

SPECIAL EDUCATION IN NORTH DAKOTA

North Dakota Department of Public Instruction
Dr. Wayne G. Sanstead, State Superintendent
Office of Special Education
600 E Boulevard Ave., Dept. 201
Bismarck ND 58505-0440

701-328-2277 (Voice)
701-328-4920 (TDD)
701-328-4149 (Fax)

DISABILITY SERVICES DIVISION

North Dakota Department of Human Services
Carol Olson, Executive Director
600 South Second Street, Ste 1A
Bismarck, ND 58504-5729

701-328-8930 (Voice)
701-328-8968 (TDD)
701-328-8969 (Fax)



Guidelines:

*Resources for Working with Children,
Youth, and Young Adults with
Emotional Disturbance in North Dakota*



NOTICE OF NON-DISCRIMINATION
NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION

The Department of Public Instruction does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities. John Dasovick, Assistant Director, Child Nutrition and Food Distribution, 600 E Boulevard Avenue, Dept 201, Bismarck, ND 58505-0440, 701-328-2260, has been designated to handle inquiries regarding non-discrimination.

CIVIL RIGHTS STATEMENT: In accordance with all regulations, guidelines and standards adopted by the US Department of Education, the US Department of Agriculture and the ND Human Rights Act, the ND Department of Public Instruction prohibits discrimination on the basis of age, gender, race, color, religion, national origin, status with regard to marriage or public assistance, disability or political beliefs. All divisions of the Department of Public Instruction will insure that no one is denied participation in, or denied the benefits of, or subjected to discrimination under any department program or activity.

Equal education opportunity is a priority of the ND Department of Public Instruction.

Publication Date: 3/21/07

Cover artwork reprinted by permission from Circle of Friends by Robert and Martha Perske, Nashville: Abingdon Press

ACKNOWLEDGEMENTS

The North Dakota *Guidelines: Resources for Working with Children, Youth, and Young Adults with Emotional Disturbance* was developed by the North Dakota Department of Public Instruction, the North Dakota Department of Human Services and Department of Correction and Rehabilitation (Juvenile Services Division). All agencies gratefully acknowledge the involvement of the members of the ED Task Force for their assistance in the development of this document.

Special appreciation is extended to Carol Massanari from Mountain Plains Regional Resource Center, an Office of Special Education Programs (OSEP) funded projects, for her technical assistance.

ED Task Force Members

- Deb Balsdon, Administrator of Children and Family Supports, Developmental Disabilities Unit, Department of Human Services
- Carla Kessel, Children's Mental Health Services Programs Administrator, Mental Health & Substance Abuse Division, Children & Family Services Division, Department of Human Services
- Susan Wagner, Division of Juvenile Services
- John Porter, Special Education Regional Coordinator, ND Department of Public Instruction
- Carol Jabs, Director, Sheyenne Valley Special Education Unit
- Vivian Drees, Parent
- Carlotta McCleary, Parent, Federation of Families for Children's Mental Health
- Linsey Schott, Coordinator and Teacher, Dickey/LaMoure Special Education Unit
- Carrie Weippert, Teacher, Grand Forks Public Schools
- Betty Omvig, Infant Development, Northwest Infant Development Program
- Nancy Rubbelke, Regional Development Disabilities Program Administrator, North Central Human Service Center
- Deb Keller, School Social Worker, Souris Valley Special Education Unit
- Jennifer Hefter, Coordinator and Teacher, Peace Garden Special Education Unit
- Wayne Leben, School Psychologist, Buffalo Valley Special Education Unit
- Dr. Lynne Chalmers, Professor, University of North Dakota
- Dr. Johnna Westby, Professor, Minot State University

North Dakota ***Guidelines: Resources for Working with Children, Youth, and Young Adults with Emotional Disturbance*** was produced by the Office of Special Education, Department of Public Instruction and the Disabilities Services Division of the Department of Human Services.

Alison Dollar

D.Guy McDonald

Colleen Schneider

Darla Van Vleet

Jean Foltz

Teresa Monicken

Nancy Skorheim

Mary Hoberg

John Porter

Michelle Souther

Jeanette Kolberg

Robert Rutten

Gerry Teevens

RESOURCES FOR WORKING WITH CHILDREN, YOUTH, AND YOUNG ADULTS WITH EMOTIONAL DISABILITIES IN NORTH DAKOTA

Table of Contents

I.	Introduction	1
II.	Screening & Prevention	
	a. Screening	5
	b. Early Intervention ((birth to 3 years of age)	6
	c. Education (ages 3 through 21)	6
	d. Mental Health	9
	e. Juvenile Justice	9
III.	Eligibility	
	a. Early Intervention (birth to 3 years of age)	13
	b. Developmental Disabilities (3 years or older)	14
	c. Education or Special Education	15
	d. Children’s Mental Health	21
	e. Treatment Services	21
	f. Juvenile Justice	22
	g. Child Welfare	25
	h. Private	25
IV.	Interventions	
	a. Infants/Toddlers (birth to 3)	27
	b. Children and Youth/Young Adults (ages 3 though 21)	28
V.	Tools & Resource Information	
	a. Sample Observation Form	51
	b. Functional Behavioral Assessment	52
	c. Behavior Intervention Plan (BIP)	55
	d. Individualized Education Program (IEP)	68
	e. Individual Family Service Plan (IFSP)	75
	f. Sample IFSP Information	78
	g. Sample Single Plan of Care	84
VI.	Glossary	86

I. INTRODUCTION

Addressing the emotional and behavioral needs of children and youth is a shared responsibility between public agencies, private providers, and families. The role of the family generally is clear and understood regardless of which service provider is working with the child or youth. On the other hand, the roles or missions of service providers are often not easily understood, even when the service is designed to address the same audience or to affect a similar outcome. Service providers tend to use different terms that can have different meanings depending on the context, use different eligibility criteria and procedures, and have a different program focus. Given the growing complexity of needs and the realization that these needs cannot be met by any one group in isolation from others, it is imperative that providers and families begin to build a shared understanding and common language.

This document was developed to provide guidance to the North Dakota system of care that supports children and youth birth to 21 years of age, with or at risk of developing emotional or mental health disorders and their families. More specifically, the intent behind this document is to:

- Increase understanding of requirements and practices among system partners that will lead to greater continuity and move closer to a true comprehensive system of care.
- Clarify various laws, regulations, or policies, especially where they impact eligibility decisions.
- Strive for greater consistency in practice among school districts.
- Provide information about best practice and strategies for intervention and support.

In the end, this document was developed from a desire to ensure children and youth with behavioral and emotional needs are able to receive services that effectively address these needs.

Development of this document was a collaborative effort between two state agencies with primary responsibility for serving children and youth, the Department of Public Instruction and the Department of Human Services. A task force representing schools, early intervention, child welfare, children's mental health, families/parents, juvenile justice, developmental disabilities, and child welfare identified the content for this document¹. An external facilitator was used to facilitate the work of the group and develop the draft document. The Department of Public Instruction and the Department of Human Services maintained final authority for approval of the final document.

¹ It is important to clarify that not everyone served by juvenile justice, substance abuse, child welfare or developmental disabilities has an emotional disability. However these service agencies serve children and youth whose behavior might be compounded by an emotional disability. As such, these agencies screen children and youth for emotional or mental health needs and ensure services are provided to address such needs, and subsequently are part of the system of care. Because of this, they were considered integral to the development of this document.

"The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them. It is time that we as a Nation took seriously the task of preventing mental health problems and treating mental illnesses in youth."

Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (Department of Health and Human Services, <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>)

"For all children, but perhaps even more so for young children with disabilities, interactions with caregivers shape a child's ability to learn, give and accept love, feel confident and secure, and demonstrate empathy and curiosity – all abilities that are central to success in school." (IDEA Infant & Toddler, Coordinators Association)

The Issue

Nationally, the mental health needs of children and youth are being seen as a growing concern associated with a health crisis. Behavioral issues are taking on more serious consequences and significant behavioral concerns are being noted in younger and younger children. Despite this, mental health services are often not provided until a child is older (e.g., age 10) (Steve Forness, 2005, Presentation at the Surgeon General's Conference on Children's Mental Health, <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>). This often is after the time when interventions have the greatest potential for benefit. Walker, Golvin & Ramsey (1995) report that patterns of antisocial behavior, which can be an indicator of potential mental health needs, can be identified accurately at age 3 or 4. Their research indicates that if patterns are not changed by grade 3, they result in needing to be treated as chronic problems much like diabetes.

Just as there is a growing recognition of a need to better address the mental health and behavioral needs of children and youth, there is a growing recognition that this cannot be done by one system or one agency alone. In fact, responsibility for meeting the mental health needs of children and youth runs across multiple systems including the family, school, mental health, juvenile justice, early intervention, child welfare, and substance abuse treatment systems. Addressing the complexity of needs requires collaboration across systems to ensure efficient use of resources and maximum benefit to children, youth, and their families. One strategy for addressing this complexity is through the building of comprehensive community systems of care.

Community Systems of Care

Comprehensive community systems of care have emerged as a way to address the needs of community members in the community setting rather than in institutions or confined settings. Systems of care bring together a variety of community participants in an effort to extend resources and provide services designed to meet the needs of the child/youth and the family. These systems of care build on community resources including public and private resources as well as business and social units. Principles of a system of care include:

Principle 1: A team centered approach to decision making with a child and family team.

Principle 2: Services recognize that the family is the primary support system for the child and is a full partner in the process.

Principle 3: Services are delivered in the child's home community drawing on formal and natural supports.

Principle 4: Services are planned in collaboration with all child-service systems involved in the child's life.

Principle 5: Services are culturally competent.

Principle 6: Services take place in the least restrictive and least intrusive environment.

Principle 7: Services are delivered in a strengths-based approach with concentration on the strengths of the child, family, and community.

Systems of care bring together a variety of community participants in an effort to extend resources and provide services designed to meet the needs of the child/youth and the family.

The National Mental Health Information Center provides the following list of characteristics that make a system of care unique². This list contains characteristics that might be part of an ideal system, but not all systems may have reached this ideal.

- Every child and family receives an individualized service plan tailored to their unique needs.

² National Mental Health Information Center. *Systems of Care a Promising Solution for Children with Serious Emotional Disturbances and Their Families.* <http://www.mentalhealth.org/publications/allpubs/Ca-0030/default.asp>.

- A full array of services and supports are provided in the home community in which the child lives.
- No child or adolescent is ineligible to receive services based on the severity of his or her behavior or disabilities. Providers do “whatever it takes” to ensure children, youth, and families receive appropriate services and supports for as long as they are needed.
- Services are delivered in the least restrictive, most natural environment that is appropriate for the child’s needs.
- Family members of children and youth who need mental health services work together with service providers to develop, manage, deliver, and evaluate policies and programs.
- Child- and family-serving agencies establish formal linkages to ensure that the system of care is adequately coordinated and integrated.
- Case management services are provided to ensure that the full range of services are delivered to help the child and family move through the system as their needs change.
- Early identification and intervention are essential to promoting positive outcomes.
- Adolescents are ensured a smooth transition service system as they reach maturity.
- The rights of the child and family are always protected.

Systems of care exist at varying degrees of development in ND communities. As communities, and specifically agencies serving children and youth, work together to better understand the issues and needs of children with emotional disturbance, systems of care will undoubtedly improve and develop more fully.

One Family’s Perspective

... we have been able to develop a care plan, and with the help from a care coordinator, we have been able to merge services provided by individual agencies into one plan that is followed by each agency working with our son. We have formed a crisis team made up of trained individuals who are willing to help Justin at times when de-escalation techniques may be needed. Trained and caring individuals are now available to work as mentors.

Organization of Document

As noted earlier, this document has been developed as a guide and resource tool for professionals in ND who work with children and youth with emotional disturbance, i.e., children and youth with mental health needs. Every attempt has been made to make this document easy to use and logical in its content and sequence. Most of the contents should be applicable across agencies or providers. In such instances, there is no attempt to differentiate between whether something is specific to education versus early intervention versus children’s mental health, etc. However, where such differentiation is critical, e.g., eligibility process and criteria, the information is organized by agency or provider. The remainder of this document includes the following sections: prevention and screening, eligibility for targeted services, intervention, transition, and tools.

Stories told from the family point of view are scattered within the document. These stories illustrate the situations of children and youth who can benefit when the guidance in this document is used.

This document was developed from what is known today. However, new research produces new knowledge, and the reader is encouraged to seek out new knowledge in order to continuously improve services to children and youth in ND. Caution is raised, however, for there are always those who are attempting to sell their own ideas and products. Such products or materials may or may not be based on research. The reader is encouraged to scrutinize material, to ask for evidence of success in multiple settings across time, and to seek specific information that describes the population and context in which success was obtained as part of the process for determining the appropriateness of the material under consideration.

Parents and other regular caregivers in children's lives are "active ingredients" of environmental influence during the early childhood period. Children grow and thrive in the context of close and dependable relationships that provide love and nurturance, security, responsive interaction, and encouragement for exploration. Without at least one such relationship, development is disrupted and the consequences can be severe and long lasting. If provided or restored, however, a sensitive caregiving relationship can foster remarkable recovery.

National Research Council and Institute of Medicine (2002) *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, D.C.: National Academy Press.

II. SCREENING AND PREVENTION

SCREENING

The primary purpose of screening is to identify if there is a need for further evaluation or assessment. Screening instruments are used to inform parents and those working with children to

Screening is a relatively brief process designed to identify children and adolescents who are at risk of having disorders that warrant immediate attention, intervention or more comprehensive review.

(Minnesota DHS,
Memorandum, Recommended
Children's Mental Health
Screening Instruments, March
5, 2004)

determine if there is a need for further evaluation. Screening alone is never sufficient to diagnose a child or youth. Additionally, parents and families are, and always will be, the first line of prevention and identification of health problems for their children, including emotional and behavioral problems. Whenever individualized mental health screening is being considered, parents must be consulted and informed consent must be obtained in accordance with federal and state regulation³.

Screening is used to identify children or youth who appear at risk of developing significant problems that can affect their ability to function within the expectations of a given environment. Consideration of risk is triggered by an observable change in how a child or youth thinks, feels, and acts that raise suspicion of deeper concerns. It is used to indicate those whose behavior

appears outside of the expected norm for same-aged peers and may signal the possibility that more severe problems could develop over time if left unattended. When considering factors that might signal at risk concerns, current research-based knowledge suggests that biological, social, psychological and environmental factors are all important considerations.

In their book, *Antisocial Behavior in School: Strategies and Best Practices* (1995, Brooks/Cole Publishing Company), Walker, Colvin, and Ramsey provide a set of guidelines for screening and identifying antisocial behavior patterns. The guidelines, while applied by Walker, et. al. to screening for antisocial behavior patterns, are based on principles that are applicable to screening for any mental health issue. They are included here as principles to guide screening practice whenever screening is used.

Principles to Guide Screening Practices

- A *proactive* rather than a *reactive* process should be used to screen and identify students at risk [for mental health concerns].
- Whenever possible, a multi-agent (teacher, parent, observer) and multi-setting (classroom, playground, home setting) screening-identification approach should be used in order to gain the broadest possible perspective on the dimensions of the target student's at-risk status.
- At-risk students should be screened and identified as early as possible in their school careers—ideally at the preschool and kindergarten levels.
- Teacher nominations and rankings or ratings should be used in the early stages of screening and supplemented later in the process, if possible, by direct observations, school records, peer or parent ratings, and other sources as appropriate.

Walker, H.M., Colvin, G., & Ramsey, E. (1995)

³ Requirements for informed parental consent can vary slightly from agency to agency and the screening design or purpose. For example, universal screening where every child is treated the same is used within education, but does not apply to other situations such as juvenile justice. Universal screening in educational settings generally does not require consent; however, when singling a student out for different assessment, parental consent is generally required. It is critical to consult the specific federal and state regulations applicable to each situation. When in doubt, it is always safest to involve parents and ensure they are informed about and support the screening process.

Screening Practices and Procedures

Team Members

- Agency Staff
- Friends
- Family Members
- Natural Supports
- Clergy
- Neighbors
- Others identified by family

Screening generally is conducted by teams, regardless of the agency. Written and verbal results of screening processes are provided to the family, the teacher, and other team members. Results summaries should include resources, supports, and suggested interventions to address the needs of the child or youth. If a referral for further mental health assessment is deemed necessary to obtain further evaluation data and determine service needs, screening results are included with other referral information. Determination of educational needs includes academic, behavioral, social-emotional, and developmental aspects.

Universal screening is a term commonly used to refer to whole populations receiving the same screening process. For example, screening infants for hearing loss at the time of birth has become routine in most states. It is automatically done at the time of a birth, if the child is born in a hospital or setting where such screening is provided. In schools, universal screening might occur at several points in a school year to determine how students are progressing or if they are meeting identified learning targets. Universal screening may not be sufficient to identify a problem, and often further screening might be needed before proposing an in-depth evaluation. While **universal screening** is applied to a **whole population** (e.g., all babies, all members of a classroom, all members of a school), **individualized screening** is conducted for **one or a few children or youth**.

Remember...
Individualized screening may require parental consent. Check the procedures and policies of your agency.

Early Intervention (birth to three years of age)

In ND, social emotional screening for infants and toddlers is available through the Right Track Program. An initial Right Track screening is offered at no cost to all families who have an infant or toddler with environmental or biological risk factors or parental concern. Early intervention professionals will come to the family's home to complete developmental screenings, provide information to parents, and refer appropriate services as needed. More information regarding the Right Track program can be found at <http://www.state.nd.us/humanservices/services/disabilities/earlyintervention/parent-info/index.html>.

Education (ages 3 through 21)

In the school setting, universal screening is conducted in an effort to provide the earliest possible intervention. A response to intervention approach applies screening at the universal level in an effort to find students who are at risk of developing learning or behavioral problems. It provides educators an opportunity to try general interventions in the least restrictive setting and without a label in order to determine if future behavioral or learning problems can be averted with targeted interventions over a brief period of time.

It is important to note that whenever screening, universal or individualized, shows evidence of an acute or immediate need, a referral for further diagnostic evaluation should be completed immediately. For more information about the evaluation for special education, see the ND Department of Public Instruction Evaluation Guidelines at

<http://www.dpi.state.nd.us/speced/guide/index.shtm>

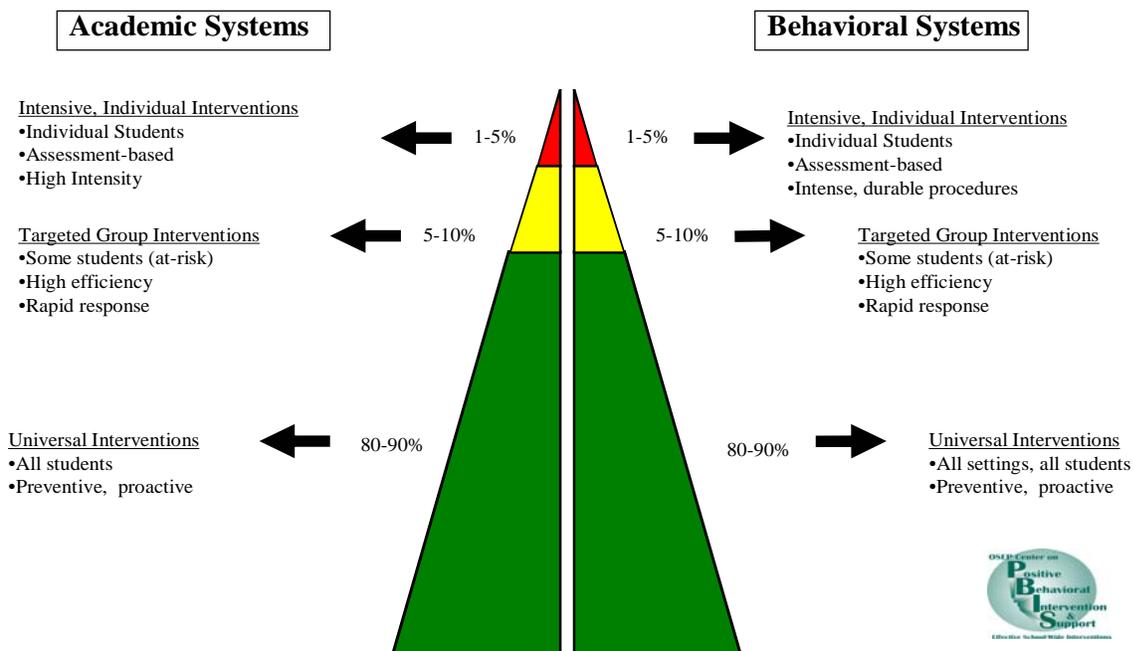
Response to Intervention

Response to intervention (RTI) is a process that applies the concept of universal screening, accurate implementation of interventions for those identified as at risk, careful documentation of the results of intervention, and use of data to make decisions about the need for more intense or targeted interventions or referral for further evaluation. RTI uses a data-driven problem solving approach that applies continuous progress monitoring and tiers of interventions with increased intensity where data indicates a need. (Figure 1 is a graphic depiction of how the tiers can be viewed across three levels. This figure was created by the Center for Positive Behavioral Interventions and Supports.) While RTI is generally thought to be applicable to the identification of Specific Learning Disability (SLD), in actuality, it is an approach that can be used to improve academic and functional performance of all children and youth.

RTI Critical Features	
◆	high quality, research-based instruction in the general classroom
◆	universal screening of academics and behavior
◆	active use of data from assessment in the general curriculum
◆	multiple tiers of research-based instruction/intervention with increasing levels of intensity
◆	continuous progress monitoring data used within a set of decision rules
◆	assurances that interventions are implemented with fidelity

Figure 1

Tiered Approach to Intervention



RTI uses a school-based intervention team to work with the classroom teacher in making decisions about interventions and in analyzing the data from the progress monitoring. In ND, many schools may use the Building Level Support Team (BLST) as this school-based intervention team. The BLST provides a process for school building teams to analyze needs and clarify school support systems for teachers, students, and parents. Parents must be involved in the decision making process before individualized screening or assessment takes place in the area of social-emotional needs. The BLST must address social/emotional needs with documentation of observations and interventions tried and their results. (For more information on the BLST process see:

BLST goals are to:

- ◆ Assist classroom teachers and other support individuals with advice, strategies, and support; and
- ◆ Provide interventions before recommending an evaluation or considering a referral to special education.

<http://www.dpi.state.nd.us/speced/guide/evalproc.pdf>.)

What is progress monitoring?

Progress monitoring is a process that uses regular assessment data to measure a student's growth toward instructional goals. It is used to assess student performance and evaluate the effectiveness of instruction or a particular intervention. Teachers cannot predict with complete certainty that a particular intervention will be effective with a selected student. Only through careful observation and data collection can teachers know if an intervention is truly effective.

Progress monitoring is used to measure student progress by collecting data on the student's behavior during the intervention to determine if the behavior is changing. Data are collected at the beginning of the intervention and frequently throughout the intervention or instructional process to assess how students are learning (i.e., if behavior is changing) and whether or not changes should be made in the instruction or intervention. An example might be to collect baseline data on a behavior (e.g., how many times a student is disruptive over a set period of time), introduce an intervention (e.g., a reward system), and then collect data on the behavior regularly (e.g., once a day for a set period of time) to determine if the intervention (i.e., the reward system) is having an effect.

Progress monitoring is assessment used to determine the extent to which children and youth are benefiting from classroom or individualized instruction.
<http://www.studentprogress.org/>

Progress monitoring requires that you collect data frequently on the student's behavior and use the data to make decisions about interventions. Collecting data on a regular and ongoing basis reduces the probability of the teacher introducing error (i.e., making inferences about the student's behavior). It also reduces the likelihood of terminating an effective intervention or continuing an ineffective intervention.

When should a referral for targeted or intense services be made?

It is necessary to attempt a series of less-intrusive interventions before making a referral for targeted or intense services. However, teams must look at the data. There will be times when screening data, including results of a single screening instrument, will indicate a child/youth to be at high risk and that further evaluation is required immediately. When screening data indicates an emotional, behavioral, or mental health need, consultation with an individual who has extensive background and experience in emotional/behavioral disorders is required. This would include individuals such as a teacher with specialized training in the area of emotional or behavioral disorders, a school counselor, a school psychologist, or other mental health professional/provider.

