the Classroom
2. Silver Bullets
3. Quicksilver
4. Cowstails and Cobras
5. Teamwork/Teamplay

Affective/ Social Personal Software
A comprehensive list of affective computer software has been complied and is available at FDLRS 305-274-2501
Catalogues
1. WPS (Western Psychological Services) Creative Therapy Store
   www.creativetherapystore.com
2. Psychological Assessment Resources www.parnic.com
3. Wellness Reproductions and Publishing, LLC A guidance Channel Company
   www.wellness-resources.com
5. CHILDCRAFT preschool-4th grade www.childcraft.com

Topics for Affective Education

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Goal Setting</th>
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<tbody>
<tr>
<td>Coping Skills</td>
<td>Mainstreaming</td>
</tr>
<tr>
<td>Social interactions</td>
<td>Values</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>Career Education</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>Vocational Skills</td>
</tr>
<tr>
<td>Family</td>
<td>Relationships</td>
</tr>
<tr>
<td>Peer Pressure</td>
<td></td>
</tr>
<tr>
<td>Drug and Alcohol Abuse</td>
<td></td>
</tr>
</tbody>
</table>
Centennial Eagles are Traveling to the Super Bowl
Level System of the E.H. Program

1. Every player (student) will be able to earn up to $10.00 per hour (period) to equal $100.00 per day.

2. Every player will be able to earn up to $50.00 in bonuses per day. (This can be given to the student for immediate reinforcement in the form of a token, point card, sticker, and teacher’s choice.)

3. Players will receive their checks from their teachers only on Fridays to avoid any confusion. Teachers may decide to deduct off level, timeout, no day fees before paying the player or have the player write out a check to the teacher (teacher’s choice). *remember they still have to pay for reinforcement!!*

4. When the player completes a level, it is considered a “TOUCHDOWN”; he/she receives a $1,000 bonus, in the form of a check.

5. If the player does not make their day by 20% below or more, he/she will still move back a day and pay the no day fee.

6. Teachers/Paras’ should have a separate folder for behavior reports where the students can store their check books and issued checks.
List of Fines

1. No Days = $ 10.00 (20% below)
2. Off- Levels = $ 50.00 each
3. Time Out 1 = $ 5.00
4. Time Out 2 = $ 20.00

Levels/Teams

Level 1- Pre-Season
30 days  70%
69-40 same day
39 and below, move back a day

Level 2- Regular Season
35 days  80%
79-60 same day
59 and below, move back a day

Level 3- Play Offs
40 days  90%
89-70 same day
69 and below, move back a day

Level 4- Pro’s
40 days  95%
94-75 same day
74 and below, move back a day

Level 5- Super Bowl
35 days  100%
80-70 same day
69 and below, move back a day
The Team System provides EH students an opportunity to assume responsibility for their own behavior. The teacher assists the student by labeling their behavior into four teams (Bronze, Silver, Gold and All Stars). All students new to the program begin on the Bronze Team. The following chart provides an overview of common elements for all teams.

**Bronze Team**
Criteria: 10 days of 60 points
Privileges: Activity at seat during activity time
Shop at store
Movement through Team: 60 points and above-move up a day
50-59 points-stay on same day
Less than 50 points-move back a day

**Silver Team**
Criteria: 15 days of 70 points
Privileges: Activity at seat during activity time
Classroom helper
Shop at store
Movement through Team: 70 points and above-move up a day
60-69 points-stay on same day
Less than 60 points-move back a day

**Gold Team**
Criteria: 20 days of 80 points
Privileges: Activity at seat during activity time
Classroom helper
Go on field trips
Run errands
Shop at store
Movement through Team: 80 points and above-move up a day
70-79 points-stay on same day
Less than 70 points-move back a day
All Star Team
Criteria: 25 days of 90 points
Privileges: Activity at seat during activity time
  Classroom helper
  Go on Field trips
  Run errands
  Special individual activities
  Shop at store
Movement through team: 90 points and above-move up a day
  80-89 points-stay on same day
  Less than 80 points-move back a day

Benched

At times, a student may be benched from their team. When a student is benched, he/she cannot earn any privileges or move up on their team. A student will be benched for the following reasons:

1. Cursing
2. Fighting
3. Leaves the classroom and/or school grounds
4. Stealing

Every time a student is benched, he/she will be required to fill out a Benched Form that will be sent home for parent/guardian signature. The student will be returned to their team, when they have earned the points needed for their current team for three days.
# Miami-Dade County Public Schools
## Sample Point Sheet