Mental Health

Screenings in Mental Health are conducted through Right Track, Health Track, Early Head Start, and Head Start. If a child is not in a program that provides screening, the Ages and Stages Social-Emotional Questionnaire and Pediatric Symptoms Checklist can be used. Child Welfare also uses the Safety Strength Risk Assessment and the Wraparound process to assess safety, permanency, and well-being.

Juvenile Justice

Screening within the Division of Juvenile Services takes on a slightly different meaning than screening within other systems, especially education. Youth are not screened to determine if they are in need of a referral to the juvenile justice system for targeted intervention. Entry into the juvenile justice system begins at the juvenile court level because of a legal offense. Screening is conducted to determine various risk factors, the potential for accompanying mental health needs, and to make referrals to appropriate service providers.

If youth are placed on probation status, informal or formal, the juvenile court officer assigned to the youth completes a risk assessment that includes questions about mental health in the social history domain of the assessment. The YASI, Youth Assessment Screening Instrument, contains highly relevant assessment content and provides the factors that are critical to positive outcomes for juvenile probation clients. A pre-screen, which provides an initial determination of risk, is administered at the point the youth is placed on probation. If the results of the pre-screen are high, then the full risk assessment is completed. The full assessment includes detailed risk and protective factor profiles that are used to develop and adjust the case plan and supervision guidelines for each youth. A computer program assists in the collection and scoring of the results of the assessment.

The juvenile court system has supported the implementation of a mental health screening tool to be in place by fall 2006. The MAYSI-2, Massachusetts Youth Screening Instrument Version 2, will be administered to youth on probation in addition to the YASI. The MAYSI-2 is a brief screening tool to assist juvenile justice professionals to identify mental health needs, especially those that might require additional intervention. The MAYSI-2 does not provide a diagnosis; rather it provides information that suggests the possibility of a mental health need. This screening tool is used exclusively by juvenile justice professionals.

The North Dakota Division of Juvenile Services (DJS) is the custodial agency for youth adjudicated of delinquent and unruly offenses. The Division receives legal care, custody, and control of adjudicated youth from the juvenile court. Upon commitment to the Division, a case manager is assigned to work with the youth and family for the duration of the court order. The DJS staff uses the MAYSI-2 to assist in determining if youth are experiencing a mental health need. The case manager will administer the MAYSI-2 to the youth, usually on the day of commitment. Depending on the results of the screening, a second screening may be administered to further determine the immediacy of the mental health need.

The Division of Juvenile Services utilizes a full risk/needs assessment in addition to the above-mentioned mental health screen. COMPAS is a comprehensive assessment administered to each youth committed to the Division. COMPAS involves gathering background information on the youth and family, conducting a home visit, and interviewing the youth. The results of the interview are entered into a computer program which scores 32 risk/needs factors and computes a risk of recidivism score. As the case managers interpret the results of the interview, they are able to develop an initial case plan within 60 days of commitment. Case plans are reviewed and adjusted on a formal basis every 90 days, but more importantly, they are adjusted based on the juveniles' response to supervision and/or treatment at any time. An official reassessment is conducted six months from the date of the initial assessment.

Additional information about the Juvenile Justice process can be found in the Eligibility for Services Section (pp. 22).

PREVENTION

Prevention is about early intervening services and practices designed to either reverse potential problem situations or develop replacement behaviors that prevent issues from growing into complex needs that are difficult to address. Prevention includes early identification, assessment, and clinical treatment incorporated into existing programs to address the unmet social-emotional health needs of children and youth. Practices that focus on prevention include:

- ◆ Positive behavioral supports at home,
- ◆ School-wide positive behavioral interventions and supports,
- ◆ Parenting education,
- ◆ Community based programs,
- ◆ Public awareness activities associated with mental health,
- ◆ Supports available in local communities provided through churches and community agencies,
- ◆ Creating healthy and safe home environments,
- ◆ Creating healthy and safe school environments,
- ◆ Creating healthy and safe community environments, and
- ◆ Early bonding with consistent adults.

“Central to this challenge (of prevention) is the need to accurately differentiate transient emotional difficulties that reflect a “phase” that the child will outgrow from diagnosable disorders that require clinical treatment.”

(Children’s Emotional Development is Built into the Architecture of Their Brains, National Scientific Council on the Developing Child).

Prevention also focuses on increasing protective factors. Protective factors include:

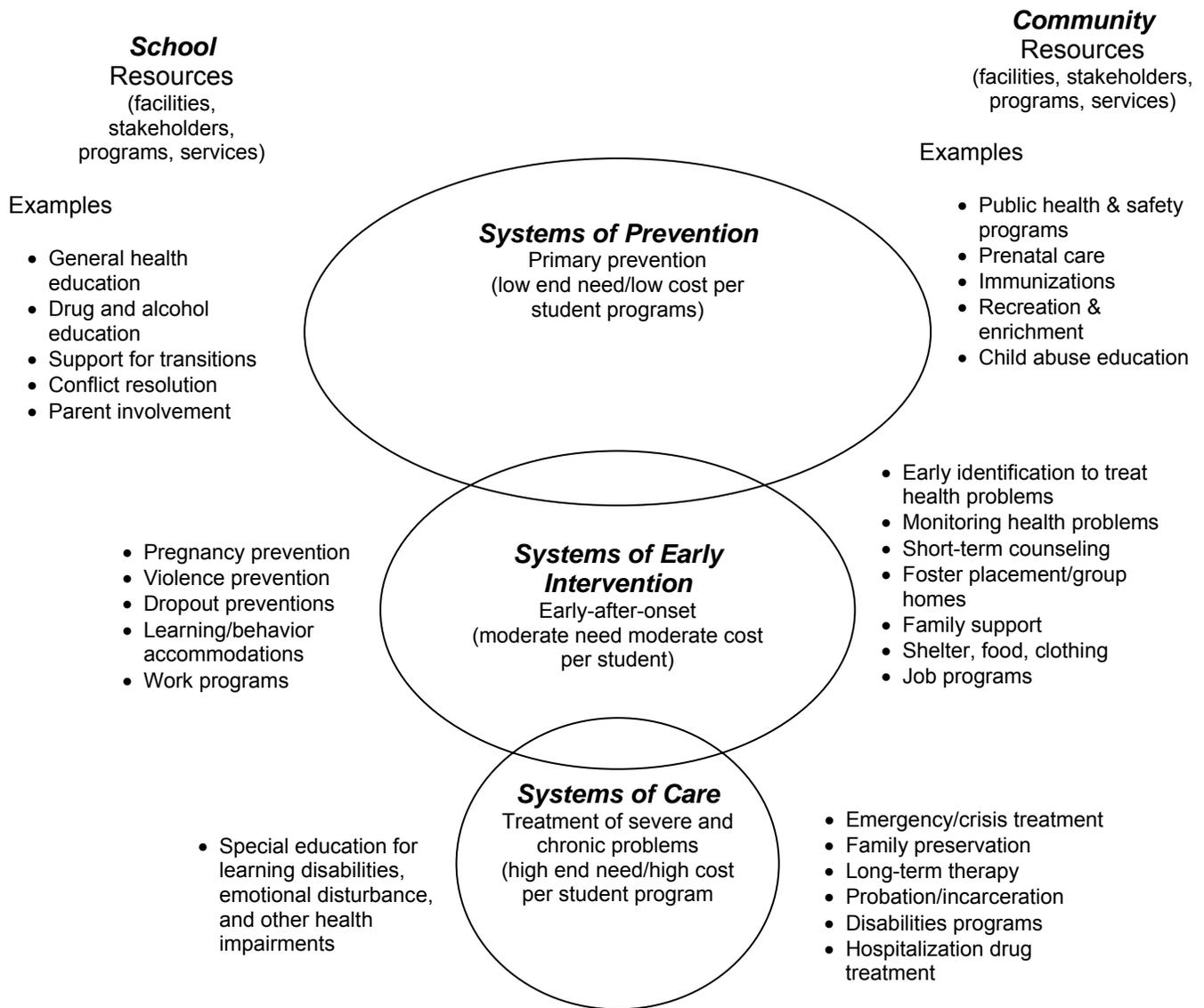
- ◆ Caring community (e.g., awareness for the need of children to grow up safe, healthy and strong);
- ◆ Positive activities (e.g., specially designed after school programs),
- ◆ Positive peer interactions
- ◆ Positive adults in child’s life (e.g., parents, teachers, mentors, ministers, neighbors),
- ◆ Basic needs met (e.g., food, shelter, etc.),
- ◆ Safety in home, school, and community (e.g., free from harm, bullying, drugs, molestation, etc), and
- ◆ Promotion of awareness of wellness for both physical and mental health.

Prevention includes upfront efforts and activities that increase and promote healthy development in children and youth. To ensure the use of the most appropriate interventions, a continuum that includes prevention, early intervention, and intervention should be found in systems of care. Prevention starts with the promotion of health, social, and emotional development. This can include:

- ◆ Providing information about social-emotional development to all parents, health care providers, child care providers, and educators as part of child find and public awareness efforts.
- ◆ Providing information about the early foundations of school readiness to parents of young children.
- ◆ Routinely discussing the social, emotional, and developmental milestones as part of conversations between families, health care providers, child care providers, and educators.
- ◆ Integrating social-emotional and developmental concepts into training for personnel working with children and youth and their families.

The following chart was taken from *Integrating Agenda for Mental Health in Schools into the Recommendation of the President's New Freedom Commission on Mental Health (March 2004, Volume 9, No. 1, Addressing Barriers to Learning, Newsletter of Center for Mental Health in Schools (UCLA) and Center for School Mental Health (University of Maryland))*. This chart demonstrates a continuum of school and community programs and services to ensure use of the least intervention needed.

Interconnected Systems for meeting the needs of all students
**Providing a Continuum of School-community Programs & Services*
**Ensuring use of the Least Intervention Model*



Note: This list is included to serve as examples of what schools or communities might consider or develop. Not all items on this list are found in all ND schools or communities.

One Family's Perspective

We returned home from vacation the Sunday before the first day of school. That evening we received a phone call from John's new teacher asking if our son would like to go to the classroom and pick out a desk and visit with her. At that moment, our nervousness over the difficult transfer began to melt. At that first meeting they began to click. Over the summer she had begun talking with the principal about various needs and modifications our son would need in the classroom.

III. ELIGIBILITY FOR SERVICES

INTRODUCTION

The missions, policies, and resources of various agencies are different and generally do not overlap. While it might be ideal to have a single eligibility process, it is not possible at this point. Therefore, it is important that those working with children and youth with mental health needs have some understanding of the different eligibility criteria and processes required by the various providers. This section is an attempt to provide a description of the eligibility criteria and processes for the primary service providers.

EARLY INTERVENTION (birth to 3 years of age)

Access to early intervention services requires eligibility for Developmental Disabilities Case Management provided by the North Dakota Department of Human Services. To be eligible for Developmental Disabilities Case Management, a child, birth to age three must meet one of the following four criteria:

1. The child is performing 25 percent below age norms in two or more areas.
 - a. Cognitive development
 - b. Gross motor development
 - c. Fine motor development
 - d. Sensory processing (hearing, vision, touch)
 - e. Communication development (expressive or receptive)
 - f. Social or emotional development
 - g. Adaptive development

OR

2. The child is performing 50 percent below age norms in one or more areas.
 - a. Cognitive development
 - b. Physical development
 - c. Communication development (expressive and receptive)
 - d. Social or emotional development
 - e. Adaptive development

OR

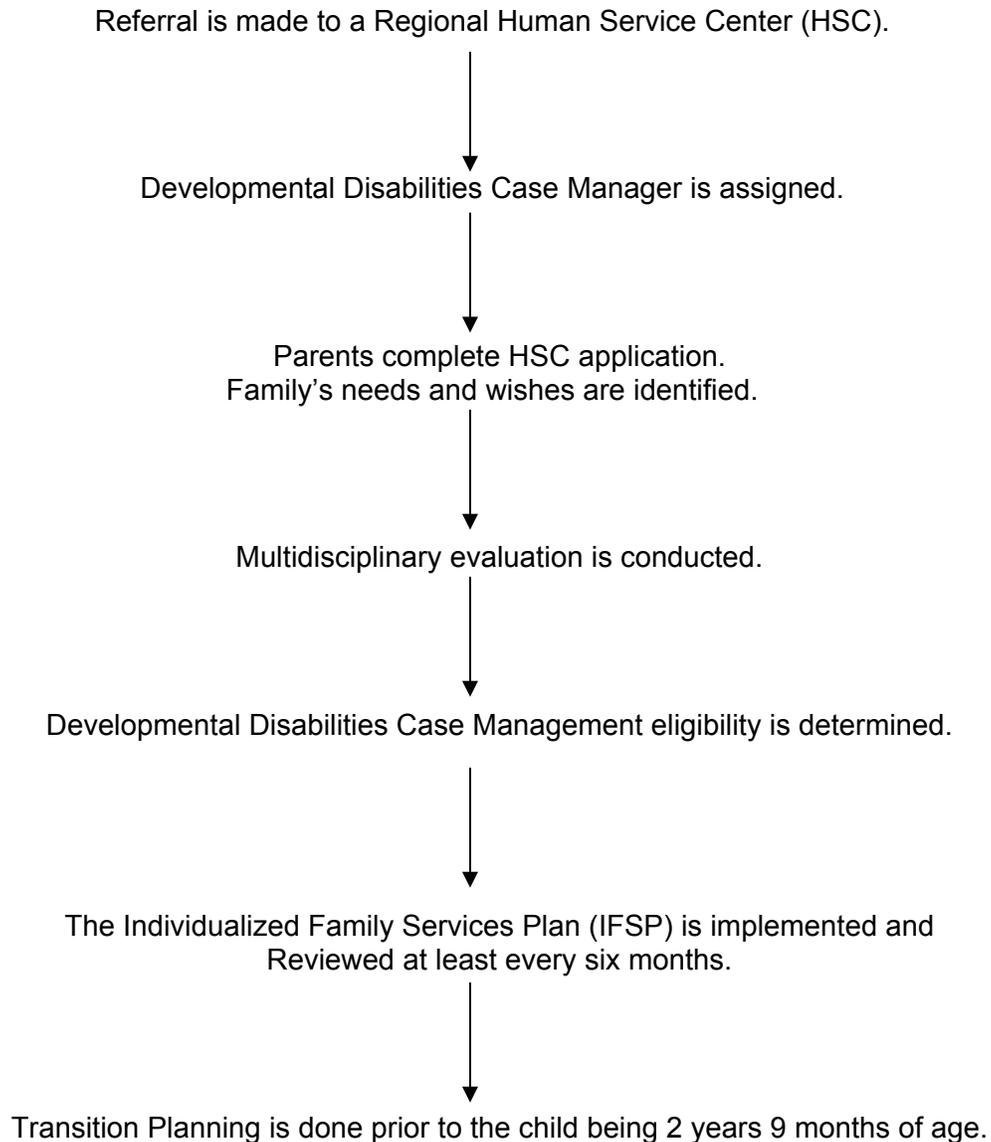
3. The child has a diagnosed physical or mental condition that has a high probability of resulting in a developmentally delayed.

OR

4. Based on informed clinical opinion, which is documented by qualitative and quantitative evaluation information, the child has a high probability of becoming developmentally delayed.

The evaluation to determine a developmental delay must be completed in all developmental areas. Additional information including developmental history, parental observations, and medical information will assist the team in the consideration of developmental delay. The eligibility team consists of at least three professionals from the Human Service Center. Parents are invited to participate and provide information regarding their child.

**North Dakota Early Intervention
Process for Children Birth to Age Three**



DEVELOPMENTAL DISABILITIES (3 years or older)

Access to services through Developmental Disabilities for children over 3 requires redetermination of eligibility for DD case management. Children 3 years of age or older are eligible for DD Case Management services if they meet **one** of the following three criteria:

- 1) Have a diagnosis of Mental Retardation that results in a Developmental Disability.

OR

- 2) Have a diagnosis of Mental Retardation that does not result in a Developmental Disability but they benefit from services designed for individuals with Mental Retardation and they need support due to a cognitive deficit.

OR

- 3) Do not have a diagnosis of Mental Retardation but do have a Developmental Disability that is not a result of Mental Illness and would benefit from services designed for individuals with Mental Retardation and they need support due to a cognitive deficit.

The complete Eligibility Code is located in the North Dakota Administrative Code 75-04-06 and can be found at <http://ndearlyintervention.com>

EDUCATION OR SPECIAL EDUCATION

Special education is specially designed instruction to meet the unique needs of students with disabilities who are unable to make sufficient progress in the general education curriculum with only instruction provided by general education teachers. In order to receive special education, a student first must be found to meet one of 13 categories of disability as specified in the Individuals with Disabilities Education Improvement Act (IDEA). One category of disability is the category called emotional disturbance, the focus of this document.

The IDEA, as passed by Congress, does not provide guidance on how to classify a student as having emotional disturbance, but some guidance can be drawn from the definition found in the federal regulations (Section 300.8(c)(4)). Even though the federal regulations provide a definition, states have the option of using a different definition and/or establishing more specific eligibility criteria. The North Dakota Department of Public Instruction (NDDPI) has chosen to use the federal definition of emotional disturbance. Local Education Agencies (LEA) have the option of establishing eligibility criteria so long as the criteria are not more restrictive than the federal definition (i.e., the criteria does not result in excluding a child or youth who might otherwise qualify for services). However, to create greater consistency across the state, NDDPI strongly encourages LEAs to use the eligibility criteria described in this document⁴.

Criteria for eligibility are determined by breaking apart the definition. The definition is first provided in its entirety as it appears in Section 300.8(c)(4) of the IDEA regulations. This is followed by a further delineation of each of the specific components of the definition.

Definition

Emotional disturbance is defined as follows:

- (i) The term means a condition exhibiting **one or more** of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
 - (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
 - (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
 - (C) Inappropriate types of behavior or feelings under normal circumstances.
 - (D) A general pervasive mood of unhappiness or depression.
 - (E) A tendency to develop physical symptoms or fears associated with personal or school problems.
- (ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

⁴ This criteria was recommended by the Task Force after reviewing criteria of a variety of ND LEAs, policy from other states, and professional references.

Description of each of the components

A condition – A condition is defined as a state of being. It is not intended necessarily to be a diagnosed label.

Over a long period of time – The behavior has existed over a significant amount of time. Best practice suggests using a standard of 6 months, although the age of the student and the intensity of the behavior must be considered. “According to OSEP, a generally acceptable definition of “a long period of time” is a range of time from two to nine months, assuming preliminary interventions have been implemented and proven ineffective during that period. *Letter to Anonymous*, EHLR 213;247 (OSEP 1989).” (LRP Publications. 1999. *The Answer Book on Special Education Law*, p. 1:9)

To a marked degree – In determining this qualifier, evidence of the behavior should be observed by more than one person across a variety of settings and environments. It should occur in noticeable, predictable patterns, and be considered significant in rate, frequency, intensity, or duration. The problem behaviors must be more severe or frequent than the normally expected range of behavior for individuals of the same age, gender, and cultural group. Finally, the problem behaviors have not been changed or improved after implementation of at least two planned and documented interventions applied in the school setting prior to referral. Behavioral characteristics should not be a secondary manifestation attributable to substance abuse, medication, or a general medical condition (e.g., hypothyroidism).

Adversely affects educational performance – The behavior significantly impacts a student’s educational progress, which takes into consideration academic performance and/or social emotional growth. Academic performance is more than achievement level. It includes things such as an inability to take on what is expected at the age level, sudden changes in grades, inconsistent performance, spending excessive time or energy to complete assignments to maintain grades, or excessive energy to maintain effort in the classroom. Social emotional growth may include difficulties in the areas of social relationships, personal adjustment (self-esteem and self-concept), self-care, and vocational skills. Considerations in this area generally include the frequency, duration and intensity of the behavior in comparison to peers. It also can include consideration of whether the behavior adversely affects the education of others.

↑
↑
R
E
Q
U
I
R
E
D

E
L
E
M
E
N
T
S

↓
↓

ONE or MORE of the following . . .

An inability to learn that cannot be explained by intellectual, sensory, or health factors – The student cannot learn in a regular classroom or integrated early childhood setting. The student failed to attain a satisfactory rate of educational progress, which cannot be explained by intellectual, sensory, health, cultural, or linguistic factors.

An inability to build or maintain satisfactory interpersonal relationships with peers and teachers – This characteristic is a pervasive inability to develop appropriate relationships with others across multiple settings or situations. It requires documentation that the student is unable to initiate or to maintain satisfactory interpersonal relationships with peers and adults in multiple settings, at least one of which is educational. Satisfactory interpersonal relationships include, but are not limited to, the ability to demonstrate sympathy, warmth, and empathy towards others; to establish and maintain friendships; to be constructively assertive;

and to work and play independently. Examples of unsatisfactory student characteristics may include behaviors, such as, physical or verbal aggression, lack of affect, disorganized/distorted emotions toward others, demands for attention, or withdrawal from social interactions. These should be considered when observing the student's interactions with peers and adults.

Inappropriate types of behavior or feelings under normal circumstances – Inappropriate behavior can be withdrawn, deviant, or bizarre behavior, not just aggressive or acting-out behavior. Some children express their inappropriate behavior or feelings through confused verbalizations, fantasizing, preoccupation with emotional conflict in their art work, written expression, or other outlets. Feelings deviate significantly from expectations for the student's age, gender, and culture across different environments. Examples of behavior or feelings that might be inappropriate under normal circumstances may include:

- Limited or excessive self-control;
- Low frustration tolerance, emotional overreactions, and impulsivity;
- Limited premeditation or planning;
- Limited ability to predict consequences of behavior;
- Rapid changes in behavior or mood;
- Antisocial behaviors;
- Excessive dependence and over-closeness, and inappropriate rebellion and defiance; and
- Low self-esteem and/or distorted self-concept.

Once it is established that the inappropriate behaviors are significantly deviant, it also must be determined that they are due to an emotional condition (see definition of condition on page 16). The condition is documented by a comprehensive assessment. The Multi-disciplinary Team (MDT) must determine whether the student's inappropriate responses are occurring "under normal circumstances." When considering "normal circumstances," the MDT should take into account whether a student's home or school situation is disrupted by stress, recent changes, or unexpected events. However, such evidence does not preclude an eligibility determination.

A general pervasive mood of unhappiness or depression – This characteristic requires documentation that the student's unhappiness or depression is occurring across most of the student's life situations. The student must demonstrate a consistent pattern of unhappiness or depression, which may include:

- Depressed or irritable mood most of the time (e.g., feeling sad, appearing tearful);
- Diminished and unexpected changes in weight or appetite;
- Insomnia or hypersomnia nearly every day;
- Fatigue or diminished energy nearly every day;
- Feelings of worthlessness or excessive or inappropriate guilt;
- Diminished ability to think or concentrate, or indecisiveness, nearly every day; and
- Recurrent thoughts of death, or suicidal ideation.

The characteristics cannot be the effect of normal bereavement.

A tendency to develop physical symptoms or fears associated with personal or school problems – This might be marked by physical complaints or consistent physical symptoms that cannot be easily checked or verified and are most visible during stressful situations. Behaviors that may indicate physical symptoms can include excessive absences, tardiness, truancy, refusals to attend school, self-mutilation, unusual sleeping or eating patterns, accident prone, flinching or cowering, neglecting self-care and hygiene, auditory or visual hallucinations, psychosomatic illnesses, headaches, asthma, stomach aches, refuses to attend school extremely anxious, fearful of getting hurt or rejected, tiredness, clingy, or

constantly complaining of being picked on. Symptoms suggesting physical disorders are present with no demonstrable medical findings. The symptoms are not culturally sanctioned response patterns.

Exclusionary clause . . .

The term does not include socially maladjusted – Socially maladjusted has proven to be a difficult term to define. It is not defined by IDEA regulations and is not considered a legal term. LRP Publications notes that “social maladjustment generally is considered to be a persistent pattern of conduct in which the basic rights of others and other age-appropriate societal norms are violated.” (LRP Publications, 1999, *The Answer Book in Special Education Law*. P. 1-11) A chart that compares emotional disturbances (ED) with socially maladjusted has been included in the Tools Section, page 46.

Eligibility Process

An overview of the special education process for children and youth ages three through 21 is provided in Figure 2. When a student is suspected of having an emotional disturbance, a referral must be made to the multi-disciplinary team. (For more information on the referral and evaluation process, see ND Guidelines: Evaluation Process at <http://www.dpi.state.nd.us/speced/guide/evalproc.pdf>.) The multi-disciplinary team reviews available information, determines additional testing that is needed, and meets to “integrate” or discuss findings to determine eligibility for special education. It is important to note that a diagnosis determined by using the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revised (DSM-IV-TR) does not automatically make a student eligible for special education as emotionally disturbed (ED). In making a determination of eligibility, the MDT must:

- Have documentation – both qualitative and quantitative – of evidence that meets the criteria specified in the definition.
- Be sensitive to the seriousness of the label.
- Be made by a team of qualified professionals, including the principal, general education teacher, and a specialist with knowledge in the area of the suspected disability, and the parent. One member of the MDT should be a licensed school psychologist, a licensed psychologist, or an individual with extensive background and experience in emotional/behavioral disabilities⁵.

Special Considerations

A clinical diagnosis alone is not sufficient to establish eligibility for special education nor is a clinical diagnosis required to determine eligibility for the category of ED. The presence or absence of a clinical diagnosis does not relieve the LEA of its obligation to conduct an evaluation.

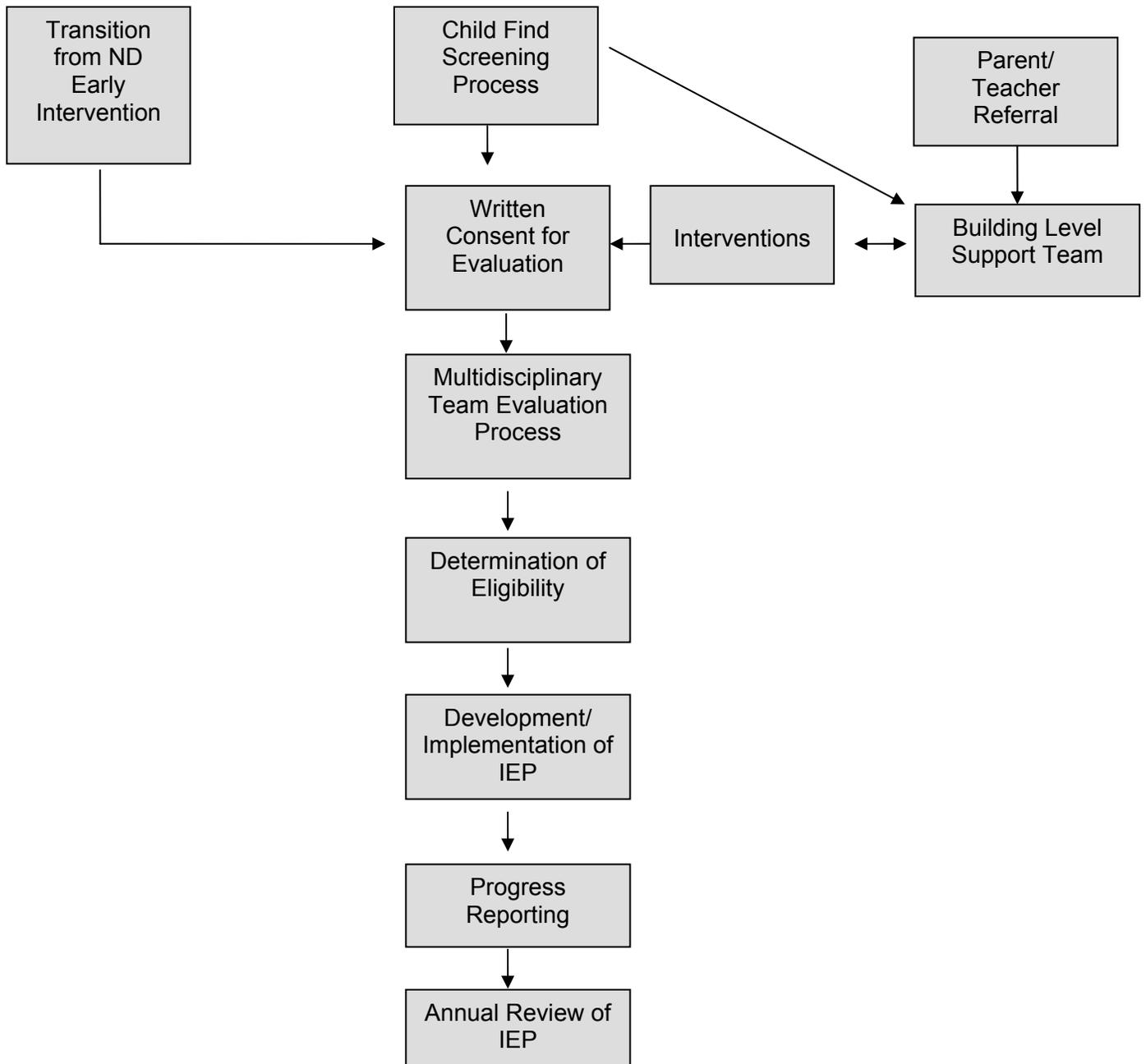
When considering a determination of ED, careful consideration of benefits and risks associated with a label need to be taken into account, not just for the immediate situation, but for the future as well. Some labels, including emotional disturbance, carry greater potential for negative impact than others, and we do not want to label children or youth unnecessarily. Labels are necessary at times for receipt of certain services and interventions; but the label itself does not necessarily prescribe the needed intervention strategy. Rather, interventions are based on the strengths and needs of the specific student.

⁵ See page 8 for a definition of an individual with extensive background and experience in emotional/behavioral disabilities.

When a child, youth, or young adult needs services, it is critical that they be provided. Wherever such services can be provided without labeling a child or youth, they should be. Where a label is required and the criteria for eligibility are clearly evident, it should in no way deter schools from using the ED label. The key is to first ensure that appropriate services would not be available or provided without such a label.

It is also important to know that a diagnosis of ED does not automatically qualify a child for special education. In an educational setting, eligibility for ED must be accompanied by evidence documenting the need for special education and related services. Children who do not meet ED eligibility under IDEA (i.e., do not need special education) should be referred for eligibility determination under Section 504. See <http://www.dpi.state.nd.us/504/index.shtm> for more information about Section 504 of the Vocational Rehabilitation Act and how to develop 504 plans.

Figure 2
ND Special Education Process for Children and Youth
Ages Three Through 21



CHILDREN'S MENTAL HEALTH

Mental Health Services are offered through a wide array of agencies, providers and services, which all have various eligibility criteria. Services can be accessed through private agencies, human service centers, hospitals, day and evening treatment programs, support groups, parent support programs including the Federation of Families for Children's Mental Health, The Protection and Advocacy Project, Extension Offices, Mental Health Association, and public and private health facilities. Services are generally obtained through an intake process and eligibility is generally not as stringent or defined as it is for educational services. The intake process is determined by the specific service provider. A list of resources and services can be found by checking your local telephone book under Physicians; psychiatrists, social workers, and/or mental health services for a listing of providers and services. In addition, connection to information, referral and crisis management in North Dakota can be obtained by dialing 2-1-1.

Children's Mental Health Services, also referred to as the Partnership Program for Children's Mental Health provides therapeutic and supportive services to children with serious emotional disturbances (SED) and their families so they can manage their illness and live in the community in the least restrictive setting.

The North Dakota Partnership Program for Children's Mental Health (referred to as the ND Partnership Program) has specific criteria for eligibility. To be eligible for the Partnership Program, children must:

- *Be 18 years old or younger.*
- *Have a diagnosable mental, behavioral, emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV); or that resulted in a functional impairment of 50 or less on the GAF scale of the DSM-IV or their ICD-10-CM⁶ equivalent (and subsequent revisions), with the exception of the DSM-IV-Text Revision V-codes, substance abuse, and developmental disorders unless they co-occur with another diagnosable serious emotional disturbance.*
- *Meet the GAF score of 50 or less to initiate this service. Children who would have met functional impairment criteria during the prior year without the benefit of treatment or other support services are included in this definition. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.*

Global Assessment of Functioning (GAF) is for reporting the clinical judgment of an individual's overall functioning and provides information used in planning treatment and measuring progress.

TREATMENT SERVICES

North Dakotans can access substance abuse treatment services from public and private treatment providers. As with Mental Health services, access to substance abuse services is determined through an intake process rather than a stringent set of pre-defined eligibility criteria. Young adults with substance abuse issues can receive a full array of services that range from prevention to aftercare services. The N.D. Department of Human Services Division of Mental Health and Substance Abuse Services has a Prevention Resource Center consisting of a large library of written and video materials covering topics in mental health, substance abuse, and disabilities.

⁶ International Classification of Diseases, Tenth Revision, Clinical Modification

Items are loaned to North Dakotans free of charge. To request materials, call 701-328-8919 or 1-800-642-6744, or visit <http://www.state.nd.us/humanservices/services/mentalhealth/prevention.html>.

Licensed substance abuse treatment programs in North Dakota offer services that follow a continuum or various levels of care. The full continuum of care ranges from assessment and early intervention services (such as the DUI seminar), outpatient services for adults and adolescents, intensive outpatient treatment for adult and adolescents, day treatment for adults and adolescents, intensive inpatient treatment for adults and adolescents, medium-intensity residential care for adolescents, high-intensity residential care for adults, low-intensity residential care for adults and adolescents, and social detoxification. Clients are seen for an initial addiction evaluation or through emergency services and then referred to the appropriate level of care, based on the admission criteria. The treatment duration varies with the individual.

The public treatment system includes eight regional human service centers. They provide treatment services using a sliding fee scale that is adjusted for income and household size. No one is refused services because of inability to pay.

To locate licensed treatment providers in North Dakota, contact the Division of Mental Health & Substance Abuse Services, North Dakota Department of Human Services, 1237 W Divide Ave., Suite 1C, Bismarck, ND 58501-1208, Phone: 701-328-8920 or 1-800-755-2719 (ND only) or use the SAMHSA treatment locator tool at: <http://dasis3.samhsa.gov/>. Information about the regional human service centers is available on-line at:

<http://www.nd.gov/humanservices/locations/regionalhsc/index.html>

JUVENILE JUSTICE

The juvenile court operates in each region of the state. Referrals come from law enforcement as well as parents and schools. The most formal referral comes from law enforcement in the form of a citation that the youth receives after having been picked up for committing an offense. Depending on the level of the offense as well as the youth's history, the court decides how to proceed.

- ◆ If the offense is a status offense (i.e., truancy, minor in possession or consumption, unruly behavior) the court may decide to divert the youth to services in the community.
- ◆ If the history is such that the behavior is ongoing, then they may decide to schedule an informal adjustment or file a petition for a formal court hearing.
 - If they schedule an informal hearing, notice is sent to the youth and parent(s). They appear and discuss the offenses and related behavior with the juvenile court representative.
 - If they admit to the offenses, it's a voluntary admission. The court has them sign a form acknowledging their admission and then they proceed to make recommendations for services to address the concerns. Often they place a youth on informal probation and they then report to a probation officer periodically.
 - If the youth denies the offense, they may proceed to a formal process then or make the recommendations for services and watch the situation.
 - If they file a petition and a formal court hearing is held, the youth has the right to legal representation as do the parents. If they qualify for court appointed counsel, that is done. If not, they can choose to hire an attorney.
 - The youth and parents attend the hearing. The first part of the hearing is the finding of facts where the offenses are presented and the youth admits or denies.
 - The youth is then adjudicated unruly or delinquent or both depending on the offenses.
 - The second stage of the hearing is disposition.

- Recommendations are usually presented by a juvenile court representative or the county states attorney. Again, the recommendations depend on the offenses and history of the youth.
- The judge or juvenile referee can order the youth to formal probation or place them under the legal care, custody, and control of the Division of Juvenile Services or County Social Services.
- If the youth does not have a long history, the court usually attempts formal probation before a custody transfer unless the offenses are very serious.
- If there's a history of ongoing problematic behavior and prior probation or county social service involvement, then the court will place the youth with Division of Juvenile Services.
- Along with the custody transfer, the court gives the authority to place outside the home as deemed appropriate, ability to refer for services, and other conditions like restitution, community service, treatment, school obligations.
- Custody can be given for up to 12 months and then if ongoing custody is needed, an affidavit outlining the reasons along with reasonable efforts that have been attempted is sent to the court.
- A review hearing is then set.

Figure 3

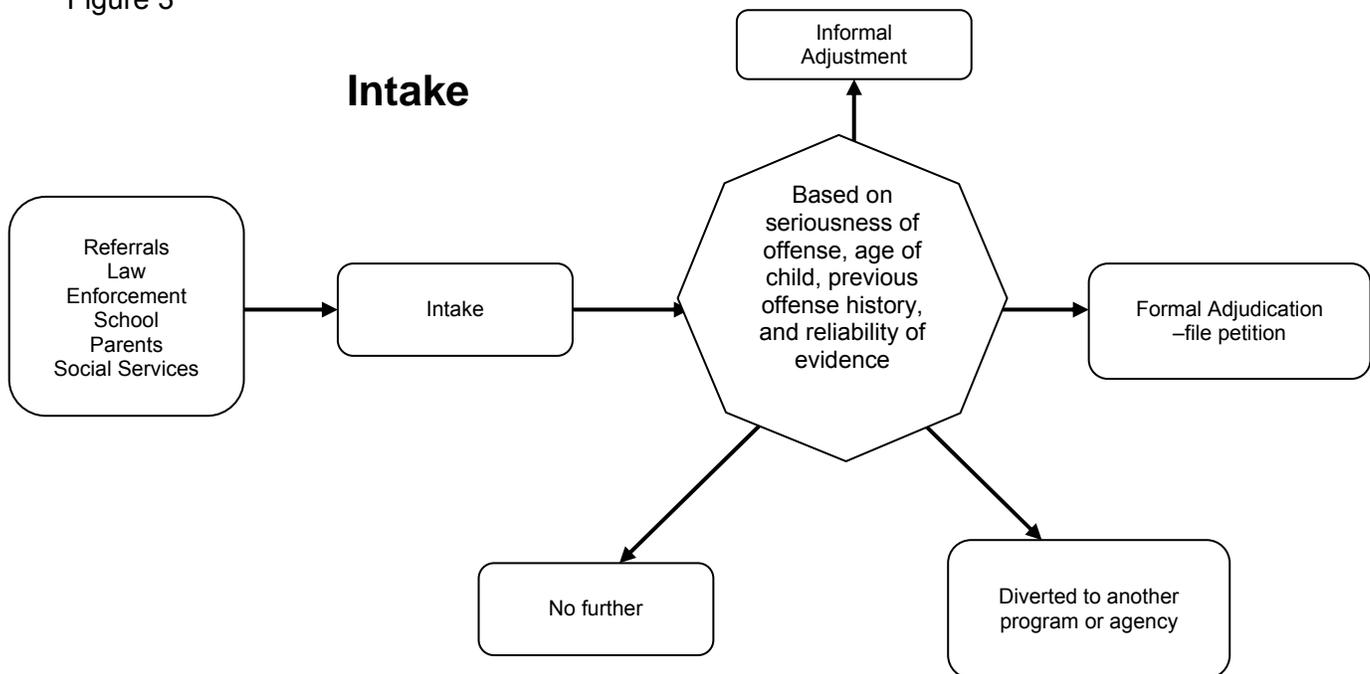


Figure 4

Informal Adjustment

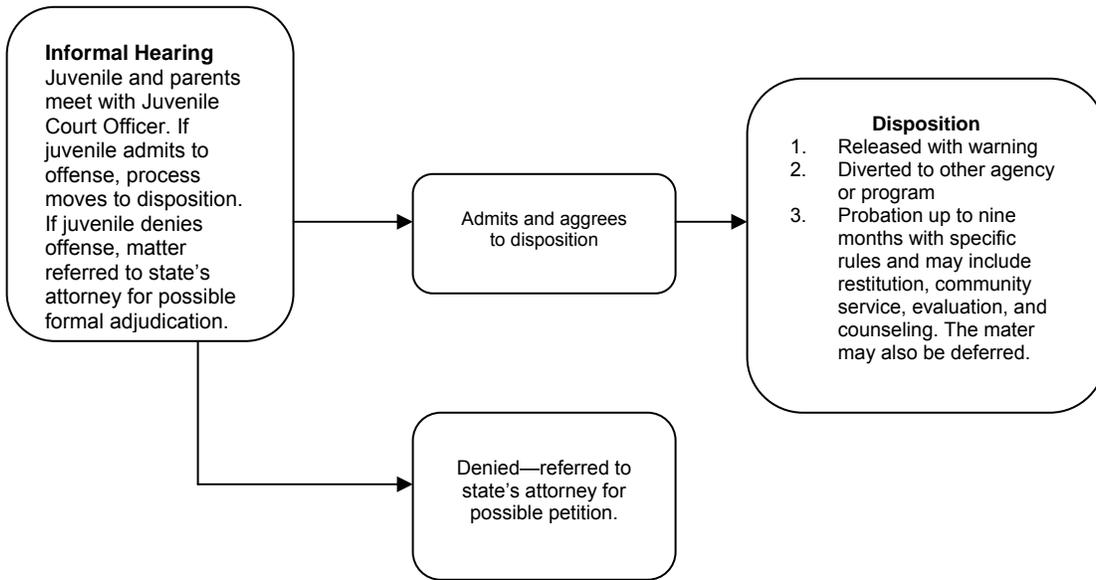
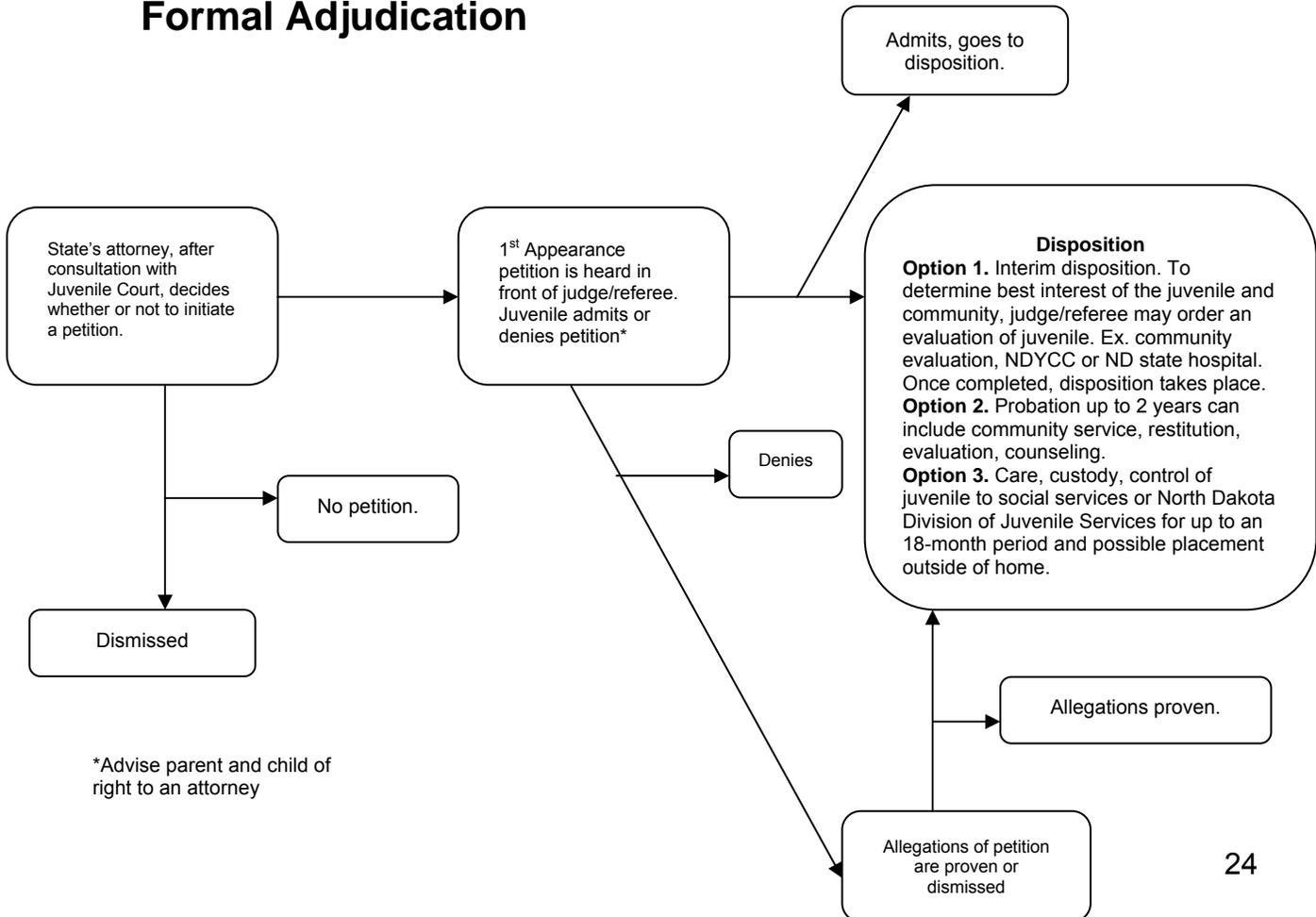


Figure 5

Formal Adjudication



CHILD WELFARE

Children and families become involved with the Child Welfare system when the following risk factors are present:

1. Parents in need of parent education and family support;
2. Children who are suspected of being abused or neglected
3. Children who have been adjudicated to be deprived, delinquent or unruly and who are in need of foster care services;
4. Children from the foster care system who are free for adoption (or an adoption is planned) and their adoptive families;
5. Adolescent and high risk unwed parents and their children;
6. Children who are at risk of becoming any of the above populations;
7. Children in need of early childhood services and their families;
8. Unaccompanied minor refugee children and refugee families requiring case management; and
9. Families and children who are in need of intensive intervention services to prevent the re-occurrence of maltreatment, out-of-home placement and/or reunification efforts.

More information about Child Welfare can be found by contacting your County Social Services Office.

PRIVATE

Many communities have one or more mental health providers (e.g., psychologists, clinical social workers) who may operate a private business. It is not possible to specify all the various eligibility criteria, but in most cases, all it takes is a telephone call to find out. The more critical question when exploring private providers is to learn about their fees and their policies around acceptance of insurance or third-party payments. When seeking a private provider, it is wise to get a referral from a reliable source or to take time to learn more about the individual's qualifications, including education/training, years of experience, and area of focus. It is important to remember that not everyone has expertise with children. A therapist who specializes in adult behavior may or may not be able to work effectively with children and youth.

One Family's Perspective

The doctor recommended hospitalization, and Wes was diagnosed with a bipolar disorder. Suddenly, there was a cabinet full of medications and an entire new set of problems. The medications produced a variety of side affects such as tremors, sleeplessness, loss of appetite, upset stomach. The family was at a loss to know how to handle all of this. When Wes returned to school, people treated him like a time bomb that could go off at any moment. They worked out a detailed plan of action with people to supervise his every movement, who to call in case of emergency and what to do if bad voices followed Wes to school. The hospital connected the family with a counselor to see Wes, but it was a 2-hour drive and the counselor didn't seem too familiar with Wes's problem when it occurred in a child. With time, people at school relaxed a bit. Wes did not "freak out" in an instant, although the voices did come and the plans the team made were implemented. It just wasn't as scary as they had imagined. The family was able to find a counselor closer to home who seemed very comfortable working with Wes, and he even agreed to see him at school.

IV. INTERVENTIONS

INTRODUCTION

“Because emotional and behavioral disorders have multidimensional facets, interventions for children with these disorders must be multifaceted and comprehensive . . . Interventions should be planned by a team that includes (as appropriate) the parent, the child whenever possible, the school psychologist and other student services personnel, teachers, administrators, and community service providers. Intervention plans should take into account the strengths of the child, the family, the child's teacher(s), and the school. Children with significant emotional or behavioral disorders often need interventions provided both inside and outside of the school. . . Careful attention to the use of effective discipline practices is critical as children with emotional and behavioral disorders frequently have disruptive behaviors. The discipline system in the school should be used to support the student with an emotional and behavior disorder in becoming more effective in school.”

http://www.nasponline.org/information/pospaper_sebd.html

The above quote from the National Association of School Psychologists points out some of the complexity involved with providing effective interventions for children and youth with mental health needs. Generally, the needs are multidimensional and require services and supports from more than one provider. The specific intervention strategies are often similar regardless of the service provider. The challenge is to determine which provider should provide what service, which may be dependent on who pays for the service. This is another reason why it is so critical for providers to work together in supporting the child or youth and the family.