**Name:** ______________________  **Week of ________________**

**Team:** Bronze Silver Gold All Star  **Day:** ______ Benched Yes No  **Day:** ______

### Monday

<table>
<thead>
<tr>
<th>Daily Responsibilities</th>
<th>PM Yes No</th>
<th>AM Yes No</th>
<th>Points /10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Bus Rules</td>
<td></td>
<td></td>
<td>/4</td>
</tr>
<tr>
<td>Wear Uniform</td>
<td>Yes NO</td>
<td></td>
<td>/2</td>
</tr>
<tr>
<td>Return Homework and Progress report</td>
<td>Yes NO</td>
<td></td>
<td>/2</td>
</tr>
<tr>
<td>Bring School Supplies to School</td>
<td>Yes No</td>
<td></td>
<td>/2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Points /10</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 AM</td>
</tr>
<tr>
<td>Stay in Seat</td>
</tr>
</tbody>
</table>

| Points /40 |

**Adult/Peer Interaction**

<table>
<thead>
<tr>
<th>Points /30</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 AM</td>
</tr>
<tr>
<td>Speak Respectfully to Peers</td>
</tr>
</tbody>
</table>

| Points /20 |

**Individual Replacement Behaviors**

<table>
<thead>
<tr>
<th>Points /20</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 AM</td>
</tr>
<tr>
<td>Ignore Negative Comments</td>
</tr>
</tbody>
</table>

**Total Points ______/100**

### Tuesday

<table>
<thead>
<tr>
<th>Daily Responsibilities</th>
<th>PM Yes No</th>
<th>AM Yes No</th>
<th>Points /10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Bus Rules</td>
<td></td>
<td></td>
<td>/4</td>
</tr>
<tr>
<td>Wear Uniform</td>
<td>Yes NO</td>
<td></td>
<td>/2</td>
</tr>
<tr>
<td>Return Homework and Progress report</td>
<td>Yes NO</td>
<td></td>
<td>/2</td>
</tr>
<tr>
<td>Bring School Supplies to School</td>
<td>Yes No</td>
<td></td>
<td>/2</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Points /10</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 AM</td>
</tr>
<tr>
<td>Stay in Seat</td>
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</table>

| Points /40 |

**Adult/Peer Interaction**

<table>
<thead>
<tr>
<th>Points /30</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9 AM</td>
</tr>
<tr>
<td>Speak Respectfully to Peers</td>
</tr>
</tbody>
</table>

107
| Keep Hand, Feet, Objects to Self | | | | | | | | | | | | Points | /7 |
| Individual Replacement Behaviors | 8-9 AM | 9-10AM | 10-11 AM | 11-12AM | 12-1PM | 1-2PM | 2-3 PM | | | | | | Points | /30 |
| Ignore Negative Comments | | | | | | | | | | | | Points | /7 |
| Correct Mistakes when given opportunity | | | | | | | | | | | | Points | /7 |

| Team: Bronze Silver Gold All Star Day: _____ Benched Yes No Day: _____ |
| Daily Responsibilities | PM Yes No AM Yes No | Points | /10 |
| Follow Bus Rules | | | /4 |
| Wear Uniform | Yes NO | | /2 |
| Return Homework and Progress report | Yes NO | | /2 |
| Bring School Supplies to School | Yes No | | /2 |
| Points | /10 |
| Follow School / Class Rules | 8-9 AM | 9-10AM | 10-11 AM | 11-12AM | 12-1PM | 1-2PM | 2-3 PM | | | | | | Points | /40 |
| Stay in Seat | | | | | | | | | | | | Points | /7 |
| Raise Hand | | | | | | | | | | | | Points | /7 |
| Follow Directions | | | | | | | | | | | | Points | /7 |
| Stay on task | | | | | | | | | | | | Points | /7 |

| Adult/Peer Interaction | 8-9 AM | 9-10AM | 10-11 AM | 11-12AM | 12-1PM | 1-2PM | 2-3 PM | | | | | | Points | /30 |
| Speak Respectfully to Peers | | | | | | | | | | | | Points | /7 |
| Speak Respectfully to Adults | | | | | | | | | | | | Points | /7 |
| Keep Hand, Feet, Objects to Self | | | | | | | | | | | | Points | /7 |

| Individual Replacement Behaviors | 8-9 AM | 9-10AM | 10-11 AM | 11-12AM | 12-1PM | 1-2PM | 2-3 PM | | | | | | Points | /20 |
| Ignore Negative Comments | | | | | | | | | | | | Points | /7 |
| Correct Mistakes when given opportunity | | | | | | | | | | | | Points | /7 |