When working collaboratively across multiple service providers, it becomes especially important to understand the limitations or boundaries within which each provider operates. One place where this is often confusing is in education, or more specifically special education. Special Education is defined as “specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability” (Public Law 108-446, §602 (29)). A student who is identified as needing special education might also need related services. Related services are services “designed to enable a child with a disability to receive a free appropriate public education as described in the individualized education program of the child . . . as may be required to assist a child with a disability to benefit from special education” (Public Law 108-446, §602 (26)). Related services do not include medical services except where such services are needed for diagnostic or evaluation purposes. Psychological and counseling services are included on the list of possible related services. The challenge to special educators has been to determine when psychological services are educationally related rather than medically related. (See Counseling Section, page 37)

Intervention can be provided in a variety of settings. Even though some agencies provide services in specific settings (e.g., day treatment or residential settings), the interventions used can be similar to interventions used in another setting (e.g., classroom). For this reason, this chapter is organized around age categories and considerations for choosing interventions and the types of interventions rather than by specific setting, agency, or service provider. For more specific information about eligible services provided by different agencies, see Section III, Eligibility.

Infants/ Toddlers (Birth To 3)

Infant toddler mental health encompasses a continuum of approaches for working with young children and their families that include:

- ◆ the *promotion* of healthy social and emotional development;
- ◆ the *preventive-intervention* of mental health difficulties; and
- ◆ the *treatment* of mental health conditions among very young children in the context of their families.

Promoting healthy social and emotional development should be done with all children and families. Preventive-intervention⁷ activities occur with those young children who have or are at-risk for exhibiting social/emotional delays. Treatment is for children with identified mental health issues and should be addressed by mental health providers who can work with the child and family.

Specific intervention activities for infants and toddlers vary in accordance with the approach needed. The following provides examples of intervention activities organized by the continuum of approaches.

Infant Mental Health

... developing capacity of the child from birth to age 3 to: experience, regulate, and express emotion, form close and secure interpersonal relationships; and explore the environment and learn –all in the context of family community and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development.”

Promotion activities:

- Providing information about social-emotional development in the context of care giving relationships to all parents, health care providers, and child care providers as part of child find and public awareness efforts.
- Disseminating information about the early foundations of school readiness to parents of young children with disabilities, and talking to them about how these apply to their children. (Examples of early foundations include things like encouraging curiosity in a child who needs assistance in mobility or developing self-regulation in a premature infant.)
- Routinely talking about social and emotional milestones as part of developmental anticipatory guidance on home visits.
- Integrating infant mental health concepts into training for personnel working with young children and their families.

Preventive-Intervention Activities:

- Screening and assessment of social and emotional development as part of the early identification process.
- Carefully listening to families to help them identify, clarify, and address the issues that may be affecting the developing relationship with their child.
- Working with community mental health and public health providers when there is concern about maternal depression, parental substance abuse, and other family mental health needs.
- Assisting parents/caregivers to understand and respond sensitively to cues the child gives.
- Supporting families as they increase their coping skills and build resilience in their children.

⁷ Preventive interventions are interventions that are used to reduce the possibility that risk factors lead to more significant problems or the likelihood that a disorder will result. They are interventions that occur before the onset of a disorder.

- Consulting with parents through relationship based practice, in order to promote the parent-child relationship.

Treatment:

- Assisting eligible children to access mental health providers for appropriate diagnostic and treatment services within the context of their family.
- Maintaining a collaborative relationship between the parent/caregiver, early intervention team members, and mental health treatment professionals to assure coordinated intervention efforts.
- Creating or adapting models for cross-disciplinary work between mental health and early intervention providers (e.g., implementing a mental health consultation model to support early intervention personnel; creating a team approach between a home visitor and an infant mental health specialist) or mental health providers with experience working with very young children and families.

Children and Youth/Young Adults⁸ (Ages 3 through 21)

In order for children and youth with emotional disabilities to be successful in a program or service, comprehensive program plans must be designed and implemented according to individual needs, and not according to traditions, personal theoretical preference, or a single approach. Programs should seek to teach children and youth how to gain internal control over their behavioral responses and emotions. Interventions that contribute to successful outcomes for the child and family share several foundational principles. These principles include the following:

1. All children and youth need systematic instruction in the academic, behavioral, and physical development.
2. Social literacy and behavior control are prerequisites for learning, socializing, and life skill development.
3. Most children and youth need structured and predictable educational and home environments.
4. All children and youth and families need ongoing trusting relationships with significant others across environments.
5. All children and youth need an emotionally supportive environment that includes behavioral control and structure to focus attention on educational activities.
6. Academic achievement is critical for positive emotional adjustment.
7. Given a core set of information and mental health skills, children and youth and families can utilize these techniques for more effect living.
8. Communication and coordination with families is integral to student success.
9. Intervention strategies can be implemented in a variety of educational settings from least restrictive to most restrictive.
10. Individualized programs and outcomes are adjustable to individual potential for growth and development.
11. Support for and optimal progress of children and youth with emotional disturbance depends on the coordinated efforts of all school personnel and team members.

A comprehensive program for any given child or youth should include consideration of a variety of interventions. For purpose of discussion these interventions have been divided across five categories. When designing an individualized program, consideration of each category should be

⁸Persons ages 19-21 are young adults and might not be considered by all as youth. However, the term youth in this document is intended to include young adults as well as those younger than 19 who have moved from child to youth.

included in order to identify appropriate instructional or intervention strategies. The five categories are:

- *Environment*
- *Behavior Management*
- *Academics*
- *Moral/Affective Development*
- *Counseling/Therapy*

Environment

Creating an environment that is both safe and supportive is paramount to effectively addressing the educational needs of students with seriously emotional disorders. The willingness of a child or youth to initiate interactions or ask questions is a demonstration that the emotional climate is safe. The key principles that drive decisions about environment include:

Environmental management strategies provide a basis for the application of the other four intervention strategies and thus, should be viewed as a prerequisite for successful implementation of other program components.

- The organization of the setting and management practices support functional behaviors.
- Resources are adequate and appropriate personnel with expertise in instruction, behavior, and emotional needs are available.
- Physical space/layout is used intentionally to support children and youth with emotional/behavioral needs.
- Scheduling is done intentionally to support children and youth with emotional/behavioral needs.
- Communication systems facilitate support for the student in the total environment.

The goal of environmental management is to manage or alter the environment so that the student will have the greatest opportunity for success during the day. When it is evident that the varied environments of the child or youth do not foster successful participation, service providers need to consider restructuring the student's schedule, setting, and interactions to maximize the potential for student achievement. Effective environmental management requires that all people in the child's or youth's environment work cooperatively in order to ensure:

1. Consistent communication and enforcement of expectations, with consistent functionally appropriate consequences for undesirable behavior.
2. Provision of nurturing, encouragement, and support.
3. Systematic monitoring of student performance and regular specific feedback about performance.
4. On-going communication between student, teachers, and parents regarding the student's progress.

Other environmental considerations include *structural aspects* of the setting, *social and emotional supports*, and *instructional supports*.

Environmental Intervention Examples

- Smaller classes
- Cueing systems
- Schedule modifications
- Multiple communication systems
- Student advocacy systems
- Computer-assisted instruction and production
- Room design modification
- Adaptive equipment
- Parent support programs
- Alternative high-interest instructional materials
- Structured behavior plans

The *structural environment* refers to aspects of the physical setting that support student success such as:

- ◆ Room size (appropriate adult/teacher ratio; percentage of students with special needs; accessible to students using wheel chairs),
- ◆ Seating arrangement (proximity to peers, support personnel and teachers),
- ◆ Room arrangement (placement of desks, tables and students; accessibility of teacher; work tables; time out or refocusing areas),
- ◆ Lighting (glare, intensity of light),
- ◆ Materials (availability of text books, remedial materials, alternative materials, learning center options),
- ◆ Multi-modal instructional resources and equipment (computers, Internet access, audio recorders and players, overhead projectors),
- ◆ Visual distractions (posters, bulletin boards, windows, pencil sharpeners),
- ◆ Noise levels, and
- ◆ Classroom schedule and daily routines.

The *social and emotional supports* that a student receives from peer interaction, family involvement, home/school involvement and community participation all influence student success.

Instructional supports assist students in successful participation in a variety of settings as well as in extra-curricular/recreational and community activities. These supports may include such things as:

- ◆ 1:1 or small group assistance,
- ◆ Accessibility of special education and related services personnel or therapeutic and support personnel,
- ◆ Peer-mentoring programs,
- ◆ Job-shadowing opportunities, and
- ◆ Vocational training.

Instructional supports should be chosen after careful consideration of the child's or youth's strengths and needs.

Behavior Management

The primary premise behind behavior management is that behavior is learned and can be taught. Behavior management interventions are those that focus on generating appropriate behavior from children and youth. Such interventions include strategies to extinguish undesirable behaviors while increasing desirable behavior, including teaching replacement, or appropriate, behaviors.

Characteristics of effective behavior management include:

- ◆ Systems for classroom management facilitate appropriate behavior.
- ◆ Procedures and modifications assist students in following the school and/or bus rules.
- ◆ Management systems, clearly understood by all, guide responses to atypical and crisis situations.
- ◆ A system for individual behavior management facilitates development of appropriate behavior.
- ◆ Behavioral intervention or interactions encourage students to be more responsible for their behavior.
- ◆ Behavior management systems involve key people in the student's environment.

Designing effective behavior management requires understanding the role and nature of reinforcement. Reinforcement is considered in terms of a behavior, consequence, and the effects on future behavior. Generally there are three types of reinforcement: positive, negative, and punishment. Positive reinforcement involves adding something in order to increase a response (e.g., student is working, teacher praises work, and student is more likely to engage in work in the future). Negative reinforcement involves taking something away in order to increase a response (e.g., when student asks for break, materials are taken away and student is less likely to ask for break). Punishment can be positive or negative. Positive punishment occurs when something is added to decrease the likelihood that it will occur again (e.g., detention). Negative punishment occurs when something is removed to decrease the likelihood that the behavior will occur again (e.g., removing preferred activity if no work is completed and behavior is less likely to occur in the future).

Punishment and reinforcement are dependent on the effects on future behavior. What is perceived as a punishment or a reinforcer for one person is not necessarily a punisher or reinforcer for the next. Designing an effective behavior plan should include input from someone who understands and has expertise in the use of reinforcement and the effects various reinforcement strategies have proven to have in modifying behavior. The word punishment has strong negative connotations and is often perceived as punitive. For this reason, the term consequence is seen as more appropriate since it has a wider acceptance and is a natural part of life.

In behavioral terms, positive and negative are only used in reference to whether something is applied (positive) or removed (negative). It does not matter if others perceive these consequences as good or bad. Reinforcement and consequences are only used in relation to the effect they have on the behavior. It is a reinforcer if the person is more likely to engage in the behavior in the future and a punishment if the person is less likely to engage in the behavior in the future.

Rule of Thumb

Always use the least intrusive strategy to which the child or youth responds.

Behavior management is associated with extinguishing unwanted behavior and as such is assumed to include only methods for “controlling” behavior. However, the research in the area of positive behavioral interventions and supports (PBIS)⁹ has shown that it is just as important to teach the desired behavior and to create positive environments that

encourage appropriate behavior. A behavior plan should include plans that teach new behaviors as well as strategies for extinguishing undesired behavior. When developing a behavioral management plan, it is important to remember that behavior is a form of communication and is triggered by a reaction to some cue in the environment. In other words, behavior generally serves a function. To know which management strategies work best for a given student, it is important to understand the function of the behavior by conducting a functional behavioral assessment. (See <http://www.dpi.state.nd.us/speced/guide/policy/behavior.pdf> for further description of functional behavior assessment and see the Tools section for a sample of a functional behavioral assessment and an outline of a behavior plan.)

Behavior management strategies fall on a continuum that range from least intrusive to moderately intrusive strategies. **It is imperative that the level of intervention strategies is carefully planned and discussed with all team members¹⁰ and care providers. As interventions become more intrusive, it is critical that appropriate documentation of plans and strategies takes place prior to implementation of any behavior management strategies. Individuals responsible for implementing these techniques**

⁹ For more information about PBIS, see www.pbis.org.

¹⁰ In an educational setting, the general education teacher must be included in developing this plan. As per IDEA 2004, “a regular education teacher . . . shall, to the extent appropriate, participate in the development of the IEP. . . including the determination of appropriate positive behavioral interventions and supports. . .” [PL 108-556, Sec 614, (d)(3)(C)].

should be able to demonstrate basic knowledge of the principles of behavior management.

Least Intrusive Behavior Management Strategies:

- ◆ **Self-Monitoring** – a component of self-management where the child or youth tracks the occurrence of a pre-defined behavior using a process designed and taught by the adult. This process could include making a notation on a tracking sheet each time the behavior occurs in a way that allows the child or youth to chart their progress over time.
- ◆ **Systematic Ignoring** - attention getting behavior is ignored by the teacher to decrease the frequency of such behavior.
- ◆ **Signal Interference (Cueing)** – signal from adult is used to focus child’s attention to controlling their behavior or impulsive action.
- ◆ **Proximity and Touch Control** – teacher uses physical proximity, moves around the classroom, places an arm around a child or pats child on the shoulder to increase child or youth security and provide ego support.
- ◆ **Hypodermic Affection** – adult use frequent demonstrations that the adult cares about the child or youth.
- ◆ **Inanimate Object Control** – adult uses inanimate objects such as clocks, timers and rules to defer control (e.g., saying something like “The clock says it’s time to put our things away.”).
- ◆ **Tension Decontamination Through Humor** – well-trained attempts at “kidding” are used without using sarcasm, irony, or cynicism, as well as using humor to laugh with children or youth on a regular basis.
- ◆ **Hurdle Help** – help child or youth over intermediate hard spot on the way to a goal to avoid potential inappropriate behavioral reaction.
- ◆ **Neutrality** – teacher maintains a position of neutrality when confronted and refrains from engaging or arguing with children or youth.
- ◆ **Time for Compliance** – adults give children or youth sufficient time and additional time if needed to comply with requests.
- ◆ **Limited Questions** – the intervener only asks true questions that require an answer, avoid stating commands as questions unless the answer “no” is acceptable.
- ◆ **Regrouping** – the grouping of children is changed so that those who don’t work well together are not grouped together.
- ◆ **Restructuring** – an activity/program is abandoned when it is not working and substituted with an alternative rather than lecturing the child or youth about not being able to succeed with program.
- ◆ **Direct Appeal** – a direct appeal is made to the child’s loyalty, knowledge of peer group behavior code, pride in personal improvement, or knowledge of undesirable consequences.
- ◆ **Limiting Space and Tools** –stimulating items are removed with reassurance that the object may be regained when the child or youth is able to control their behavior with the object.

Considerations for choosing an appropriate behavior management strategy

- Consider the individual child.
- What works for one does not necessarily work for another.
- What is rewarding for one is not necessarily rewarding for another.
- Choice must follow an analysis of the function of the behavior

- ◆ **Physical Movement** – children or youth are allowed opportunities to move around frequently in the classroom.
- ◆ **Choice Control** – numerous small choices are given about minor details to provide child or youth with feeling of control so that they can more easily defer control to the teacher on larger issues.
- ◆ **Avoiding Confrontations** – when a behavior is generally unacceptable, cannot be eliminated, and is being used provocatively, it may be openly permitted, thus taking out the potential positive effect of attention seeking behavior.
- ◆ **Support from Routine** – dependable, posted daily and weekly schedule is used to inform children or youth of any changes in routine.
- ◆ **Praise** – frequent, immediate, positive, precise and genuine praise is given often.
- ◆ **Premack Principle** – a desirable or high probability activity is provided immediately following a less desirable or low probability activity (e.g, desert is given after eating peas).
- ◆ **Token Reinforcement** – tokens are given to the child contingent upon occurrence of specific desirable behaviors and can later be exchanged for other reinforcers. A reinforcement system in which conditioned reinforcers called tokens are delivered to individuals for desirable behaviors. The tokens are later exchanged for backup reinforcers.
- ◆ **Prompting** – the adult provides additional cues to assist a child to perform correctly and gradually removing those cues as child can succeed without the extra support. Prompts are used to increase the likelihood that an individual will engage in the correct behavior at the correct time. A prompt may involve the behavior of the trainer (response prompt) or supplemental environmental stimuli (stimulus prompts).
- ◆ **Shaping** – a response most closely resembling a specified target behavior is rewarded. Each successive rewarding is made contingent upon a response which more closely approximates the target behavior. The reinforcement of successive approximations to a target behavior is used to establish a novel topography or dimension of a behavior.
- ◆ **Modeling** – the adult demonstrates a behavior to a child and then asks the child to immediately imitate the behavior. Also “think alouds” can be used to model ways to deal with frustration, anger, mistakes, etc. Modeling works best in conjunction with instructions and in situations where the individual has an opportunity to rehearse the behavior immediately after a role-play.
- ◆ **Contingency Contracting** – a contract is developed between adult and child or youth outlining mutually agreed upon tasks, mastery level, and negotiated reinforcers.
- ◆ **Differential Reinforcement of Incompatible Behavior** – the adult selects and reinforces a behavior that is compatible with the appropriate target behavior.

REMINDER

Check your local policies and procedures about the use of aversive management strategies. At a minimum, use of any of these strategies should be included as part of a behavioral plan that clearly specifies when and how they will be used. Ensure the behavior plan has been shared with the parent/family.

Mildly Intrusive Behavior Management Strategies

- ◆ **Time out** – the withdrawal or removal of a child or youth from a reinforcing situation is used for a predetermined period of time (not to exceed 5-7 minutes) following the occurrence of specific undesirable behaviors. At this level, it does not include a time out booth or time out room. Time out from positive reinforcement is a type of negative punishment in which, contingent upon the occurrence of the problem behavior, the individual loses access to positive reinforcers for a brief period of time. Typically, the individual is removed from the reinforcing environment in a time-out procedure.
- ◆ **Response Cost** – a specified amount of an available reinforcer is withdrawn following and contingent upon the occurrence of a specified behavior. The amount of reinforcement which is withdrawn should be less than the total amount of reinforcement available and opportunities to regain the lost reinforcer should be prominently available. Response cost is a negative punishment procedure in which, contingent upon a behavior, a specified amount of a reinforcer is removed.
- ◆ **Extinction** – a behavior previously reinforced by some stimulus in the environment is no longer reinforced through the removal of that stimulus in order that the behavior will decrease in frequency. When inappropriate behavior is being ignored, another, more appropriate behavior should be selected for reinforcement.

Intrusive Behavior Management Strategies

- ◆ **Negative Practice (Satiation)** – the child or youth is required to continuously engage in a behavior until fatigue becomes associated with it and ceasing the performance of this behavior avoids a noxious situation. Satiation is the progressive (and ultimately total) loss of effectiveness of a reinforcer. Example: Having a child or youth who spits on others go outside and spit until he becomes extremely tired of this activity.
- ◆ **Negative consequence** – the practice of applying something aversive or negative in an effort to increase the likelihood of getting a desired behavior. Negative consequence is the process in which a behavior is followed by a consequence that results in the decrease in the future probability of the behavior. Example: Keeping a child or youth in from recess until he or she completes an assignment. The threat of losing recess is used to motivate the child or youth to complete the assignment.
- ◆ **Overcorrection** – a child or youth is required to engage in a more desirable behavior for an extended (aversive) period of time contingent upon the occurrence of a related undesirable response. This procedure is used for those behaviors for which no restitution may be possible. Overcorrection is a positive punishment procedure in which, contingent upon the problem behavior, the individual is required to engage in effortful activity for a brief period of time. Positive practice and restitution are two types of overcorrection. Example: Having a child or youth who purposely spills milk clean up not only the milk but the entire lunchroom as well.

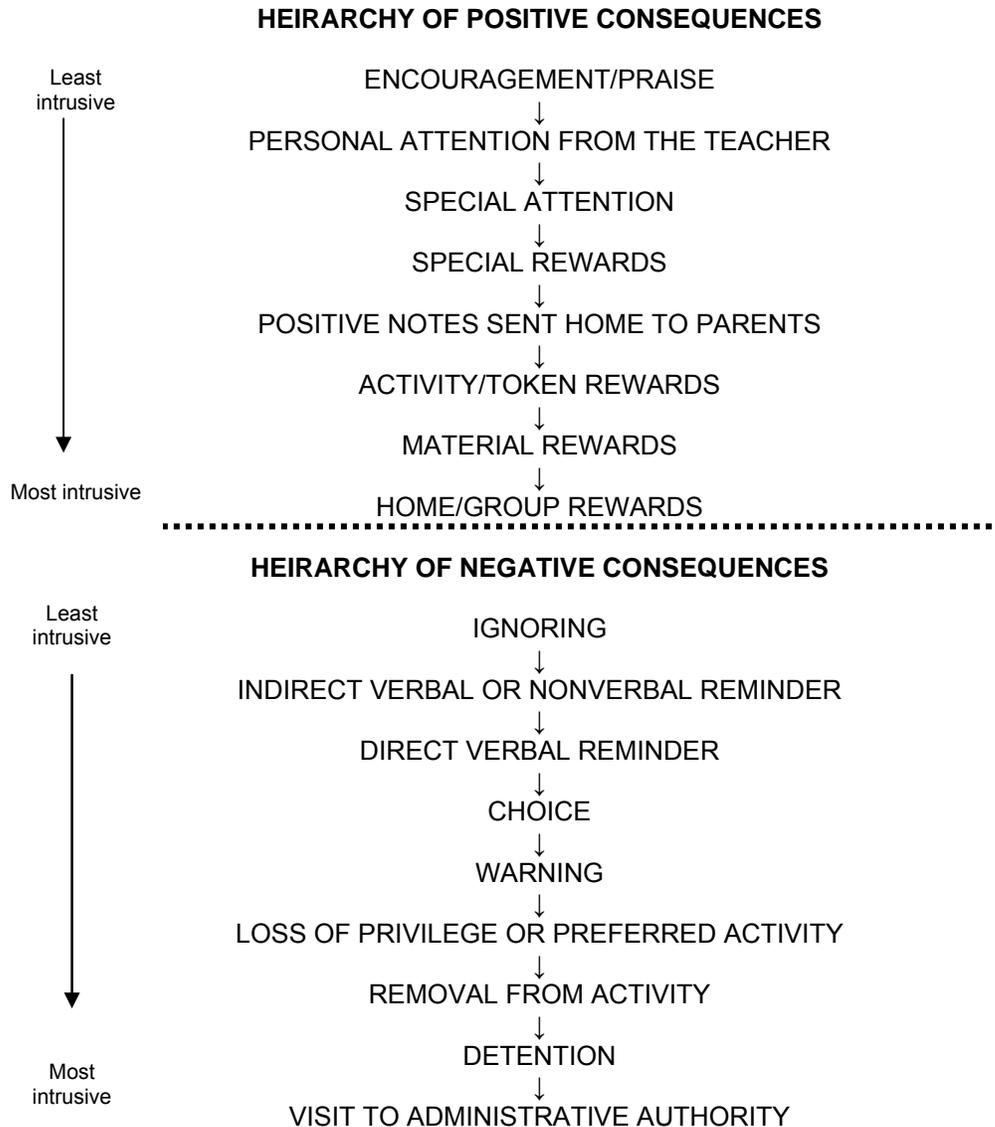
Important . . .

Intrusive strategies should only be used when all else fails, or as a last resort in situations where there is harm to self or others. Most intrusive strategies require specialized training. Implementation must follow the training guidelines. Such strategies should only be used if identified in a behavior plan. Please refer to agency specific guidelines before identifying or using intrusive behavior management strategies.

- ◆ **Time Out** –a child or youth is removed from a reinforcing situation following the occurrence of a specific undesirable behavior. Such exclusion may involve either removal to a designated area or to a time-out room for a fixed period of time. Time out from positive reinforcement is a type of negative punishment in which, contingent upon the occurrence of the problem behavior, the individual loses access to positive reinforcers for a brief period of time. Typically, the individual is removed from the reinforcing environment in a time-out procedure.
- ◆ **Physical Restraint** –Physical restraint should be used only in cases where harm to self or others is likely to result otherwise, and only by individuals trained in the appropriate techniques of physical restraint. It should never be used as a punisher or consequence and only as a last resort to ensure safety. Except in emergency, the use of physical restraint must be delineated in an IEP or treatment plan. Specialized training is offered and available to those who are in situations where physical restraint might be needed. Some examples of this training include Crisis Prevention or Therapeutic Intervention.

The following flow chart is another way to view behavior management strategies on a continuum from least instructive to most intrusive.

Figure 6



Academic or Learning Strategies

Children and youth with mental health issues require environmental and behavioral supports and interventions to facilitate their ability to learn. When these supports are in place, these children learn best using research-based instructional strategies and best practice as used in general and special education classrooms for children without mental health issues. Children and youth with mental health needs may not require academic strategies that are different from those used with other children or youth, so long as the environmental supports and considerations are in place.

Moral/Affective Education Strategies

Moral/affective education is designed to provide each child or youth with an instructional approach to positive mental health. Moral/affective education involves teaching social skills, but is a

more comprehensive approach in that it also builds understanding about personal and relationship successes and pitfalls (Neel, et. al., 2003). The key characteristics of effective moral/affective education are:

- ◆ Children or youth are systematically taught appropriate social skills and behavioral responses.
- ◆ Moral/affective education covers personal, relationship and life skills.
- ◆ Curriculum is selected on the basis of individual child or youth needs.
- ◆ Good instructional practices are employed to teach moral/affective education.
- ◆ Transference and maintenance of skills is systematically planned and taught.

Instructional content in moral/affective education programs typically includes things such as:

- ◆ Identification and appropriate expression of feelings,
- ◆ Personal awareness,
- ◆ Communication,
- ◆ Problem solving,
- ◆ Decision making,
- ◆ Group and systems understanding,
- ◆ Significant relationships,
- ◆ Lifestyle choices (drugs, risk taking, illegal behavior, etc.),
- ◆ Coping strategies,
- ◆ Stress management, and
- ◆ Life planning.

Counseling/Therapy Interventions

The difference between counseling and therapy can be found in the definitions of each word as provided at www.freedExceptionary.com. Counseling is described as an exchange of ideas or as providing guidance or advice. Therapy is described as the treatment of illness or disability. This difference in definition underscores the difference in approaches across agencies. Schools focus more on counseling, even though it might be psychological counseling as opposed to therapy, which is about treatment, and thus, more of a medical service.

The issue of medical versus educational services has led educators to avoid the use of the term *therapy* in that therapy is generally associated with a medical approach. Educators are more comfortable with the term counseling. But even this presents challenges in that IEP teams find themselves in a position of needing to determine the type of psychological or counseling services that are needed for the child or youth to benefit from special education. A child or youth might require more psychological or counseling services, but the additional services might go beyond the need to benefit from special education. For example, the child or youth might be able to complete work in school and function well in school with a minimal amount of counseling, but at home or after school the child or youth is unable to maintain a satisfactory level of functioning. This might call for more counseling or psychological services that go beyond the responsibility of the school.

These challenges have not proven to be easy issues for IEP teams and local school administrations. In the end, the most effective approach is for schools to work with mental health providers to develop collaborative and cooperative agreements. Such agreements should delineate the responsibility of each provider in meeting the mental health needs of children and youth in the community, including specifying funding or payment of these services.

Career/Life Skills or Post-Secondary Transition

Transition planning is essential any time a child or youth moves from one milestone to another or from one setting to another. IDEA contains specific requirements for transition planning at the secondary level with an emphasis on career and life skills. A focus on transition refers to

“systems which develop those skills necessary for productive meaningful life outside of school. These systems provide the link between the skills a child or youth gains in his/her high school experience and application of those skills in the non-academic setting” (Cessna et. al 1992). It is critical to assist children or youth with emotional disabilities in developing competencies that will lead to productive meaningful lives outside of school and after they leave school. To assist children or youth in this process, career and life skills education must be an integral part of every program from the elementary grades to graduation. These programs can be integrated into direct instruction, service-learning, and work-study opportunities.

The key characteristics of effective career/life skills/transition programming include:

- ◆ Children or youth are systematically provided with information/skills necessary for life outside of school.
- ◆ Curriculum is appropriate in content, level, scope and developmental sequence.
- ◆ Effective instruction is used.

Career/life skills intervention or training includes programs, curricula, and activities that provide experiences designed to help individuals become oriented to, select, prepare for, enter, become established, and advance in an individually satisfying and productive adult life. Living skills may include instruction and guided practice in the following areas:

- ◆ Domestic skills,
- ◆ Health,
- ◆ Transportation,
- ◆ Citizenship,
- ◆ Community resources,
- ◆ Leisure and recreation,
- ◆ Time management, and
- ◆ Independent living skills such as communication and money management.

Effective transition planning cannot be done by one agency alone. Rather, it requires the involvement of multiple agencies and the coordination of services. Vocational Rehabilitation is one resource that can assist with job training needs. Student Services offices at higher education facilities are a valuable resource to help children or youth understand the expectations and supports available at the higher education level. Developmental Disabilities services are a potential resource for assistance with independent living needs. Each community might also have independent or private agencies that provide supports to assist with the transition process. Service providers working with children or youth in the area of transition to post-secondary life will need to take time to seek out and learn about the various services within the local community that can be used to assist in the design and delivery of transition services.

Summary

This section described the various strategies that are used when addressing the needs of children and youth/young adults with mental health needs. The strategies described can be applied in a variety of settings, across ages, and by various service providers. In most instances, providing effective services to meet these needs cannot be provided by one agency alone as stated earlier. Rather, it requires collaboration among agencies. The services provided by one agency are defined by their respective mission and policies and generally do not cover the entire need of the child or youth.

Effective collaboration across agencies requires purposeful action. It requires individuals within one agency to reach out and communicate with individuals from other agencies. It requires

opportunities to get to know the parameters and requirements of other agencies. More importantly, it requires opportunities to establish and develop working relationships. Hopefully this guidance document will be one tool for sharing some information across agencies. In the end, however, it will require those who work at the community level to create opportunities for various service providers to come together. The best way to do this is to start with one case and develop an effective plan for the child/youth and their family that clearly delineates the roles and responsibilities of each provider. As the plan is carried out, it is important to document the effects, to periodically review the data, and then together make adjustments to the plan.

One Family's Perspective

She has been willing to do whatever it takes to make our son successful in the classroom. In her positive philosophy, she has gently nudged him to volunteer in the library four days a week. But the most innovative teaching tool she has implemented has been placing our son in a leadership role by having him help a student who recently immigrated to our community learn the English language. By helping this new student with the language, it in turn develops and expands his language. He has flourished as a person and is learning, even beyond what we might have hoped.

V. TOOLS AND RESOURCE INFORMATION

This section of the document has been developed to provide the reader with information that elaborates on or extends the information provided in the first sections of the document. It is intended to serve as a reference or tool and includes information about the screening and evaluation process, a list that compares ED characteristics with social maladjustment, sample documents, and other resources for gathering additional information.

Screening and Evaluation

Screening alone cannot determine an emotional disturbance. A combination of screening and evaluation results is used to determine the presence of an emotional disturbance and to identify strengths and needs of the child or youth. The person who is obtaining information related to the emotional issues of children or youth needs to know the limits of his/her training. An interviewer, for example, needs to know when to stop an interview and refer to someone with more expertise within the system of care. When using specific screening or evaluation instruments, the publisher's required level of training in the use of specific instrument must be met. The American Psychological Association standard of ethics should be adhered to in the assessment process.

Screening and evaluation can use a variety of formats or tools to gather information. These include family assessment (especially for very young children), interview, observation, rating scales, self-report, and situational/social emotional measures. Each of these is not necessarily used for every evaluation. The specific tool should be selected based on the type of data that is needed in making reliable decisions about the child or youth. Each of these tools is described in a bit more detail, and are organized in alphabetical order.

Multidisciplinary team findings may include documentation derived from assessment procedures from as many sources as possible including:

- Rating scales
- Observations
- Self reports
- Interviews
- Situational/Social emotional measures
- Academic achievement results
- Clinical findings
- Family assessment (Birth to 3)

Family Assessment. Family assessment is most often associated with early intervention because families are often the recipient of services when children are so very young in age. Family assessment is useful in planning the evaluation process and developing the IFSP (e.g. strengths, interests, routines, priorities, resources and concerns). The family and the service coordinator or infant development staff member has a conversation about why the information requested will be useful to evaluation/IFSP team members. Information gathering is an ongoing process and can be recorded at multiple times and a variety of ways. For example, the information might be obtained during conversations between the family and the early intervention staff or the family may complete a checklist independently and then review the information with early intervention staff.

Interviews. Interviews can be structured or unstructured. They are important in obtaining information about the student's medical and developmental history, social-emotional functioning, educational progress or history, and community involvement. The family is a critical component in identifying home environmental factors that may be impacting the child's behavior.

Observation. Systematic observation is completed in the child's environment and yields data critical to any evaluation procedure. It increases the chance of making correct assumptions. Observations must reflect multiple settings and time periods.

Observations require a greater degree of planning and execution beyond merely watching a child perform within a particular setting and summarizing one's opinions about the child's behavior.

When planning for an observation the purpose or goal of the observation is of primary consideration. Observations of children and youth should not be conducted for the sole purpose of meeting a procedural requirement. Rather, observations should be designed to address a specific purpose, need or question. For example, a specific, clearly written question such as "Does Sally demonstrate a greater degree of off-task behavior during math class than same aged peers?" will facilitate a more economical and purposeful observation.

Depending upon the type of data collection system used, several behaviors may be included in any individual observation. Positive observational goals should be considered for inclusion in any plan. For example, in the case of Sally, an additional question to guide the observation might be "What is Sally's rate of positive interaction with her peers during free time?"

Observations should be written as descriptive statements rather than subjective, inferential statements. For example, "the child was observed tapping his pencil and staring out the window" provides a clearer picture than "the child was day dreaming." Observers who pre-define observational goals can more easily develop descriptive statements of particular behaviors, and this practice will minimize the opportunity for inferential observation errors. The following table provides other examples of descriptive versus inferential descriptions:

Table 1
Descriptive versus Inferential Statements

Behavioral Descriptive Statements	Behavioral Inferential Statements
The child or youth kicked his desk	The child or youth was frustrated
The child or youth refused a teacher directive to return to seat.	The child or youth was oppositional
During this observation the child or youth passed a spelling test with 19/20 words correct.	The child or youth does not appear to have any difficulties with spelling.

It is important that observations be conducted to gather demonstration of the behaviors not information *about* the behavior. The interpretation of the behavior should occur after the data is analyzed. During functional behavioral analyses, accurate descriptive statements of the antecedents and consequences should accompany observations of the predetermined target behavior.

There are several effective methods for observational recording. The type of recording used should be chosen based on the setting, skill of the observer, and the type of data needed. Table 2 provides an overview of observational recording methods with how to apply each and lists some of the advantages and disadvantages of each.

Table 2
Observational Recording Methods

Recording Method	Types	Applications	Data	Advantages	Disadvantages
<p>Narrative Recording Behavior is comprehensively described.</p>	<p>Anecdotal recording: Anything that appears noteworthy is recorded.</p> <p>Running record: Observer makes an on-the-spot description of behaviors.</p>	<ul style="list-style-type: none"> ▪ Is useful precursor to more specific and quantifiable observations. ▪ Helps in the development of hypotheses about factors controlling target behaviors. ▪ Provides an in-depth picture of behavior. 	<ul style="list-style-type: none"> ▪ No specific quantifiable data, although the record can be analyzed for various occurrences of behavior. 	<ul style="list-style-type: none"> ▪ Provides record of child's behavior and general impressions. ▪ Maintains original sequence of events. ▪ Facilitates discovering critical behaviors and noting continued difficulties. ▪ Requires a minimum of equipment. 	<ul style="list-style-type: none"> ▪ Is not well suited to obtaining quantifiable data. ▪ Is costly in terms of time and person power. ▪ Is difficult to validate. ▪ Is time consuming. ▪ May be insensitive to critical behaviors. ▪ Produces findings with limited generalizing.
<p>Event Recording Each instance of specific behavior (event) is observed and recorded.</p>	<p>Event: Observer waits for pre-selected behavior to occur and the records its occurrence.</p> <p>Duration: Observer determines the amount of time that elapses between the beginning and end of the behavior.</p> <p>Intensity: Behavior is divided into various degrees of intensity, and behavior of each degree is recorded separately.</p> <p>Latency: Observer determines the amount of time that elapses between the initiation of the request and the onset of the behavior.</p>	<ul style="list-style-type: none"> ▪ Is useful for behaviors that have clearly defined beginnings and endings, such as spelling words, rocking movements, asking questions, and speech errors. 	<ul style="list-style-type: none"> ▪ Number of occurrences of the behavior-frequency count. ▪ Also, in some cases, rate of behavior, duration of behavior (time), intensity of behavior (if built into code), latency of behavior (time). 	<ul style="list-style-type: none"> ▪ Facilitates detection of low incidence behaviors. ▪ Facilitates study of many behaviors in an economical and flexible manner. ▪ Provides information about the frequency with which behavior is performed and changes in behavior over time. 	<ul style="list-style-type: none"> ▪ Provides an artificial view of behavior sequence and breaks up continuity of behavior. ▪ Is not suited for recording discrete behaviors. ▪ Presents difficulties in establishing reliability. ▪ Limits quantification of the hows and whys associated with behavior. ▪ Makes comparisons across sessions and is difficult if the length of the observation period is not consistent.
<p>Interval Recording Observational period is divided into brief segments or intervals; observer notes</p>	<p>Partial-interview time sampling: Behavior is scored only once during the interval, regardless of</p>	<ul style="list-style-type: none"> ▪ Is useful for behaviors that are overt or easily observable, that are clearly discrete, and that occur with 	<ul style="list-style-type: none"> ▪ Number of intervals in which target behaviors did or did not occur. 	<ul style="list-style-type: none"> ▪ Defines important time-behavior relationships. ▪ Facilitates checking inter-observer reliability. 	<ul style="list-style-type: none"> ▪ Provides somewhat artificial view of behavior sequence. ▪ May lead observer to overlook important behaviors ▪ Usually tells little about the quality of

<p>whether a behavior occurs in each interval.</p> <p>Observational period is divided into brief segments or intervals; observer notes whether a behavior occurs in each interval.</p>	<p>duration or frequency of occurrence.</p> <p>Whole-interval time sampling: Behavior is scored only when it lasts from the beginning to the end of interval.</p> <p>Point-time interval sampling: Behavior is scored only when it occurs at a designated time during the interval.</p> <p>Momentary time interval sampling: Behavior is scored only when it occurs at the end of the interval.</p> <p>Variable interoccasional interval time sampling: Behavior is scored only when it occurs at designated random interval.</p>	<p>reasonable frequency (for example, reading, working, roughhousing, smiling, or playing with toys).</p>		<ul style="list-style-type: none"> ▪ Maintains standard observational conditions in an economical way. ▪ Enhances attention to specific behaviors. ▪ Allows for flexibility in recording large numbers of behaviors. 	<p>behavior of situation.</p> <ul style="list-style-type: none"> ▪ Provides numbers that are usually not related to frequency behaviors. ▪ Is not sensitive to low-frequency behaviors and point-in-time sampling behaviors of short duration.
--	---	---	--	---	--

Sattler, J.M. Assessment of children 2nd ed. San Diego: Jerome Sattler (pp. 506-507)

Rating Scales. Rating scales are used to identify characteristics of ED, to identify the extent of behaviors (intensity, frequency) and to reflect the observations of caregivers. Rating scales may be completed by anyone who knows the child. It should be understood that **rating scales are not exact and should be used in conjunction with other methods of collecting data.**

Readers are encouraged to verify the reliability and validity of any screening or rating scale chosen. The following table has been included to provide some general guidance in making decisions about the potential confidence in a given rating scale or formal assessment tool.

Table 3

General Rating Criteria for Evaluating Scales				
Criterion Rating	Exemplary	Extensive	Moderate	Minimal
Alpha-coefficient	.80 or better	.70 to .79	.60 to .69	<.60
Test-Retest Reliability	Scores correlate more than .50 across a period of at least 1 year.	Scores correlate more than .40 across a period of 3-12 months.	Scores correlate more than .30 across a period of 1- 3 months.	Scores correlate more than .20 across less than a 1 month period
Convergent Validity	Highly significant correlations with more than 2 related measures.	Significant correlations with more than 2 related measures.	Significant correlations with 2 related measures.	Significant correlations with 1 related measure.
Discriminant Validity	Significantly different from four or more unrelated measures.	Significantly different from two or three unrelated measures.	Significantly different from one unrelated measure.	Different from one correlated measure.

Source: Robinson JP, Shaver PR, Wrightsman LS. *Measures of Personality and Social Psychological Attitudes*. San Diego, CA: Academic Press, Inc., 1991.

Self-Report. Self-report allows the child to express inner feelings and perceptions of his/her behavior. Some rating scales include self-reporting forms (e.g., the Achenbach has a self-reporting scale).

Situational/Social Emotional Measures. Situational/social emotional measures provide information about a child's social or emotional development. Such measures are most often used in screening very young children and information is generally gathered from the observations or views of others. Gathering and interpreting such data must be done with care in that cultural characteristics can be a factor in the social emotional development of a child and must be given careful consideration before drawing conclusions about a child.

A Guide for Differentiating ED and Social Maladjustment

The special education definition for ED includes an exclusion clause (i.e., a child or youth can not be found to be ED if the behavior is specifically the result of a social maladjustment. Determining the difference between ED and social maladjustment can be confusing. The following chart found in a document developed in Texas helps to illustrate how the two can be differentiated.

Table 3

Emotional Disturbance (ED) Using IDEA Definition	Social Maladjustment
<p>1. "...condition..." Inappropriate behaviors must be indicative of an emotional condition. The condition is documented by behavior observations, self-report (interviews, questionnaires), projective responses in the following areas:</p> <ul style="list-style-type: none"> ▪ Feelings are often emotional overreactions including anxiety, depression, and guilt. ▪ Thoughts may be inappropriate to situation, confused, bizarre, tangential, and emotionally overloaded. ▪ Perceptions are often not congruent with usual perceptions of reality and can be confused or overly suspicious. ▪ Behaviors may be idiosyncratic, unusual, bizarre, as well as inappropriate. ▪ Lack of social awareness. Student may not understand or may misinterpret social conventions and behavioral expectations. 	<p>1. Inappropriate behaviors which originate in social maladjustment and are not indicative of an emotional condition:</p> <ul style="list-style-type: none"> ▪ Emotional overreactions may occur only when behavior is criticized and punishment is applied. Anger is the most frequent reaction. ▪ Thoughts are usually practically related to situations. ▪ Perceptions are usually practically related to situations and congruent with other people's perceptions. ▪ Behavior may be goal directed, self-serving, and manipulative. Student acts according to own perception of self-interest (even though others may consider behavior to be self-defeating). ▪ Student usually understands, but chooses not to accept, general social conventions and behavior standards. However, student may accept and follow counter-cultural standards of neighborhood and peer groups.
<p>2. Exhibited "...over a long period of time..."</p> <ul style="list-style-type: none"> ▪ ED behaviors must be persistent, generalized, inappropriate behaviors over time and situations. 	<p>2. Socially maladjusted behaviors may or may not be exhibited over a long time period.</p> <ul style="list-style-type: none"> ▪ May often be situation-specific rather than occurring in many situations. ▪ Are often not observed until pre-adolescence or adolescence.
<p>3. "...to a marked degree..."</p> <ul style="list-style-type: none"> ▪ Serious Problems ▪ Low frequency in peer group 	<p>3. Socially maladjusted behaviors:</p> <ul style="list-style-type: none"> ▪ May or may not be serious. ▪ May occur with higher frequency in delinquent peer group.
<p>4. "...which adversely affects educational performance..."</p> <ul style="list-style-type: none"> ▪ ED behaviors result in a demonstrable educational need in achievement, grades and/or dysfunctional behaviors in academic situations. 	<p>4. Socially maladjusted behaviors:</p> <ul style="list-style-type: none"> ▪ May or may not have adverse affect on educational performance. ▪ Educational deficits, when present, are often related to truancy, tardiness, work refusal, and occasionally to limited intellect or educational background.

	<ul style="list-style-type: none"> A subgroup of socially maladjusted students have a history of language deficits and lowered verbal intelligence which predisposes them to chronic educational problems and social maladjustment related to lack of success.
<p>Associated Characteristics</p>	
<p>1. ED student usually has limited or no social support for inappropriate behavior.</p>	<p>1. Possible home, neighborhood, and/or peer support for socially maladjusted behavior.</p>
<p>2. ED student usually demonstrates limited self-control.</p> <ul style="list-style-type: none"> Low frustration tolerance, emotional overreactions, and impulsivity are common. ED Student often displays limited premeditation or planning and has limited ability to predict consequences of behavior. Behavior escalates quickly and cool down periods are often needed. 	<p>2. Socially maladjusted students have variable rather than limited self-control. They may preplan behavior and may be vigilant in social situations to avoid detection of misbehavior. Misbehavior may be goal-directed, even though the goals may be limited rather than long range. Socially maladjusted students may be able to stop misbehavior quickly if apprehended by authorities.</p>
<p>3. ED behaviors generally are dissocial and have no clear relationship to social morals or law enforcement.</p>	<p>3. Socially maladjusted behaviors are antisocial in that they violate social conventions and often exploit others. Attitudes and behaviors are generally anti-law enforcement: law enforcement officers are seen as interfering with the achievement of their self-interest.</p>
<p>4. Inappropriate behavior is disturbing to the ED student.</p> <ul style="list-style-type: none"> May experience anxiety, guilt, depression, distress. ED student often expresses desires to want to change or improve behavior. 	<p>4. Inappropriate behavior is not disturbing to socially maladjusted students.</p> <ul style="list-style-type: none"> Limited emotion may be attached to misbehavior. Socially maladjusted student may have an incentive to continue misbehavior to reach goals.
<p>5. Social relationships are distorted and may be characterized by inappropriate dependence and over-closeness and/or inappropriate rebellion and defiance.</p>	<p>5. Social relationships tend to be superficial and transitory, although loyalty may be given to a delinquent peer group.</p>
<p>6. Self-esteem is usually low and self-concept is usually distorted.</p>	<p>6. Socially maladjusted student may appear to others to have adequate self-esteem and self-concepts; however, feelings of inadequacy often underlie veneer of adequacy. Student may show bravado and "macho" attitudes.</p>

7. ED student is often preoccupied with his/her conflicts and overly self-concerned; however, some ED students translate their problems into behavior immediately and have limited self-awareness.	7. Socially maladjusted students often have a very superficial sense of self and are rarely self-reflective.
8. ED student is more likely to respond to psychotherapeutic interventions.	9. Because of the characteristics mentioned above, including difficulty forming relationships and limited affective development, the socially maladjusted student who is not SED is less likely to respond to psychotherapeutic interventions. Alternative educational programs need to be developed for these students.
Adopted unanimously by the Texas Joint Task Force Emotional Disturbance. This information was taken from a document that is no longer in production. However, the information is still relevant and applicable.	