| Team: Bronze Silver Gold All Star Day: _____ Benched Yes No Day: _____ |
| Daily Responsibilities | PM Yes No AM Yes No | Points | /10 |
| Follow Bus Rules | | | /4 |
| Wear Uniform | Yes NO | | /2 |
| Return Homework and Progress report | Yes NO | | /2 |
| Bring School Supplies to School | Yes No | | /2 |
| Points | /10 |
| Follow School / Class Rules | 8-9 AM | 9-10AM | 10-11 AM | 11-12AM | 12-1PM | 1-2PM | 2-3 PM | | | | | | Points | /40 |
| Stay in Seat | | | | | | | | | | | | Points | /7 |
| Raise Hand | | | | | | | | | | | | Points | /7 |
| Follow Directions | | | | | | | | | | | | Points | /7 |
| Stay on task | | | | | | | | | | | | Points | /7 |

<p>| Total Points _______/100 | Team: Bronze Silver Gold All Star Day: _____ Benched Yes No Day: _____ |</p>
<table>
<thead>
<tr>
<th>Adult/Peer Interaction</th>
<th>8-9 AM</th>
<th>9-10AM</th>
<th>10-11 AM</th>
<th>11-12AM</th>
<th>12-1PM</th>
<th>1-2PM</th>
<th>2-3 PM</th>
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<tbody>
<tr>
<td>Speak Respectfully to Peers</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speak Respectfully to Adults</td>
<td>/7</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Keep Hand, Feet, Objects to Self</td>
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Points /30

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<th>9-10AM</th>
<th>10-11 AM</th>
<th>11-12AM</th>
<th>12-1PM</th>
<th>1-2PM</th>
<th>2-3 PM</th>
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<tr>
<td>Ignore Negative Comments</td>
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<td></td>
<td></td>
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<td>Correct Mistakes when given opportunity</td>
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<td></td>
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Points /20

Total Points ______/100

Team: Bronze  Silver  Gold  All Star  Day: ______  Benched  Yes  No  Day: _____

Friday

<table>
<thead>
<tr>
<th>Daily Responsibilities</th>
<th>8-9 AM</th>
<th>9-10AM</th>
<th>10-11 AM</th>
<th>11-12AM</th>
<th>12-1PM</th>
<th>1-2PM</th>
<th>2-3 PM</th>
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<tbody>
<tr>
<td>Follow Bus Rules</td>
<td>PM Yes No</td>
<td>AM Yes No</td>
<td>/4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wear Uniform</td>
<td>Yes NO</td>
<td>/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return Homework and Progress report</td>
<td>Yes NO</td>
<td>/2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bring School Supplies to School</td>
<td>Yes NO</td>
<td>/2</td>
<td></td>
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</table>

Points /10

Follow School / Class Rules

<table>
<thead>
<tr>
<th>8-9 AM</th>
<th>9-10AM</th>
<th>10-11 AM</th>
<th>11-12AM</th>
<th>12-1PM</th>
<th>1-2PM</th>
<th>2-3 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay in Seat</td>
<td>/7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raise Hand</td>
<td>/7</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Follow Directions</td>
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<tr>
<td>Stay on task</td>
<td>/7</td>
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Points /40

Adult/Peer Interaction

<table>
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<tr>
<th>8-9 AM</th>
<th>9-10AM</th>
<th>10-11 AM</th>
<th>11-12AM</th>
<th>12-1PM</th>
<th>1-2PM</th>
<th>2-3 PM</th>
</tr>
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<tbody>
<tr>
<td>Speak Respectfully to Peers</td>
<td>/7</td>
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<tr>
<td>Speak Respectfully to Adults</td>
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<tr>
<td>Keep Hand, Feet, Objects to Self</td>
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Points /30

Individual Replacement Behaviors

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<th>9-10AM</th>
<th>10-11 AM</th>
<th>11-12AM</th>
<th>12-1PM</th>
<th>1-2PM</th>
<th>2-3 PM</th>
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<tbody>
<tr>
<td>Ignore Negative Comments</td>
<td>/7</td>
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<tr>
<td>Correct Mistakes when given opportunity</td>
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Points /20

Total Points ______/100

Observation Notes:

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Parent Contacts:

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
Sample Parent Support Group Questionnaire