Settings or Placement Options

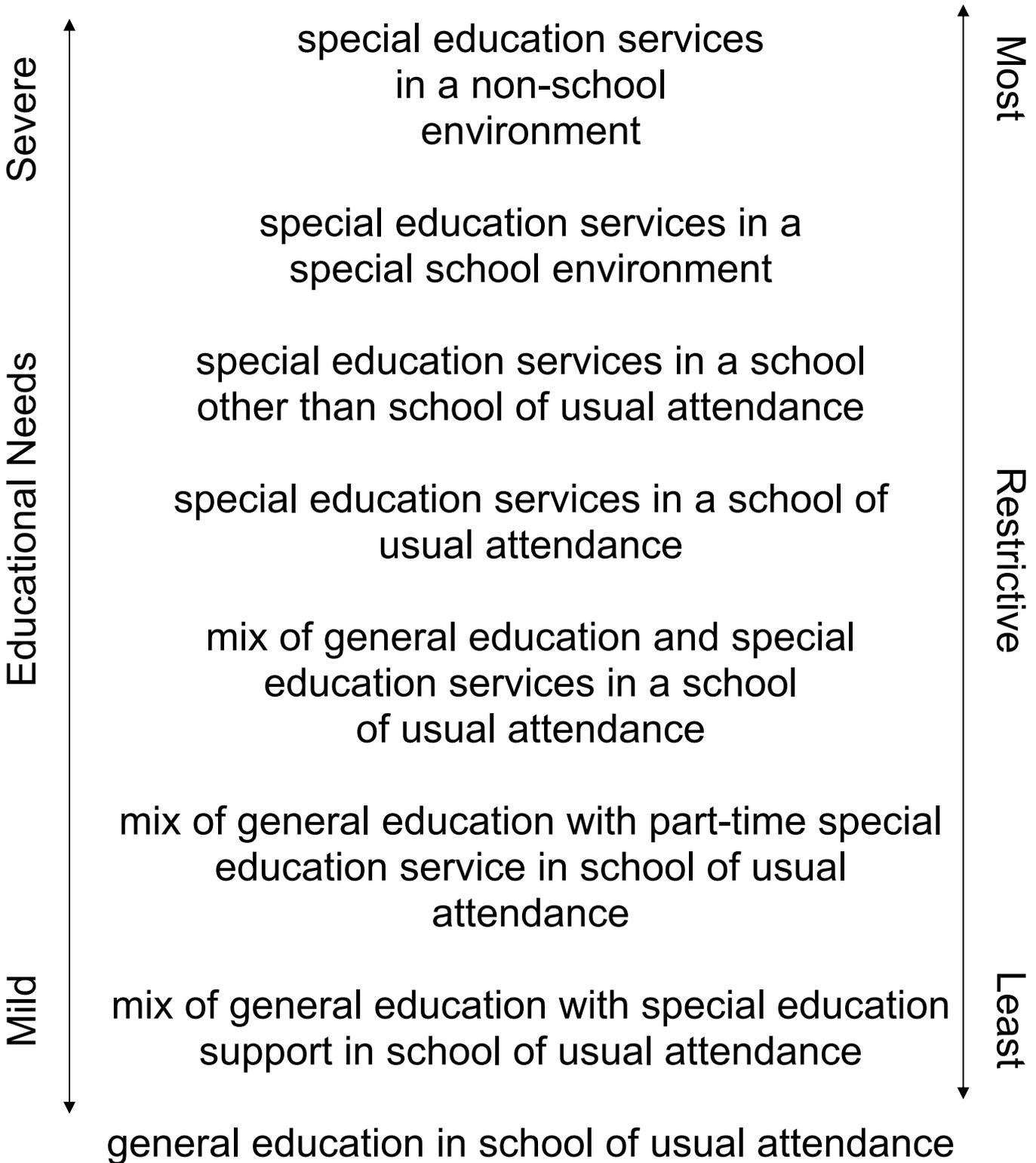
Services for children and youth with ED are provided in a variety of settings based on the specific needs of the child or youth and the agency providing the services. Section IV discusses various interventions or strategies for working with and addressing the needs of children and youth with mental health needs. As stated in that section, the strategies can be applied in most settings or placement options. The following provides a description of the types of settings in which services might be provided:

1. **Natural Environment** – This setting term is used with early intervention (birth through 3) but could apply to other ages as well. The natural environment is the environment where you would expect to find other children of the same age. For very young children, this generally is the home, but it could include the park, a restaurant, or any other setting that the child frequents regularly.
2. **Home** – Services can be provided in the home and most often is used for early intervention or preschool. However, some older children or youth may require services provided in the home (i.e., homebound) for short periods of time.
3. **Early childhood setting** – Such settings are programs designed for preschool children and are primarily for children without disabilities. This may include, but is not limited to: regular kindergarten classes, public or private preschools, Head Start Centers, child care facilities, preschool classes offered to an eligible pre-kindergarten population by the public school system, home/early childhood combinations, home/Head Start combinations, and other combinations of early childhood settings.
4. **Early childhood special education setting** – Such settings are programs designed specifically for children with disabilities. This may include, but is not limited to: special education preschool classrooms in regular school buildings; special education classrooms in child care facilities, hospital facilities, on an outpatient basis, or other community-based settings; and special education preschool classrooms in trailers or portables outside regular school buildings.

5. **Special education classroom in a public school** - Children and youth found to be in need of special education receive their services in a special education classroom as determined by their IEP. The amount of time spent in a special education classroom will be determined by the need and the IEP team determination about the best way to meet that need. Children and youth can receive special education services along a continuum that includes itinerant services (i.e., services provided through consultation with the classroom teacher) or pull-out (i.e., services provided in a separate classroom). The amount of time in a separate classroom can range from a small part of the day (e.g., 30 minutes) up to the full day.
6. **Separate day school (public or private)** - Another service setting is the separate school, which may be referred to as day-treatment programs. Students may get their services in a setting away from the regular school or program in a setting specifically designed to address the needs of students with ED. These programs can be either public or private. In some communities, schools and mental health agencies work together to create a special day program for students with more intense emotional needs.
7. **Counseling or Mental Health Office** – Services might be provided in the office of a mental health worker. This could occur after school as a medical service, or during school as a related service.
8. **Residential facility** - Residential settings are considered the most restrictive and generally are used as a setting of last resort. In such cases, the child or youth is either voluntarily placed by the parents, placed by the school with parental permission, or court ordered to attend a residential facility away from home. These settings should be considered only when other less restrictive settings have not proven effective and for short periods of time. Progress should be monitored regularly to determine when the child or youth is ready to return home and the public school should be included in developing the transition plan
9. **Correctional facility** -- These settings are used where youth offenders are placed through a judicial proceeding, including short-term detention facilities (community-based or residential). Educational and rehabilitative services are provided through the correctional facility.

Figure 7

Continuum of Educational Services



Sample Documents

In this section you will find a number of sample forms that are commonly used to develop plans to address the needs of children and youth with SED needs. There are blank forms that can be used as templates as well as completed forms that can be used as samples. Forms found in this document include:

1. Observation Form – This is a sample form that can be used to document observations of a child or youth. The form indicates that it is designed for use in a classroom, but it can easily be used in other situations as well.
2. Functional Behavioral Assessment (FBA) – One blank FBA is included to serve as a template. There is an additional completed FBA to provide an example of what a FBA might look like. The sample FBA is found as part of a case study.
3. Behavioral Intervention Plan (BIP) – One blank BIP has been provided as a template that anyone can use for developing a specific behavioral intervention plan. Two additional completed forms are included as samples of what a BIP might look like. The samples are part of the case study and found following the sample FBA.
4. Individualized Education Plan (IEP) – Most school districts use their own version of an IEP. The form included here is one that will provide an introduction to anyone unfamiliar with an IEP and provides a template to show the type of information that is contained in an IEP.
5. Individual Family Service Plan (IFSP) – The IFSP is used for early intervention programs. A blank form is provided to illustrate the kind of information that is included in an IFSP. A sample of some sections of a completed IFSP is included to illustrate how an IFSP might appear when completed.
6. Treatment Plan – Each region of the state might have their own treatment plan. Partnerships use the Single Plan of Care as the treatment plan for children and families (see blank copy).

Sample Observation Form

Observer Last Name	Teacher's Name	Subject	Student's Name
--------------------	----------------	---------	----------------

CLASSROOM BEHAVIOR OBSERVATION RECORD

Pupils		1	2	3	4	5	6	7	8	9	10
Obs. #											
Type Of work											
Date											
Time:											
—											
to											
—											

Student Responses			
A =	Disturbing others by direct aggression	VA =	Verbal aggression
X =	Gross motor behavior	M =	Disruptive noise with objects
O =	Orienting, turning head or body at least 3 seconds	D =	Daydreaming, at least 3 seconds
I =	Blurting out; disruptive talking or noises	T =	Talking when not permitted
// =	Other non-appropriate behavior	S =	Student behavior; doing what is asked

Teacher Reaction		Method of Presentation		Type of Material		Peer Reactions	
R =	Reinforce activity	p =	Provide	A =	Auditory	“+” =	Positive
A =	Attend w/no deliberate	e =	Explain	T =	Tactile	“-“ =	Negative
I =	Ignore	c =	Command	V =	Visual	“=” =	Neutral
P =	Punish, aversive to S	d =	Demonstrate	k =	Kinesthetic		

Functional Behavioral Assessment

Student _____ Date _____

Team Member's Name

Team Member's Position

A. Describe the behavior:

1. What is the behavior?
2. How is the behavior performed?
3. How often does the behavior occur?
4. How long does the behavior last when it occurs?
5. What is the intensity of the behavior when it occurs?

B. Define setting events and environmental factors that predict the behavior (describe the following variables):

1. Classroom structure (physical).
2. Class rules and procedural expectations.
3. Instructional delivery (lecture, cooperative learning, labs, etc.)
4. Instructional materials (textbooks, worksheets, hands-on activities).
5. How are directions presented?

C. Define specific immediate antecedent events that predict when the behaviors are most likely to occur:

1. When are the behaviors most likely to occur?
2. When are the behaviors least likely to occur?
3. Where are the behaviors most likely to occur?
4. Where are the behaviors least likely to occur?
5. During what activities are the behaviors most likely to occur?
6. During what activities are the behaviors least likely to occur?

D. Identify specific consequences/outcomes that follow the behavior.

1. What specific consequence/outcome is most likely to immediately follow the behavior?
 a. Gain attention. Explain.

 b. Gain a tangible consequence. Explain.

 c. Gain a sensory consequence. Explain.

 d. Escape from or avoidance of an undesirable situation. Explain.

 e. Other. Explain.
2. Do consequences/outcomes occur in all settings?
3. What is the source of the consequence/outcome?
 teacher imposed student imposed

E. Summary

1. What is the function of the behavior?

2. What are some possible intervention strategies?

Behavior Intervention Plan (BIP)
Template

Behavior Intervention Plan

Student: _____ Date of Birth: _____ Age: _____

School: _____ Case Manager: _____

Grade: _____ Date: _____

Targeted problem behavior (information gathered through FBA/baseline data):

Hypothesized function of the problem behavior:

Desired replacement behavior:

Methods of teaching the replacement behavior:

- direct instruction social skills training anger management use of mentor(s)
 providing cues role playing modeling
 behavior contract stress management decision-making training

Other: _____

Positive reinforcement for displaying the replacement behavior:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> verbal praise | <input type="checkbox"/> computer time | <input type="checkbox"/> immediate feedback | <input type="checkbox"/> earned privileges |
| <input type="checkbox"/> positive phone call home | <input type="checkbox"/> free time | <input type="checkbox"/> tangible rewards | <input type="checkbox"/> positive visit to administrator |

Other: _____

Positive Behavioral Supports

- | | | |
|--|--|---|
| <input type="checkbox"/> clear, concise directions | <input type="checkbox"/> supervise free time | <input type="checkbox"/> provide alternate recess |
| <input type="checkbox"/> frequent reminders/prompts | <input type="checkbox"/> avoid strong criticism | <input type="checkbox"/> avoid physical contact |
| <input type="checkbox"/> frequent breaks/vary activities | <input type="checkbox"/> predictable, routine schedule | <input type="checkbox"/> provide cooling off period |
| <input type="checkbox"/> teacher/staff proximity | <input type="checkbox"/> specified study area | <input type="checkbox"/> provide highly-structured setting |
| <input type="checkbox"/> reprimand the student privately | <input type="checkbox"/> preferential seating | <input type="checkbox"/> communicate regularly with parents |
| <input type="checkbox"/> modify assignments | <input type="checkbox"/> avoid power struggles | |
| <input type="checkbox"/> review rules & expectations | <input type="checkbox"/> specifically define limits | |

Other: _____

Consequences for displaying excessive/extreme behavior:

- | | | |
|--|--|---|
| <input type="checkbox"/> phone call home | <input type="checkbox"/> level drop/loss of points | <input type="checkbox"/> escort to another area |
| <input type="checkbox"/> send to office | <input type="checkbox"/> loss of privileges | <input type="checkbox"/> in-school suspension |
| <input type="checkbox"/> time out | <input type="checkbox"/> detention | <input type="checkbox"/> out-of-school suspension |
| | | <input type="checkbox"/> None needed |

Other: _____

Methods of measuring progress:

- | | | |
|---|--|---|
| <input type="checkbox"/> direct observation | <input type="checkbox"/> weekly behavior sheet | <input type="checkbox"/> self-monitoring |
| <input type="checkbox"/> daily behavior sheet | <input type="checkbox"/> charting/graphing | <input type="checkbox"/> number of discipline referrals |

Other: _____

Persons responsible for implementing the plan:

- | | | |
|---|--|---|
| <input type="checkbox"/> gen ed teacher(s) | <input type="checkbox"/> administrator | <input type="checkbox"/> paraeducator |
| <input type="checkbox"/> sp ed teacher(s) | <input type="checkbox"/> parent | <input type="checkbox"/> behavior intervention specialist |
| <input type="checkbox"/> related service provider | | |

Other: _____

Persons involved in developing/approving plan:

Signature

Title

Date

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review date:	<input type="checkbox"/> outcome achieved interventions	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue
Review date:	<input type="checkbox"/> outcome achieved interventions	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue
Review date:	<input type="checkbox"/> outcome achieved interventions	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue
Review date:	<input type="checkbox"/> outcome achieved interventions	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue

Case Study

This case study, describing Sally, is included to provide context for the next several sample forms. A completed functional behavioral assessment and behavioral intervention plan follow this case study to provide a complete illustration of how this information is used to develop a behavioral intervention plan, and what it might look like when completed.

Sally

Sally is a 9-year-old student enrolled in a regular education classroom. Her teacher, Mr. Barnes, uses an active learning approach that involves frequent cooperative group activities, choice in activities and assignments, individualized and adapted instruction and goals, self-evaluation, and feedback from peers and the teacher. In addition, Mr. Barnes's classroom has a small area that she refers to as the reading corner. This area is quiet and contains writing materials, books, and headphones with quiet music. Students are allowed to use the reading corner for independent projects, reading, time alone, and so forth.

Sally is a very good student who does well in all subject areas. She especially enjoys working on the computer, reading, and creative writing. She turns in all homework assignments and does well. She also volunteers and enjoys reading to Kindergartners.

Sally seems to prefer interacting with adults and often seeks their company instead of interacting with other kids. For example, during recess she often talks to teachers instead of playing with peers.

Although Sally is a good student, Mr. Barnes is very concerned about her behavior. Mr. Barnes feels that Sally uses the reading corner too much. She tells the ED Teacher that Sally spends most of the school day in the reading corner. For example, Mr. Barnes says that today it took a lot of coaxing to get Sally to leave the reading corner in order to join a group for a cooperative learning activity. When she did finally join a group, she sat at the edge of the group and only contributed to the group if someone asked her a question. After about 10 minutes in the group, Sally got up and returned to the reading corner.

Mr. Barnes indicated that recently, Sally has refused to leave the reading corner in order to join the class. Mr. Barnes says that if he persists in asking Sally to join the class, or insists that Sally join a group activity, Sally says that she is sick and requests permission to go to the office.

The ED Teacher observed Sally across several days and recorded the following information about both appropriate and challenging behavior:

Antecedents and Setting Events	Behavior	Consequence/Outcome
Recess, many students are playing soccer	Sets on bench, watches the game	Left alone
Teacher led group activity	Writes answers to questions on worksheet	Praise for correct answers
Cooperative groups that are loud, unstructured, with lots of movement	Moves to reading corner	Teacher tells her to return to group
Told to return to group	Refuses	Told to return to group
Note: This interaction repeats several times until Sally complies and returns to her group.		
Told to return to group	Returns to group, sits on periphery	Peer asks her a question
Peer asks her a question	Answers question	Peer says, "I knew she would

		know.”
Group continues for about 15 minutes	Returns to reading corner	Left alone
Teacher asks Sally to return to his desk	Sally returns to desk	Praise for complying
Partner reading and worksheet activity	Works with partner	Peer interaction, completes activity
Teacher led “Who Wants To Be a Millionaire” type game (teacher asks questions, students shout out answers, the first and loudest team to shout answers wins the points)	Ten minutes into game, moves to reading corner, seems agitated	Left alone
Recess	Talks to teacher assistant about the stories he is writing	Adult interaction
Transition, students moving to lunch	Goes to reading corner until other students have left the classroom	Left alone
Mr. Barnes tells her it is time for lunch	Walks to lunchroom, sits alone at end of table of peers	Left alone

Sample 1 Functional Behavioral Assessment

Student Sally Makit

Date 2/9/06

Team Member’s Name

Team Member’s Position

Janet Makit

Parent

John Johnson

Principal

Bob Barnes

Classroom Teacher

Mark Markson

Case Manager/ED Specialist

A. Describe the behavior:

1. What is the behavior?
Withdrawing from group activities
2. How is the behavior performed?
Sally quietly removes herself from groups
3. How often does the behavior occur?
2-3 times a day
4. How long does the behavior last when it occurs?
Sally remains in reading corner until asked to return to class (15-20 minutes)

6. What is the intensity of the behavior when it occurs?
Low intensity – quietly withdraws

B. Define setting events and environmental factors that predict the behavior (describe the following variables):

1. Classroom structure (physical).
Kids seated in desk groups, class set up for cooperative groups
2. Class rules and procedural expectations.
Instruction given to whole group and individually as needed. Class expectations posted and reviewed prior to group work.
3. Instructional delivery (lecture, cooperative learning, labs, etc.)
Small group/cooperative groups
4. Instructional materials (textbooks, worksheets, hands-on activities).
Leveled reading material, worksheets
5. How are directions presented?
Orally with a visual model

C. Define specific immediate antecedent events that predict when the behaviors are most likely to occur:

1. When are the behaviors most likely to occur?
At anytime throughout the day
2. When are the behaviors least likely to occur?
Varies - unknown
3. Where are the behaviors most likely to occur?
In the classroom, lunchroom, play ground
4. Where are the behaviors least likely to occur?
Library and music class
5. During what activities are the behaviors most likely to occur?
Small cooperative groups
6. During what activities are the behaviors least likely to occur?
Partner activities, individual seatwork, large group instruction

D. Identify specific consequences/outcomes that follow the behavior.

4. What specific consequence/outcome is most likely to immediately follow the behavior?

a. Gain attention. Explain.

b. Gain a tangible consequence. Explain.

c. Gain a sensory consequence. Explain.
Possible – especially when becomes loud

d. Escape from or avoidance of an undesirable situation. Explain.
Escapes from group activities

e. Other. Explain.
Able to be alone

5. Do consequences/outcomes occur in all settings?

Yes

6. What is the source of the consequence/outcome?

teacher imposed

student imposed

E. Summary

1. What is the function of the behavior?

The function of the behavior is to avoid or escape from interacting with peers in a group activity.

2. What are some possible intervention strategies?

- Positive reinforcement for group interaction
- Social skills training

Sample 1 Behavior Intervention Plan

Student: Sally Makit Date of Birth: 6/10/1996 Age: 9

School: Viking Elementary Case Manager: Mark Markson Grade: 3 Date: 2/9/2006

Targeted problem behavior (information gathered through FBA/baseline data):

Sally withdraws from all group activities, typically 3-4 times a day. She either leaves the group activity to go to the reading corner in the classroom or isolates herself when on the playground or in the lunchroom.

Hypothesized function of the problem behavior:

Sally isolates herself to avoid or escape from interacting with peers during group activities, especially when the noise level is high.

Desired replacement behavior:

Sally will interact with peers during all group activities.

Methods of teaching the replacement behavior:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> direct instruction | <input checked="" type="checkbox"/> social skills training | <input type="checkbox"/> anger management | <input type="checkbox"/> use of mentor(s) |
| <input checked="" type="checkbox"/> providing cues | <input type="checkbox"/> role playing | <input type="checkbox"/> modeling | |
| <input type="checkbox"/> behavior contract | <input type="checkbox"/> stress management | <input type="checkbox"/> decision-making training | |

Other: _____

Positive reinforcement for displaying the replacement behavior:

- | | | | |
|---|--|--|---|
| <input checked="" type="checkbox"/> verbal praise | <input type="checkbox"/> computer time | <input checked="" type="checkbox"/> immediate feedback | <input checked="" type="checkbox"/> earned privileges |
| <input type="checkbox"/> positive phone call home | <input type="checkbox"/> free time | <input type="checkbox"/> tangible rewards | <input checked="" type="checkbox"/> positive visit to administrator |

Other: Reading to a kindergarten student or a peer.

Positive Behavioral Supports

- | | | |
|--|---|---|
| <input type="checkbox"/> clear, concise directions | <input type="checkbox"/> supervise free time | <input type="checkbox"/> provide alternate recess |
| <input checked="" type="checkbox"/> frequent reminders/prompts | <input type="checkbox"/> avoid strong criticism | <input type="checkbox"/> avoid physical contact |
| <input type="checkbox"/> frequent breaks/vary activities | <input checked="" type="checkbox"/> predictable, routine schedule | <input type="checkbox"/> provide cooling off period |
| <input type="checkbox"/> teacher/staff proximity | <input type="checkbox"/> specified study area | <input type="checkbox"/> provide highly-structured setting |
| <input type="checkbox"/> reprimand the student privately | <input type="checkbox"/> preferential seating | <input type="checkbox"/> communicate regularly with parents |
| <input type="checkbox"/> modify assignments | <input type="checkbox"/> avoid power struggles | <input type="checkbox"/> review rules & expectations |
| <input type="checkbox"/> specifically define limits | | |

Other: Instructional groups will be formed strategically with careful selection of peer participants.

Consequences for displaying excessive/extreme behavior:

- | | | |
|--|--|---|
| <input type="checkbox"/> phone call home | <input type="checkbox"/> level drop/loss of points | <input type="checkbox"/> escort to another area |
| <input type="checkbox"/> send to office | <input checked="" type="checkbox"/> loss of privileges | <input type="checkbox"/> in-school suspension |
| <input type="checkbox"/> time out | <input type="checkbox"/> detention | <input type="checkbox"/> out-of-school suspension |
| | | <input type="checkbox"/> None needed |

Other: _____

Methods of measuring progress:

- | | | |
|--|---|---|
| <input type="checkbox"/> direct observation | <input type="checkbox"/> weekly behavior sheet | <input checked="" type="checkbox"/> self-monitoring |
| <input checked="" type="checkbox"/> daily behavior sheet | <input checked="" type="checkbox"/> charting/graphing | <input type="checkbox"/> number of discipline referrals |

Other: _____

Persons responsible for implementing the plan:

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> gen ed teacher(s) | <input type="checkbox"/> administrator | <input type="checkbox"/> paraeducator |
| <input checked="" type="checkbox"/> sp ed teacher(s) | <input type="checkbox"/> parent | <input type="checkbox"/> behavior intervention specialist |
| <input type="checkbox"/> related service provider | | |

Other: _____

Persons involved in developing/approving plan:

Signature

Title

Date

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions
Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions
Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions
Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions

Sample 2
Behavior Intervention Plan

Student: _____ Date of Birth: _____ Age: _____

School: _____ Case Manager: _____ Grade: ____ Date: _____

Targeted problem behavior (information gathered through FBA/baseline data):

Hypothesized function of the problem behavior:

Desired replacement behavior:

Methods of teaching the replacement behavior:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> direct instruction | <input type="checkbox"/> social skills training | <input type="checkbox"/> anger management | <input type="checkbox"/> use of mentor(s) |
| <input type="checkbox"/> providing cues | <input type="checkbox"/> role playing | <input type="checkbox"/> modeling | |
| <input type="checkbox"/> behavior contract | <input type="checkbox"/> stress management | <input type="checkbox"/> decision-making training | |

Other: _____

Positive reinforcement for displaying the replacement behavior:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> verbal praise | <input type="checkbox"/> computer time | <input type="checkbox"/> immediate feedback | <input type="checkbox"/> earned privileges |
| <input type="checkbox"/> positive phone call home | <input type="checkbox"/> free time | <input type="checkbox"/> tangible rewards | <input type="checkbox"/> positive visit to administrator |

Other:

Positive Behavioral Supports

- | | | |
|--|--|---|
| <input type="checkbox"/> clear, concise directions | <input type="checkbox"/> supervise free time | <input type="checkbox"/> provide alternate recess |
| <input type="checkbox"/> frequent reminders/prompts | <input type="checkbox"/> avoid strong criticism | <input type="checkbox"/> avoid physical contact |
| <input type="checkbox"/> frequent breaks/vary activities | <input type="checkbox"/> predictable, routine schedule | <input type="checkbox"/> provide cooling off period |
| <input type="checkbox"/> teacher/staff proximity | <input type="checkbox"/> specified study area | <input type="checkbox"/> provide highly-structured setting |
| <input type="checkbox"/> reprimand the student privately | <input type="checkbox"/> preferential seating | <input type="checkbox"/> communicate regularly with parents |
| <input type="checkbox"/> modify assignments | <input type="checkbox"/> avoid power struggles | |
| <input type="checkbox"/> review rules & expectations | <input type="checkbox"/> specifically define limits | |

Other: _____

Consequences for displaying excessive/extreme behavior:

- | | | |
|--|--|---|
| <input type="checkbox"/> phone call home | <input type="checkbox"/> level drop/loss of points | <input type="checkbox"/> escort to another area |
| <input type="checkbox"/> send to office | <input type="checkbox"/> loss of privileges | <input type="checkbox"/> in-school suspension |
| <input type="checkbox"/> time out | <input type="checkbox"/> detention | <input type="checkbox"/> out-of-school suspension |
| | | <input type="checkbox"/> None needed |

Other: _____

Methods of measuring progress:

- | | | |
|---|--|---|
| <input type="checkbox"/> direct observation | <input type="checkbox"/> weekly behavior sheet | <input type="checkbox"/> self-monitoring |
| <input type="checkbox"/> daily behavior sheet | <input type="checkbox"/> charting/graphing | <input type="checkbox"/> number of discipline referrals |

Other: _____

Persons responsible for implementing the plan:

- | | | |
|---|--|---|
| <input type="checkbox"/> gen ed teacher(s) | <input type="checkbox"/> administrator | <input type="checkbox"/> paraeducator |
| <input type="checkbox"/> sp ed teacher(s) | <input type="checkbox"/> parent | <input type="checkbox"/> behavior intervention specialist |
| <input type="checkbox"/> related service provider | | |

Other: _____

Persons involved in developing/approving plan:

Signature	Title	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions
Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions
Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions
Review date:	<input type="checkbox"/> outcome achieved	<input type="checkbox"/> continue interventions	<input type="checkbox"/> discontinue interventions

Individualized Education Program

(Rev. 7/99)

Effective dates of the IEP (month/day/year) _____ 2 / _____ 9 / _____ 2006 _____ to
--

A. Student Name (Last, First, MI) Sally Makit		Birthdate (month/day/year) _____ 6 / _____ 10 / _____ 1997		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
Grade 3	Race 1 2x 3 4 5	Student's Primary Language or Communication Mode English			
Current Address 110 Happy Lane		City Any Place	State ND	Zip 58000	Phone Number 123-4567
Serving School Any Place Elementary		City Any Place	State ND	Zip 58000	Phone Number 987-6543
Resident School (If different from serving school)		Student Social Security Number (Optional)			
School District of Residence (If different from serving district)		Check items that apply. <input type="checkbox"/> Open Enrolled in same district <input type="checkbox"/> Agency Placed <input type="checkbox"/> Open Enrolled in another district <input type="checkbox"/> Home Education			

B. Name of Parent(s) Mom Makit		Home Telephone Number 123-4567		Other Telephone Number	
Address (if other than Student's Permanent Residence Address)				Primary Language at Home	
Is there a Guardian/Educational Surrogate/Foster Parent <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Name:			
<input type="checkbox"/> Guardian <input type="checkbox"/> Educational Surrogate <input type="checkbox"/> Foster Parent					
Address		City	State	Zip	

C. IEP Case Manager		Telephone Number			
IEP Type <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Annual		Date of Last Comprehensive Individual Assessment Report (month/day/year) _____ 1 / _____ 10 / _____ 2005			
Federal Child Count Code A x B C D E F G H I		Primary Disability Emotional Disturbance		Secondary Disability(ies)	
D. Date of IEP Meeting (month/day/year) _____ 2 / _____ 9 / _____ 2006		List Names of All Team Members		Check Attendance	
*Parent				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Student				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Administrator/Designee				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Ed Teacher				<input type="checkbox"/> Yes <input type="checkbox"/> No	
General Ed Teacher				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Representative of district of residence				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

* If the parent did not attend the IEP meeting, describe effort to arrange a mutually agreed upon time and place. Include date, contact, and outcome of each effort.

E. Present Levels of Educational Performance

<p>The present level of educational performance is an integrated summary of information from all sources including the student's family. Summarize and discuss parent information and student progress toward previous goals and objectives. Include the parents' perspectives and insights about their child's learning strategies, social skills, interests, and any existing medical diagnoses that are important contributions to creating a description of the whole child. The statement should include current information about the student's specific strengths and weaknesses, progress in the general education curriculum, unique patterns of functioning, and implications of the problem areas on the student's total functioning. Performance areas to be considered include the following:</p>	
<p>Cognitive functioning Academic performance Communicative status Motor ability</p>	<p>Sensory status Health/physical status Emotional and social development, and behavior skills (including adaptive behavior, if applicable), ecological factors Functional skills, community participation</p>

Cognitive Functioning

Sally was formally evaluated in December of 2004. Her cognitive ability was found to be within the average range. Her verbal and nonverbal abilities are equally developed.

Academic Performance

Reading is an area of real strength for Sally. Sally is able to read grade level reading material. Sally demonstrates good decoding, phonetic and comprehension skills. She is currently able to read a Fountas and Pinnell level O text and the end of the year expectation for third grade is to read a level P text. During whole group reading activities in the classroom, Sally will read aloud when asked. During small guided reading groups, Sally struggles and often withdraws from participating. Sally prefers to read independently at her desk. Sally does check out books from the library and brings them home to read. Mom shared that Sally generally reads at home before bed each night. In the area of writing, Sally is at grade level. Sally will write in her morning journal and has published a few pieces during writer's workshop. Sally includes accurate capitalization and punctuation in her writing. Sally's writing also has good content and tends to be very creative. Organization of her writing is still developing. Sally is also at grade level in spelling. Sally has been earning A's and B's on weekly tests according to her teacher. Sally's mom reports that Sally studies for them at home. Math is an area of personal weakness for Sally but still near grade level. Sally is learning the beginning multiplication and division facts. He is able to add and subtract multi-digit problems with regrouping. The class is currently working on geometry and Sally is doing well with these concepts. On recent tests Sally has been earning B's and C's. Sally is still working on counting groups of mixed coins and telling time to the 5 minute interval. In the areas of science and social studies, Sally is at grade level. Sally's participation is good during whole group activities. During cooperative group work, Sally tends to withdraw. Sally's understanding of the concepts is good. Sally generally earns B's on tests and completes all daily work done independently or as a whole group. Sally's work/study skills are adequate. Sally turns most work in on time. The largest difficulty for Sally is small group work. Sally will often remove herself and refuse to participate. Sally has some difficulty making up these activities on her own. The classroom teacher shared that Sally generally puts forth good effort and adds interesting comments when she does participate. There are times even during large group activities when Sally will lay her head on her desk or will pull her hood over her head. Sally does know that whatever is not completed at school must go home. She does take her work home at the end of the day when prompted to put it in her planner.

Communicative Status

Sally's communication skills are age appropriate. There are no concerns with articulation, grammar or expressive and receptive language skills. She is able to communicate her desires in all settings effectively. Sally's voice at times will be quiet and it can be difficult to hear her in large groups.

Motor Ability

Sally's fine and gross motor skills appear to be at grade level. She is able to write legibly, appropriately grasp pencils and manipulate small objects. Sally demonstrates appropriate gross motor skills as she is able to fully participate in physical education class, is active at recess and enjoys a variety of gross motor activities.

Sensory Status

Sally's hearing and vision have been screened during school wide screenings in the fall. There have been no concerns with Sally's visual acuities or hearing.

Health/Physical Status

Sally is in good general health. Sally has good school attendance and has not missed for any long length of time.

Emotional and Social Development, and Behavior Skills

Sally has been diagnosed with depression. She is currently seeing Dr. Wonderful for therapy one time a month. She also sees Dr. Doctor for medication for this condition. Sally is often withdrawn from school activities. During small group times, Sally will go and sit in the reading corner. The classroom teacher reports that it is difficult to get Sally back to reengage with the class once she is in the reading corner. When Sally does participate there is not conflict between Sally and the other students. Sally's mom did express some concern with Sally being bullied or overpowered by other students. Sally does not speak up for herself and will just withdraw from a situation if she feels picked on. During large group work in the classroom, Sally often has her hood drawn over her head and will often lay her head down on her desk. At times it is difficult to get Sally to engage with any work.

Sally does not have strong peer relationships. Sally often spends time alone across school settings. She does have one or two kids that she calls friends. The principal shared that Sally tends to sit by herself or at the end of the table at lunch. The classroom teacher also shared that Sally has been burrowing into the snow hill at recess and has been sitting by herself within the snow pile. If Sally does engage with people at recess it tends to be the adults on the playground. It appears that Sally prefers talking with teachers more than other kids. Mom shared that Sally has never asked to have friends over at their house. Sally will at times tell her mom that he nobody likes her and that she doesn't know how to play what the kids do at recess. Mom also feels that Sally does spend considerable amounts of time worrying about school.

Sally's behavior is respectful to all adults and students in school. Sally is not in need of an individualized behavior plan.

Functional Skills, Community Participation

Sally is able to take care of her self care needs. She helps out at home by cleaning her room when asked, taking out the garbage and will at times walk the family dog. Sally is involved in the community through the after school YMCA program and is involved in park board activities in the summer months. Sally also has a tracker/mentor through Lutheran Social Services and will often attend community events with her.

F. Annual Goals, Short-Term Objectives, and Characteristics of Services

Use one page for each annual goal. Thoroughly state the annual goal. Annual goals should be reasonably achieved in one year and should be unique to the student. Related Services should appear ONLY as objectives that are integrated into the student's instructional program.

<p>Annual Goal (behavior or skill, desired ending level of achievement, intent or purpose of the behavior):</p>	<p>Goal # <u> 1 </u> of <u> </u> goals</p>
<p>Sally will accurately state the steps for joining in when prompted to do so in 4 out of 5 trials as monitored and charted weekly by the ED specialist starting 03/09/2006, with 20% current achievement, with evaluation every grading period, and with 80% target achievement completed by 03/09/2007.</p>	
<p>Short-Term Instructional Objectives and Characteristics of Services:</p> <p>List <i>objectives</i> for each goal including conditions under which the behavior is performed, the specific behavior, measurable criteria, evaluation procedures, and schedules for determining if objectives are being achieved (initiation date, dates for progress checks). The person responsible for monitoring progress will be added upon completion of Section J.</p> <p>For each objective, consider and document the following <i>characteristics of services</i> information: Does the performance specified in the objective(s) promote the child's involvement and progress in the general education curriculum? How might services be modified to enable greater involvement and progress in the curriculum? Describe the needed modifications or adaptations. If the child will not participate in the general education curriculum, provide a justification for the alternative selected. Describe the specially designed instruction (e.g., specially designed driver education) or supportive training related to the disability (e.g., Braille instruction/occupational therapy). Who will provide the modifications/adaptations OR the specially designed instruction/supportive training related to the disability described above?</p> <p>Characteristics of Services: Progress towards the goal and objectives stated below can be expected in small group settings in the ED room with specially designed materials and instruction provided by the ED teacher. Progress can also be expected in regular education settings with prompts and support provided by the classroom teacher and/or ED teacher.</p>	
<p>Progress reporting to parents will occur at least as often as reporting in general education (report cards). Written reports will be provided every:</p> <p><input type="checkbox"/> 6 weeks <input checked="" type="checkbox"/> 9 weeks <input type="checkbox"/> Other schedule (specify: _____)</p>	

I. Least Restrictive Environment Justification

This page is intended as a SUMMARY for all Goals, Objectives, Characteristics of Services, Adaptations, and Special Education and Related Services information included on pages 3 and 4. Check all settings in which the special education and related services will be provided. **Note: Use this setting information to determine the federal child count code in the left column, and circle this code in Part C on front page of the IEP.**

FEDERAL CHILD COUNT CODE: <input checked="" type="checkbox"/> A. Regular Class <input type="checkbox"/> B. Resource Room <input type="checkbox"/> C. Separate Class <input type="checkbox"/> D. Public separate school (day) facilities <input type="checkbox"/> E. Private separate school (day) facilities <input type="checkbox"/> F. Public residential facilities <input type="checkbox"/> G. Private residential facilities <input type="checkbox"/> H. Correction facilities <input type="checkbox"/> I. Homebound/hospital environments	SETTING:		Percent of time/week
		Regular Education	95
		Special Education (select if not 100% regular ed)	
		<input checked="" type="checkbox"/> limited special services (< than 21% of time/wk)	5
		<input type="checkbox"/> resource room services (21-60% of time/wk)	
		<input type="checkbox"/> separate class (> than 60% of time/wk)	
		Integrated community	
		Other	
		TOTAL	100%

Explain why options selected above are the most appropriate and the least restrictive. Describe other options considered, and provide reasons those options were rejected.

The team discussed Sally's need for opportunities for social interactions. Sally also needs social skills training. The team felt that social skills training in a small group would give Sally some of the skills she needs and also opportunities to interact with other students. These skills will be provided in a pullout model. Placing Sally outside of the general classroom for long periods of time would be too restrictive and would hamper Sally's social growth. Therefore the team felt limited special services provided outside the classroom would be most effective.

Is there a potential harmful effect to the student with this placement? Yes No

Is there a potential harmful effect to the student's peers with this placement? Yes No

If yes to either question, make sure the explanation for the selection of the placement option documents this concern for potential harmful effect.

J. Special Education and Related Services

*Services	Min./ Week	Starting Date (month/day/year)	Service Provider and Telephone	Location of Services Building Name AND Room (if another school district, provide district name)
ED Services - 60 Minutes social skills group /30 minutes 1:1 skills training	90	03/09/2006	Carrie Weippert	LD/ED Room

* The duration of these services may not exceed one year (12 months) from the date of this IEP.

Length of school day:

The student will attend for the full school day.

The student will attend for a shorter or longer school day than peers. (Explain why this is necessary.)

Extended school year MUST be considered for each student with a disability. Justification for the decision made MUST BE STATED BELOW.

The review of each goal indicates that an extended school year is needed.

The review of each goal indicates that services will be in effect for the normal school year.

The team needs to collect further data before making this determination and will meet again by _____.

Justification for the above decision:

The IEP team did not feel that Sally would regress or lose skills during the summer that could not be regained in an appropriate amount of time at the beginning of the school year.

Individual Family Service Plan

Family of: (Child's Name)

About Your Child

Child's Name:
Address:
Phone Number:
Date of Birth:
Race:
Language spoken in the home:
Primary Physician:
Infant Development Early Interventionist:
Service Coordinator:
Date of Referral:
IFSP Type:
IFSP Meeting Date:
IFSP Effective Dates:
Date of Transition:

Transition Details

(To be completed when IFSP will be used as an IEP)

School Case Manager:
Date of Last Completed Assessment:
Site:
Settings & Percentages:
Program Day Details:
Duration:
Parents School District of Residence:
School of Enrollment:
Handicapping Condition:

Present Level of Performance

Areas to be addressed and integrated into the present level of performance include:

- Family concerns, priorities, and resources related to enhancing the child's development
- Routines
- Physical development
- Communication development
- Early Literacy
- Adaptive skill development
- Social/emotional development
- Health/Medical
- Adaptive Equipment

Outcomes, Criteria and Activities

Outcome:

Criteria:

Activities: (Supporting Natural Learning Opportunities and justification if supports are not provided in environments natural for other infants and toddlers)

Case Plan

(lists the services, providers, provider contact information, funding source, start date, frequency, duration and location of services)

Review Schedule

When the IFSP will be reviewed (at least every six months) and who will be involved.

IFSP Team Members

As a member of (CHILDS NAME) IFSP Team, I agree to follow all State and Federal regulations regarding confidentiality.

First Name	Last Name	Signature	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parental Permission:

I have had the opportunity to participate in planning this Individual Family Service Plan. I understand and approve of the plan and give my permission for the agencies involved to carry out this plan with me. I understand that I may request a team review of this plan at any time.

Parent/Guardian signature Date

Please send copies of this IFSP to:

I give my permission for the agencies involved to carry out this plan with me except for the following portions:

I request another meeting to discuss the portions I do not agree with.

Parent/Guardian signature

Date

Sample IFSP Information

Present Level of Performance

Family Assessment --- collected through parent interview at intake, evaluation and review of evaluation:

Strengths: They have a place to live and have medical insurance. Mom is in school and he is exposed to other kids in home daycare. The father is in town and lives in the same building as mom and Ian. Another resident in the apartment complex (across hall way) has a routine where she cheers Ian on as he runs up and down hallway – Ian looks forward to this and seems to understand this routine

Challenge: Mom's mental health has made it difficult to focus on Ian as much as she would like however she is open to visits – seeking help and wants to learn techniques to assist with Ian's behavior. There have been issues of domestic violence between mom and dad (both physically and emotionally abusive to each other). Dad also has a gun in the home ---unsure of whether the gun is locked up. No extended family in town. Mom says she has no friends that enjoy being with Ian. Ian has significant allergies – mom smokes in bathroom with towel stuffed under the door to keep the smoke in the bathroom. Mom states this is her first child and Ian was the first baby that she ever held. She has had no exposure to other children and states she isn't sure what to do with children. She is frustrated with tantrums. She has tried time out (on her own) and it doesn't work. She feels this leads to her increasing the volume of his voice (and her voice) and then she gives in. Daycare says if behavior issues continue they will have to discontinue his care. He also appears to have high sensory needs. To cope with this Mom uses a video of Ian as a baby and has him watch it when she needs a break.

Concerns/Priorities: the number following each concern is how the family identified the level of their priorities)

Relationship with how domestic violence has affected his behavior.

First child and Mom isn't sure what to do with him or what is normal development.

Mom wants to be able to take him out in Public.(2)

Reducing episodes of behavior, so that he can stay in daycare.(4)

Ideas for daycare in how to handle Ian.

Concerns about his health and his allergies (has been hospitalized three times).

Mom wants to enjoy Ian.

Sensory issues; head-butting, hitting and kicking.

Aggressiveness

Difficulty with transitioning from one activity to the next without screaming and head butting

(3)

Lack of routines --- beginning middle and end to activities throughout the day (1)

Evaluation: Ian was evaluated on 2-2-06. There were three evaluators contributing to the evaluation and information for this current level as well as observation and parent report. The evaluators were: _____ social worker, _____ physical therapist, and _____ educator. The following tools were used in determining age levels : Gessell, HELP, Rossetti and DAYC. In addition observations and parent report were utilized.

Chronological Age: 15 months

Gross motor: Within Normal Limits

Fine motor: 11-12 months
Communication: 12 months
Cognitive: 12 months
Adaptive: Within Normal Limits
Social emotional: 12 months
Hearing: needs follow up related to middle ear difficulties
Vision: Within Normal Limits

Current level

GM: Ian's developmental skills are Within Normal Limits according to age related milestones. He is active and a climber. He is very motivated to move and has good balance. A challenge in this area could be safety. He is strong and strong willed so often moves before thinking or doesn't necessarily take direction when he is on the move. He has strong sensory needs

FM: Greatest area of delay according to age related milestones. Age range 11-12 months. When motivated can push buttons to activate certain objects or toys such as t.v. remote. He turns pages in a book. Parent report that he uses eating utensils. The area of challenge with in the fine motor area is related to attention. It is difficult to engage him in tasks related to eye hand coordination unless he chooses. He prefers to throw items rather than interact purposefully. He has no interest in puzzles or markers.

Cognitive: His age levels in this area are at approximately the 12 month level. He has strong memory skills and remembers where toys are kept in the house. When motivated he figures things out using other objects such as using a chair to get into a cupboard. Challenges in this area are related to cause and effect. He does not appear to learn when he is removed from something and disciplined. He will go right back to the item that you removed him from (or activity) and repeat that behavior. He doesn't appear to learn from his past actions. In addition lack of consistency in his routines could be contributing to this

Adaptive: This area is Within Normal Limits developmentally according to age related milestones. He problem solves where things are, what he wants, and how to get them. A challenge area is transitioning from one thing or routine to the next. An example of this is that he has extreme difficulty leaving day care to go home.

Social Emotional: Strengths are he likes to please people. He is curious and persistent. He is social and greets others. He likes to have people come over to visit. Challenges are related to his difficulty regulating emotions. He is isolated from situations because Mom is afraid to take him out on public outings. He can get angry quickly and becomes physical quickly (such as hitting and kicking others, and head banging.)

Communication: He enjoys communicating with others. He socially greets others with one-word phrases and also requests for food. Challenges in this area are because his emotions are so close to surface he screams and hits rather than uses words and behavior interferes more than a typical toddler in following requests.

Early literacy: Books in home. Mom states she tries to read with him. Challenges are his attention is short if mom tries to read he prefers to throw a book and has a meltdown.

Hearing: Recommend that he have a complete audiological evaluation. He has had numerous ear infections and has PE tubes.

Vision: He demonstrated skills Within Normal Limits using the functional visual observation checklist. He appears to be a very visual child.

The primary interventionist background is Social work and family is comfortable with that at this time.

Outcomes, Criteria and Activities Including Natural Learning Opportunities

Outcome # 1

Mom will be able to deal with Ian's temper tantrums without raising her voice

Criteria:

Mom will use one of the following techniques (1. redirection 2. calming - hold Ian back to chest with hand in between your head and his chest to protect yourself without talking to him until he calms down 3. calming - tell Ian 'X will happen once you are not crying or hitting' rather than raise her voice . This will be charted with a chart for mom to keep track of during the week and the home visitor to chart during visits at home and during outings --- the target for meeting the outcome will be when mom is able to do this a minimum of 2 out of 3 times for at least 10 consecutive days.

Activity:

Work with Mom to develop consistent routines for Ian

Work with _____ County Social Services regarding recommendations that have been made in recent investigation

Obtain In-Home Support to provide Mom with a break

Counseling for Mom at local human service center

During the home visit – discussion on how to use developmentally appropriate techniques when tantrums occur. Mom will be coached through challenging situations and encouraged to practice techniques shared. Will view videos on discipline so Mom can view other parents and situations using the techniques being discussed. Once a base line is established within typical activities in the home, the visits will then move out into community settings such as getting groceries, going for a walk, and going out to a fast food restaurant for a snack

Consult once a month with behavior analyst to determine appropriate program and make sure we are on the right track.

Outcome #2

Ian will be able to stay in his chair in a restaurant so that they can eat at a restaurant.

Criteria :

Ian will sit in his chair for at least 15 minutes in a "fast food restaurant" so that they can finish eating a "snack" in at least two different restaurants.

Activity:

Have a beginning middle and end to routine of going out to eat

Making a book that has pictures of routine (restaurant going to attend, coat shoes, food choices (apple pieces, McDonald cookies,) high chair, car, car seat

Techniques discussed with mom on how to entertain him in the highchair as well as some items that could be brought with

Discuss how to use praise and reinforcement

Discuss how to observe if he is starting to get agitated so that you can leave while his behavior is still acceptable (start with goal of 5 min)

Budget money for snack

Practice sitting in highchair at home for a snack for short time – 2-5 minutes

Review with mom verbally how to tell him what is going to happen or is expected (basic – beginning middle end) i.e. Mom get snack, get in high chair , when all done play chase game etc

Outcome #3

Mom will have an established routine at bath time that reduces Ian's temper tantrums (now has a temper tantrum after each bath because he doesn't want to leave the bath)

Criteria:

Ian will only have an occasional temper tantrum following bath (as with typically developing children) – no more than two a week

Activity:

Establish beginning, middle and end for activities

No rough play in the evening after dinner in prep for bath and bedtime

Verbally let him know that bath time going to start

Prepare a box with bath time toys

Use timer to indicate time in bath – with at least 15 min to play --- 2 min before timer to go off – verbally prepare Ian that bath time is all most over and he will be getting out

Have Ian help take toys out – then drain water

Ian given choice to crawl out of tub or have Mom pick him up

Have large towel ready and rap snugly and show him special book or toy that he can look at while mom is getting him dressed

5 min for looking at books with mom – or quiet toy that he enjoys (with Mom) – Mom then hold him with the lights dimmed and whisper nighttime songs quietly – use firm touch while on your lap as that appears to help calm him and organize

Consult once a month with behavior analyst to determine appropriate program and make sure we are on the right track

Outcome #4

Ian will be able to leave daycare and go home without having a temper tantrum

Criteria:

Ian will no longer hit, scream or head bang when leaving day care for a minimum of two weeks -- fussing or whining acceptable – do not want to see self injurious behavior or injury to others

Activities:

Establish beginning, middle and end to prepare him to leave daycare

Consultation with daycare on how to handle consistently

Daycare let Ian know 5 min prior that mom is coming –when hear mom coming in the door

have jacket and backpack ready – daycare provider will assist putting this on – have routine of saying good bye and hugs as appropriate – mom to have a special toy or book in the car and tell Ian ‘ _____ waiting for you in the car’ Mom will use a tape in car with children songs for a ride home

Mom to discuss with Ian what they will be doing when they get home (increase verbal exchanges with mom and Ian)

Case Plan

INFANT DEVELOPMENT

_____ from _____ Infant Development Program will provide INFANT DEVELOPMENT SERVICES for 2.00 Hours per Week. Services will be funded through TLTXIX-HCBS-DDD and will start 02/14/2006 and are anticipated to continue to 02/13/2007. The majority of the services will be provided in an Individual setting at Home. _____ can be reached at 701-111-1111.