- I am interested in attending parent support group meetings
- I am not interested in attending parent support group meetings
- The best day for me would be:
  - Monday
  - Tuesday
  - Wednesday
  - Thursday

2nd Choice would be:
- Monday
- Tuesday
- Wednesday
- Thursday

The best time of day is:
- Afternoon
- Evenings

The best time of day would be:
- 2-3:30
- 3-4:30
- 4-5:30
- 5-6:30
- 5:30-7:00
- 6:00-7:30
- Other

Groups to be held
- Weekly
- Twice a month
- Once a month
Sample SED Clinician
Letter to Parents

September 2, 2005

Dear Parents:

Welcome to the 2005-2006 school year. We are excited about the prospect of working cooperatively toward the common goal of helping our students access their education and become positive members of our community. In addition, we would like to take this opportunity to clarify and emphasize program and school procedures.

During the first week of school, you will be receiving information regarding the Code of Student Conduct, academic performance standards, and attendance issues. It is important to emphasize that all the school rules apply to the whole student population of Miami-Dade County Public Schools, including students who participate in the severely emotionally disturbed program. The program provides a variety of educational and therapeutic services. However, infractions to the Code of Student Conduct will result in standard and reasonable consequences provided to the general student population as dictated by the School Board Rules. The SED program is a flexible, dynamic and academically focused program. Psychiatric diagnosis, current psychological issues and side effects of medication do not provide a license to commit or intentionally violate school rules or laws. **Most importantly, violence expressed or inferred is strictly prohibited within the school.** These acts include but are not limited to: intimidation, bullying, verbal threats, destruction of property, physical threats or any perceived aggressive behavior. Under school board rules covering the maintenance of a safe learning environment, students who exhibit behavior indicating imminent threat to self and/or others will not be allowed to remain in school. Interventions may include possible hospitalizations, with or without parental consent, based on an evaluation by the SED clinician or law enforcement.

All students must meet the same graduation requirements in order to obtain a regular diploma from Miami-Dade Public Schools, including those participating in our program. Students must pass the FCAT, obtain the necessary credits, maintain a 2.0 G.P.A, and complete community service hours.

The therapeutic services provided by the clinical staff are confidential. State law mandates the following exceptions: substantial likelihood of imminent threat to self or others, suspected child abuse (current or past) and abuse of the elderly, or other vulnerable adults. The SED teachers are considered part of the treatment team, so appropriate information is shared with the teachers in order to provide individualized comprehensive educational services. As part of the treatment team, the teachers maintain confidentiality.

We appreciate your cooperation in these matters, and we want to encourage you to become active members in your child’s educational experiences. Please feel free to contact us at _______extension______. Please sign, date, and return this letter to indicate that you have read this information.

Sincerely,

S.E.D. Clinician

__________________________________  ________________________
Parent/Guardian Signature         Date

__________________________________  ________________________
Student Name               Identification Number
Sample SED Crisis Plan

Student expressing suicidal ideation/intent, making suicidal gestures or expressing homicidal intent:

A. Immediately refer to SED Clinician for screening. If clinician is not in school, inform by telephone or pager and refer the student to the Trust Counselor.

B. If the Trust Counselor is not available, proceed with steps below.

C. Inform Administration/keep Administration informed of eventual outcome and all steps taken.

D. Inform parent. Direct parent to take student for psychiatric evaluation (via emergency room, private psychiatrist, private therapist). If student agrees with the need for evaluation, refer to Northwest Dade Crisis Unit (NWDCU) at 305-825-0300, or to family’s choice of hospital.

E. If a student does not want psychiatric screening/hospitalization or if the parents cannot be reached, notify Administration and have the school Resource Officer evaluate the situation for possible Baker Act to NWDCU.

F. Contact NWDCU or other receiving facility to explain reason for referral, unless Resource Officer has already done so.

In the unlikely event that a student makes a serious suicide attempt during school:

1. Immediately contact Administration/Security to call 911 paramedics
2. Remove students from the classroom/area.
3. Contact clinician.
4. Contact parents.

Students Destroying Property:

1. Attempt physical restraint as per Safe Crisis Management guidelines. If restraint is not safely possible, contact security.
2. Notify clinician.
3. Submit written referral to Administration.

Student Fighting:

1. Attempt physical restraint (SPM) only with additional staff. If restraint is successful, immediately separate students by taking them to different rooms/officer. If physical restraint is not possible due to the number of students or to the intensity of the fight, contact security by dialing 0 in the classroom phone.
2. Remove other students from area if the fight is continuing.

3. If you deem situation to be dangerous, remove yourself from the area.

4. Contact Clinician.

5. Send written referral to Administration.

6. Contact parent.

**Students with Drugs or Weapons:**

1. Contact Administration and request School Resource Officer.

2. Contact clinician.

3. Submit written referral to Administration.

Once the immediate crisis/emergency has passed, documentation of the event is critical.

**Parents:**

The clinician will notify the parents. If clinician is not available and the staff has submitted written referral to the Administration, then he/she will usually attempt parent contact.

**Administration:**

Let school administration know the outcome of any serious situation that you have not referred directly to them, as well as all the steps taken to deal with any crisis.

**SCMS:**

Complete SCMs in detail. Separate documentation needed if physical restraint has been used.
Sample School
Psychosocial Assessment

Student's Name: ________________________________ DOB: ______

Address: ______________________________________ Birthplace:

________________________

Telephone: ________________________________ Grade: ______

________________________

Date: ________________________________ Age: ______

________________________

Date entered U.S.: ________________________________ From: __

________________________

Family members/people living in the home: relationship, name, age – indicate those in the home vs. those not living with the student.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation</th>
<th>Age/Grade</th>
<th>School</th>
<th>Occupation</th>
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A. Presenting Information:

1. Why are you in an SED program? (Main problem; how severe; how long; other problems)
   Depression; suicidal ideation; anxiety; weight problem; concentration; thinking clearly; arguments with parents; parents divorce/separation; job problems; school grades; alcohol; drugs; sex; health; criminal charges; abuse)

B. Personal Information and Family Background

1. Who primarily raised you?
2. Family dynamics: Guardian’s married, single

C. **Developmental History:**
1. Physical condition at birth; growing up? (Childhood illnesses, injuries, operations)

2. Significant experiences with family over the past three years? (Birth of sibling; divorce; separation; marriage; death; vacation; parents fight a lot; moved a lot; financial problems; fights with siblings; abuse).

3. How would you describe yourself over the past three years? Presently? (Active; passive; happy; content; unhappy; calm; nervous; fearful; moody; outgoing; shy; lonely; quiet; noisy; athletic; clumsy; intelligent; dull; other)

4. How would you describe your parents over the past three years? (Very strict; strict; average; permissive; very permissive)

D. **Educational History:**
1. Have you repeated any grades?

2. Enjoyed school; good grades; average grades; poor grades; neutral about school; disliked school.

3. School subjects: Strengths/Weaknesses?

4. Plans for High School? GED…Diploma… Drop-out

E. **Health, Habits, and Behavior:**
1. Medications? For What?

2. Past Medications? For What:

3. Physical problems, treated, or untreated? (Chest pain; difficulty breathing; dizziness; loss of consciousness; pain; stomach problems; vision problems; hearing problems)

4. Recent change in your weight, appetite.

5. Recent change in sleep? (Trouble getting to sleep; wake-up a lot; do not get enough sleep; sleep too much; restless; wake-up too early; sleep enough; but feel tired)

6. Girlfriend, boyfriend, date?
7. Smoke cigarettes? How often; how many; how long?

8. Drink alcohol? When; when did you start; how many?

9. Illegal drugs? (Past/Present Kinds/Availability - How long?)

10. Contact with legal authorities? (Arrested; warned by police; arrested more than once; juvenile detention; more than once)

11. Reasons for contact with authorities? (Curfew; drinking; truancy; drugs; drug sales; auto theft; robbery; physically threatening others; assault; weapon)

F. Family History:
   1. Is your biological mother alive?

   2. Medical problems with biological mother? (Arthritis; cancer; diabetes; epilepsy; heart problems; high blood pressure; low back pain; breathing problems; digestive system)

   3. Is your biological father alive? (Same questions as above)

   4. Medical problems with brothers/sisters?

   5. Family members with psychological problems?

   6. Family members who have a problem with alcohol or drugs?

   7. Family members have problems at school?

G. Current Situation:
   1. Responsibilities at home?

   2. Privileges at home? (Telephone; driving; curfew; home alone; buying own clothes; choosing hair style; spending money; spending night at friend’s house; unchaperoned parties; concerts with friends)

   3. Receive allowance?
4. What kind of things do you and your parents argue about? (Telephone; privacy; alcohol; drugs; friends; homework; etiquette; chores; bad language; lying; smoking; music; clothes; sex; school; bedtime; dating; money; cleanliness)

5. Discipline at home? What kind?

6. Describe your relationship with your parents in the past?

7. Relationship with siblings?

8. Describe your family relationship now?

9. How important are you in your family?

10. Ever been abused by a family member?

11. Ever plan to move out of your parent’s home?

12. Describe friendships. (Now. Many; few; none; some)

13. Describe your friends? (Type of student; jobs; use of alcohol or drugs; legal problems; pressure you)

14. What do you do for fun?
Psychiatric Consultation Report

Student’s Name: ___________________________ DOB: __________________________

School: ___________________________ Grade: __________________________

Date of Consultation: ___________________________ Clinician: __________________________

Reports attached? □ yes □ no Permission attached? □ yes □ no

I. **Background Information:**

II. **Home (Family Consultation? Group Home?):**

III. **Reason for Referral (Specific questions/concerns):**

   Verify mental health status and provide diagnostic impression.

IV. **Summary of Findings:**
V. Summary of Findings (Continued):
V. **Diagnostic Impression:**

- Axis I
- Axis II
- Axis III

VI. **Recommendations:**

__________________________________________________________________

Psychiatric Consultant

__________________________________________________________________

Site Clinician

__________________________________________________________________

Date
Sample Prescriptive Strategies Anecdotal Record

Student Name/Id#: ______________________  Teacher: ______________________
Class Period: ______________________  Date/Time: ______________________

Antecedent to the Disruptive Behavior

- Student Antagonized
- Student Appeared Irritated/Upset
- Student Frustrated by Task
- Entered Classroom Excited

Classroom Interventions

- Planned Ignoring
- In-Class Time out
- Peer Reinforcement
- Restructuring
- Proximity Control
- Change of Activity
- Interest Boosting
- Antiseptic Bouncing
- Signal Interference
- Modeling
- Hurdle Help
- Other:

Classroom Behavior

- Out of Location/in Danger Zone – Late for or leave classroom/school
- Noncompliance with a directive
- Verbally/Physically Provoking ( ) Student / ( ) Teacher
- Verbally Physically Aggressive ( ) Student / ( ) Teacher
- Throwing/Destruction of Objects/Property
- Not Responding to classroom interventions

Brief Description of Incident:

Results

- Interventions Successful/Student Remain in Class
- Referral to BMT
- Student Remains in Class
  - Completes Class Demands
  - Experiences Difficulty
- Referral to Clinician

121
The School Board of Miami-Dade County, Florida, adheres to a policy of nondiscrimination in employment and educational programs/activities and programs/activities receiving Federal financial assistance from the Department of Education, and strives affirmatively to provide equal opportunity for all as required by:

Title VI of the Civil Rights Act of 1964 - prohibits discrimination on the basis of race, color, religion, or national origin.

Title VII of the Civil Rights Act of 1964, as amended - prohibits discrimination in employment on the basis of race, color, religion, gender, or national origin.

Title IX of the Education Amendments of 1972 - prohibits discrimination on the basis of gender.

Age Discrimination in Employment Act of 1967 (ADEA), as amended - prohibits discrimination on the basis of age with respect to individuals who are at least 40.

The Equal Pay Act of 1963, as amended - prohibits sex discrimination in payment of wages to women and men performing substantially equal work in the same establishment.

Section 504 of the Rehabilitation Act of 1973 - prohibits discrimination against the disabled.

Americans with Disabilities Act of 1990 (ADA) - prohibits discrimination against individuals with disabilities in employment, public service, public accommodations and telecommunications.

The Family and Medical Leave Act of 1993 (FMLA) - requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

The Pregnancy Discrimination Act of 1978 - prohibits discrimination in employment on the basis of pregnancy, childbirth, or related medical conditions.

Florida Educational Equity Act (FEEA) - prohibits discrimination on the basis of race, gender, national origin, marital status, or handicap against a student or employee.

Florida Civil Rights Act of 1992 - secures for all individuals within the state freedom from discrimination because of race, color, religion, sex, national origin, age, handicap, or marital status.

School Board Rules 6Gx13- 4A-1.01, 6Gx13- 4A-1.32, and 6Gx13- 5D-1.18 - prohibit harassment and/or discrimination against a student or employee on the basis of gender, race, color, religion, ethnic or national origin, political beliefs, marital status, age, sexual orientation, social and family background, linguistic preference, pregnancy, or disability.

Veterans are provided re-employment rights in accordance with P.L. 93-508 (Federal Law) and Section 295.07 (Florida Statutes), which stipulate categorical preferences for employment.

Revised 5/9/03