DD CASE MANAGEMENT

_____ from _____ HSC will provide DD CASE MANAGEMENT for 4.00 Hours per Quarter. Services will be funded through TLTXIX-HCBS-DDD and will start 02/14/2006 and are anticipated to continue to 02/13/2007. The majority of the services will be provided in an Individual setting at Home. _____ can be reached at 701-111-1111.

BEHAVIOR CONSULTATION

_____ from _____ HSC will provide BEHAVIOR CONSULTATION for 1.00 Hours per Month. Services will be funded through MA-NO ICF/MR and will start 02/14/2006 and are anticipated to continue to 02/13/2007. The majority of the services will be provided in an Individual setting at Home. _____ can be reached at 701-111-1111.

PHYSICIAN SERVICES

_____ from _____ CLINIC will provide PHYSICIAN SERVICES for 1.00 Hours per Quarter. Services will be funded through MA-NO ICF/MR and will start 02/14/2006 and are anticipated to continue to 02/13/2007. The majority of the services will be provided in a/an Individual setting at Outpatient Service Facility. _____ can be reached at 701-111-1111.

FAMILY SUPORT SERVICES

_____ from _____ will provide FAMILY SUPORT SERVICES for 16.00 Hours per Month. Services will be funded through TLTXIX-HCBS-DDD and will start 02/14/2006 and are anticipated to continue to 02/13/2007. The majority of the services will be provided in an Individual setting at Home. _____ can be reached at 701-111-1111.

AUDIOLOGICAL

_____ from _____ CLINIC will provide AUDIOLOGICAL SERVICES for 2.00 Hours per Month. Services will be funded through MA-NO ICF/MR and will start 03/01/2006 and are anticipated to continue to 03/31/2007. The majority of the services will be provided in a/an Individual setting at Outpatient Service Facility. _____ can be reached at 701-111-1111.

Review Schedule

This IFSP will be reviewed monthly for at least the first 3 months to determine if progress is being made and if revision's need to be made. The review schedule will then be quarterly unless the team feels more frequent reviews continue to be needed. The team wants to make sure that appropriate support will be there for family to feel successful. At this point only the behavior analyst will be a consultant. At each review the team will determine if additional consultants such as PT or OT (for sensory needs) or SLP (to address behavior issues related to communication) are needed.

**Single Plan of Care
LAKE REGION**

Care Plan Effective Date 04/06/2006

Next Care Plan Renewal Date 07/06/2006

Case Name Jones

Client Name

MINDY JONES

Date of Birth

03/03/2003

Client Name

Date of Birth

Family composition

Client Information

Name	Role/Responsibility	Living with Family	Address	Telephone Number	Family Role
MINDY JONES	self	Y	3333 Three Road Three ND 33333	7012222222	Daughter

Living in Family

Name	Role/Responsibility	Address	Telephone Number	Family Role
CINDY JONES	Mother to provide for her daughter's needs	3333 Third St Bismarck ND 58504	7014444444	Mother

Not Living in Family

Name	Role/Responsibility	Address	Telephone Number	Family Role
------	---------------------	---------	------------------	-------------

Family's View of the Situation

I need help with 3 year old daughter's discipline and whining

Agency's View of the Situation

Child Abuse and Neglect Report recieved at the agency in regard to physical abuse and emotional neglect of daughter. Mom used physical force for discipline measures and ignored her daughter's needs on occassion. Services Required decision and parent aide services for the mother.

Single Plan of Care
LAKE REGION

Case Name Jones
Client Name
MINDY JONES

Date of Birth
03/03/2003

Care Plan Effective Date 04/06/2006
Next Care Plan Renewal Date 07/06/2006

Client Name
Date of Birth

Strengths Discovery

Basic Needs	Strengths	Needs/Risks/Safety Issues

Social/Recreational	Strengths	Needs/Risks/Safety Issues

Family	Strengths	Needs/Risks/Safety Issues
<p>Cindy has a positive relationship with the parent aide and have been working together on discipline skills for 3 years old. Cindy wants help to be able to meet her daughter's needs. Cindy does love Mindy. Cindy is a good housekeeper and provides a home safe from health hazards. Mindy goes to Cindy without hesitation or fear as observed during home visits by the parent aide. Cindy's therapist reports that she is doing well in therapy.</p>		<p>Cindy admits she loses her temper and will strike out at her daughter and call her names. Cindy has limited support to have respite from Mindy, she is not close to her parents and has had no contact for 2 years. Cindy stays home and does not work and is with Mindy 24/7.</p>

Educational/Vocational	Strengths	Needs/Risks/Safety Issues

Financial/Economic	Strengths	Needs/Risks/Safety Issues

Community	Strengths	Needs/Risks/Safety Issues

Single Plan of Care
LAKE REGION

Care Plan Effective Date 04/06/2006

Next Care Plan Renewal Date 07/06/2006

Case Name Jones

Client Name

MINDY JONES

Date of Birth

03/03/2003

Client Name

Date of Birth

Strengths Discovery - Continued

Physical Health	Strengths	Needs/Risks/Safety Issues

Legal	Strengths	Needs/Risks/Safety Issues

Emotional/Behavioral Health	Strengths	Needs/Risks/Safety Issues

Spiritual/Cultural	Strengths	Needs/Risks/Safety Issues

Narrative
Other life domains would be filled in, but this is one example for families and providers to review. The information in this Single Plan of Care (SPOC) is invented for the purpose to share what a SPOC looks like.

**Single Plan of Care
LAKE REGION**

Care Plan Effective Date 04/06/2006

Next Care Plan Renewal Date 07/06/2006

Case Name Jones

Client Name

Date of Birth

Client Name

Date of Birth

MINDY JONES

03/03/2003

**Family Plan
Family**

Strengths

Cindy has a positive relationship with the parent aide and have been working together on discipline skills for 3 years old. Cindy wants help to be able to meet her daughter's needs. Cindy does love Mindy. Cindy is a good housekeeper and provides a home safe from health hazards. Mindy goes to Cindy without hesitation or fear as observed during home visits by the parent aide. Cindy's therapist reports that she is doing well in therapy.

Needs/Risks/Safety Issues

Cindy admits she loses her temper and will strike out at her daughter and call her names. Cindy has limited support to have respite from Mindy, she is not close to her parents and has had no contact for 2 years. Cindy stays home and does not work and is with Mindy 24/7.

Goal

Cindy will provide a home free from harm and learn 2 new age appropriate discipline skills.

Tasks	Recipient	Team Member(s)	Start Date	Projected Completion Date	Task Completed
Cindy will develop and learn two new age appropriate discipline skills during her home visits with Cheryl, Parent Aide	MINDY JONES	CHERYL SMITH, CINDY JONES	04/06/2006	04/20/2006	No
Cindy will watch 1, 2, 3 Magic Video about discipline techniques & discuss with Cheryl what they saw and try some of the skills on a daily basis.	MINDY JONES	CHERYL SMITH, CINDY JONES	04/06/2006	04/15/2006	No

Commentary

Cindy reports progress in less yelling and has not hit her daughter since social services became involved.

Goal

Cindy will participate in weekly therapy to learn reasons/triggers to why she is so angry and learn to control her anger toward her daughter and others

Tasks	Recipient	Team Member(s)	Start Date	Projected Completion Date	Task Completed
Cindy will discuss her feelings regarding her anger and keep a daily Anger Journal and share with Mary on a weekly basis.	MINDY JONES	MARY MANNING, CINDY JONES	04/14/2006	07/06/2006	No

Commentary

Mary, therapist shared with the team that Cindy is beginning to develop a relationship with her and to trust her.

**Single Plan of Care
LAKE REGION**

Care Plan Effective Date 04/06/2006

Next Care Plan Renewal Date 07/06/2006

Case Name Jones

Client Name

MINDY JONES

Date of Birth

03/03/2003

Client Name

Date of Birth

Safety Plan

Potential Crisis	Client: MINDY JONES		
Cindy will lose her temper and hit and hurt Mindy			
Action Steps		Person(s) Responsible	
Cindy will leave the room after Mindy is in a safe place and location in the home, Cindy will have Mindy within eye sight and count to fifteen prior to approaching Mindy		Cindy	
Action Steps		Person(s) Responsible	
Cindy will call her sister for help/time out of the home. Cindy will call her therapist or the hot line after hours if she is unable to gain control and request help.		Cindy, Therapist, Sister- Harriet 333-4444	

Single Plan of Care

Case Name

Care Plan Effective Date

Client Name

Date of Birth

Family Composition

Living in Family

Name	Role/Responsibility	Address	Telephone Number	

Not Living in Family

Name	Role/Responsibility	Address	Telephone Number	

Family's View of the Situation

Agency's View of the Situation

Single Plan of Care

Care Plan Effective Date

Next Care Plan Renewal Date

Case Name

Client Name

Date of Birth

Diagnostic Information

Axis I

Code	Description
------	-------------

Code	Description
------	-------------

Code	Description
------	-------------

Code	Description
------	-------------

Axis II

Code	Description
------	-------------

Code	Description
------	-------------

Code	Description
------	-------------

Code	Description
------	-------------

Axis III

Axis IV

Area

Area

Area

Area

Explanation

Axis V	GAF
--------	-----

Date	Score	Psychiatrist/Clinician diagnosing
------	-------	-----------------------------------

Current GAF

Date	Score with supports
------	---------------------

Date	Score without supports
------	------------------------

Allergies

Emergency Contact Information

Physician

Single Plan of Care

Out of Home Care

Case Name	Care Plan Effective Date
Client Name	Date of Birth

**Out of Home Care, if applicable
(Non Foster Care)**

Primary Reason for Placement					
Date Entered		Anticipated Discharge		Discharge Location	
Projected Length of Stay		Facility Name			
Facility Contact			Facility Address		
Facility Phone					
Psychiatrist			Address		
Psychiatrist Phone #					

Child Welfare-CCWIPS, if applicable

CCWIPS Case Number		County of financial Responsibility	
Perm Plan Date		Date of Removal	
Primary Reason for Foster Care			
Current Placement and Dates			

Were the following people invited, in writing, to attend the permanency planning meeting?	Educational Information

Were parents notified, in writing, of any changes in the child's placement? If no, what reason?	Health Care Providers

Child's known diagnosed medical disabilities			

Date of HealthTrack screening		Independent Living Status	
-------------------------------	--	---------------------------	--

Single Plan of Care

Care Plan Effective Date

Next Care Plan Renewal Date

Case Name

Client Name

Date of Birth

Strengths Discovery

Basic Needs	Strengths	Needs/Risks/Safety Issues
Family	Strengths	Needs/Risks/Safety Issues
Financial/Economic	Strengths	Needs/Risks/Safety Issues
Educational/Vocational	Strengths	Needs/Risks/Safety Issues
Community	Strengths	Needs/Risks/Safety Issues

Single Plan of Care

Care Plan Effective Date

Case Name

Client Name

Date of Birth

Strengths Discovery-Continued

Physical Health	Strengths	Needs/Risks/Safety Issues
Legal	Strengths	Needs/Risks/Safety Issues
Emotional/Behavioral Health	Strengths	Needs/Risks/Safety Issues
Spiritual/Cultural	Strengths	Needs/Risks/Safety Issues

Narrative

Single Plan of Care

Case Name

Care Plan Effective Date

Client Name

Date of Birth

Client Name

Date of Birth

Domain

Family Plan

Strengths

Needs/Risks/Safety Issues

Goal

Tasks	Recipient(s)	Team Member(s)	Start Date	Projected Completion Date

C
C
C
C

Commentary

Single Plan of Care

Care Plan Effective Date

Case Name

Client Name

Date of Birth

Safety Plan

Potential Crisis

Action Steps	Person(s) Responsible
_____	_____
Action Steps	Person(s) Responsible
_____	_____
Action Steps	Person(s) Responsible
_____	_____
Action Steps	Person(s) Responsible
_____	_____

Other Resource Information

The eight regional human service centers are as follows:

- **Bismarck** - West Central Human Service Center, 1237 West Divide Ave, Suite 5, Bismarck, ND 58501-1208, Phone: 701-328-8888 or 1-888-328-2662
- **Devils Lake** - Lake Region Human Service Center, 200 Highway 2 SW, Devils Lake, ND 58301, Phone: 701-655-2200 or 1-888-607-8610
- **Dickinson** - Badlands Human Service Center, 200 Pulver Hall, DSU, Dickinson, ND 58601-4857, Phone: 701-227-7580 or 1-888-227-7525
- **Fargo** - Southeast Human Service Center, 2624 9th Ave. South, Fargo ND 58103-2350, Phone: 701-298-4500 or 1-888-342-4900
- **Grand Forks** - Northeast Human Service Center, 151 S 4th St., Suite 401, Grand Forks, ND 58210-4735, Phone: 701-795-3000 or 1-888-256-6742
- **Jamestown** - South Central Human Service Center, 520 3rd St. NW, Jamestown, ND 58401, Phone: 701-253-6300 or 1-800-260-1310
- **Minot** - North Central Human Service Center, 400 22nd Ave. NW, Minot, ND 58701, Phone: 701-857-8500 or 1-888-470-6968
- **Williston** - Northwest Human Service Center, 316 2nd Ave. W, Williston, ND 58801, Phone: 701-774-4600 or 1-800-231-7724

Discipline Policy Paper

<http://www.dpi.state.nd.us/speced/guide/policy/policy01.pdf>

Functional Behavioral Assessment Paper

<http://www.dpi.state.nd.us/speced/guide/policy/behavior.pdf>

Mental Health Services

To learn more about information on placement options and residential facilities go to <http://www.nd.gov/humanservices/services/mentalhealth/children.html>. This website provides important information about the voluntary treatment program and options available to families.

Web resources

About - Parenting Special Needs	http://specialchildren.about.com/od/mentalhealthissues/a/ED.htm
Center for Effective Collaboration and Practice	http://cecp.air.org/resources/20th/intro.asp
Center for Positive Behavioral Interventions and Supports	http://www.pbis.org or http://www.pbis.org/resourceLinks.htm
Federation of Families for Children's Mental Health	http://www.ffcmh.org
National Association of School Psychologists	http://www.nasponline.org/information/position_paper.html
National Dissemination Center for Children with Disabilities	http://www.nichcy.org/pubs/bibliog/bib10txt.htm
National Early Childhood Technical Assistance Center	http://www.nectac.unc.edu/
Office of Special Education Programs (toolkit)	http://osepideasthatwork.org/toolkit/index.asp
Office of the Surgeon General	http://www.surgeongeneral.gov
School Mental Health Project	http://smhp.psych.ucla.edu
Substance Abuse and Mental Health Services Administration	http://www.samhsa.gov

References

Achenbach, T.M., & Edelbrock, C. (1983). *Manual for the child behavior checklist and revised child behavior profile*. Burlington, VT: Queen City Printers.

Kennedy, C.M., & Lipsitt, L.P. (1998). Risk-taking in preschool children. *Journal of Pediatric Nursing*, 13(2), 77.

Boesky, Lisa Melanie. (2002) *Juvenile Offenders with Mental Health Disorders. Who are they and what do we do with them?* Alexandria, VA: American Correctional Association.

VI. GLOSSARY

Term	Definition
Antisocial	A pattern of irresponsible behavior with poor social relationships and nonconformity with accepted social standards; common features may include failure to conform, hold a job, plan ahead, taking part in criminal actions. Other features may include substance abuse, aggression, sexual promiscuity, tendency to seek immediate gratification, an inability to discern consequences, and a failure to learn from mistakes.
Assessment	Specific features used to gather information and can include formal and informal tests; student records; work products; and observations of the student in the classroom, other school environments and in the community.
At Risk	A designation used when there is an observable change in how a child or youth thinks, feels, and acts raising suspicion of deeper concerns. It is used to indicate behaviors that appear outside of the expectation for same-aged peers and may signal a possibility that more severe problems could develop over time if left unattended. Qualifications for determining at risk may be defined differently by agency so it is important to refer to the specific agency's regulations.
Behavior Intervention Plan	A plan that outlines a set of integrated strategies for teaching and maintaining adaptive behavior and reducing or eliminating problem behaviors.
BLST	Building Level Support Team: A child study committee located in each school building to receive and act upon referrals of students suspected of being disabled. The committee usually consists of at least three persons including the principal (or someone chosen by the principal), the teacher(s), specialists, and the referring source, if appropriate.
Care giving Relationships	According to the Social Work Dictionary by Robert L. Barker 3rd Edition, a care giver is: <i>"One who provides for the physical, emotional and social needs of another person, who often is dependent and cannot provide for his or her own needs. The term most often applies to parents or parent surrogates, day care and nursery workers, health care specialists and relatives caring for older people. The term is also applied to all people who provide nurturance and emotional support to others including spouses, clergy and social workers."</i>
Case Management	Provides support and training to individuals and families in order to maximize community and family inclusion, independence, and self-sufficiency; to prevent institutionalization; and to enable institutionalized individuals to return to the community.
COMPAS	COMPAS is a comprehensive needs, risk assessment for use by juvenile justice professionals to identify and score 32 factors that correspond to the risk and needs of individual juvenile offenders, ages 12-18. The assessment process consists of gathering relevant background information, conducting a home visit, and interviewing the juvenile. Results of the interview are entered into a computer program that scores the 32 factors and computes a risk of recidivism. The second phase of the COMPAS process is case planning. As juvenile justice professionals interpret the risk/needs profile of the individual juvenile, they prioritize risk/needs and develop a case plan from the list of 32

	<p>factors. Goals and tasks are identified for each factor in the computer program; again based on research around the most effective interventions for each factor. The juvenile justice professional then develops individual activities that describe the details of what the juvenile, family, case manager, and other service providers will be doing. An official reassessment is completed 6 months from the date of the initial assessment. Case plans are updated and modified every 90 days based on progress of the juvenile and family.</p>
Convergent validity	<p>The ability of a test to agree with other tests assessing the same dimension.</p>
Criterion-Referenced (Content-Referenced) Test	<p>Term used to describe tests that are designed to provide information about the specific knowledge or skills possessed by a student. Such tests usually cover relatively small units of content and are closely related to instruction. Their scores have meaning in terms of what the student knows or can do, rather than in (or in addition to) their relation to the scores made by some norm group. Frequently, the meaning is given in terms of a cutoff score, for which people who score above that point are considered to have scored adequately ("mastered" the material), while those who score below it are thought to have inadequate scores.</p>
Discriminate validity	<p>The ability not to agree with other tests assessing different dimensions.</p>
DSM-IV (Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition)	<p>The Diagnostic and Statistical Manual is designed to define, label, and categorize disorders based upon a clustering of similar symptoms. Its primary function is to allow the mental health provider to accurately label a disorder based upon the number and severity of observable symptoms.</p>
Early Intervention Program	<p>Designed to identify in the earliest stages children at risk of developmental delays and to provide early assistance; identifying and supporting children before the age of 3</p>
Evaluation	<p>A process of collecting information to make a judgment; judgments about children and youth should be made with care and should include multiple sources of information including formal test results, observation, and interview.</p>
Functional Behavior Assessment (FBA)	<p>A process of attempting to understand the purpose, motivation and correlates of a behavior. All behavior is believed to have a function—a way for a person to meet certain needs and desires—even when others disapprove and the behavior is considered inappropriate. Functional behavior assessments are conducted to understand the structure and function of behavior. If the purpose of the behavior from the individual's perspective is known, a behavioral intervention plan can be designed that teaches an alternative adaptive behavior.</p>
GAF (Global Assessment of Functioning)	<p>The overall level at which an individual functions includes social, occupational, academic, and other areas of personal performance and may be expressed as a numerical score from 1 to 100. Higher scores are considered better. See the DSM-IV for further information.</p>
Head Start and Early Head Start	<p>Comprehensive child development programs, serving children from birth to age five, expectant mothers and families. The overall goal is to increase the social competence of children in low-income families and children with disabilities, and improve the chances of success in school. Head Start has been a pioneer in the movement to address the needs of the whole child, including the educational, vocational and material needs of the entire family. Head Start philosophy holds that parents are the primary educators of their children, and that successful child development programs must involve and empower parents in order to have a lasting impact on the lives of low-income children.</p>

IDEA 2004	Individuals with Disabilities Education Improvement Act of 2004. It reauthorizes the Individuals with Disabilities Education Act (IDEA 97) through 2011. The purpose is to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living.
Independent Living Services	Program designed to eliminate barriers and provide assistance to individuals with disabilities so they can live and work more independently in their homes and communities.
Individualized Educational Program (IEP)	Means a written statement for each child with a disability that is developed, reviewed and revised in accordance with Section 614(d) of the IDEA 2004. IDEA 2004 specifies the information that is to be contained in an IEP, but generally speaking, the IEP is a plan that describes the present levels of academic achievement and functional performance and the goals that are designed to help the child or youth with a disability make progress and participate in the general curriculum.
Informal Assessments	Anecdotal records, personality inventories, skill inventories, interviews, observations, teacher-made tests and other non-standardized methods used to learn about a student's needs.
Intervention	Prevention, remedial, compensatory or survival services given to an individual in need.
Local Educational Agency	LEA - a local public school district; the district where a student is served; The public board of education legally constituted within a state who has administrative control and direction of a public elementary or secondary school.
MAYSI-2	Massachusetts Youth Screening Instrument - Version 2) is a brief screening tool to assist juvenile justice personnel in the identification of mental health needs of juveniles ages 12-17, especially those that might require further prompt intervention. The screening does not provide a diagnosis, only a "first look" at the possibility of a mental health need. The MAYSI-2 Second Screening is used to assist in following up on screening results that are over the Caution or Warning cut-off score for each scale. The MAYSI-2 requires a fifth grade reading level and takes approximately 10-15 minutes to complete. Scoring of MAYSI scales requires about 3 minutes.
Multidisciplinary Team	A team comprised of the family and professionals from various disciplines that meets regularly to review data, assess the needs of a child or youth, develop an intervention plan, and track the progress resulting from implementation of the plan. In educational settings, the multidisciplinary team specifically refers to the team of professionals required by IDEA 2004 to review data, determine the need for additional evaluation data, carry out the evaluations, and make decisions relative to determination of eligibility for special education services.
Norm-Referenced Test:	Any test in which the score acquires additional meaning by comparing it to the scores of people in an identified norm group. A test can be both norm- and criterion-referenced. Most standardized achievement tests are referred to as norm-referenced.
Norms vs. Standards:	Norms are not standards. Norms are indicators of what students of similar characteristics did when confronted with the same test items as those taken by students in the norms group. Standards, on the other hand, are arbitrary judgments of what students should be able to do, given a set of test items.
North Dakota Health Tracks (formerly EPSDT)	A preventive health program; free for children age 0 to 21 who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or

	becoming worse; orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling and other health services. They will help with scheduling appointments and finding transportation to the services.
OSEP (US Office of Special Education Programs)	An office within the US Education Department charged with assuring that the various states comply with IDEA. OSEP is dedicated to improving results for infants, toddlers, children and youth with disabilities ages birth through 21 by providing leadership and financial support to assist states and local districts.
Partnerships	Involves parents working together with service agencies and their natural supports. The goal is to plan and provide for the care and support of children with complex needs. It includes services across system lines and involves all providers of services. Plans are made around family choices and preferences and are focused on goals. "Wraparound" is part of Partnerships.
Prevention	A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles; measures that decrease the incidence or limit the progression of a disability; psychological and educational interventions facilitate optimal development and decrease secondary emotional disabilities;
Protective Factors	Factors that make it less likely that individuals will develop a problem or disorder. Protective factors may encompass biological, psychological or social factors in the individual, family and environment. Strengths and resources that appear to mediate or serve as a "buffer" against risk factors that contribute to vulnerability to maltreatment or against the negative effects of maltreatment experiences.
Qualitative data	Information that is difficult to measure, count, or express in numerical terms. This type of data is used in research involving detailed, verbal descriptions of characteristics, cases, and settings. Qualitative techniques rely on observation, interviewing, and document review for collecting data.
Quantitative Data	Information that can be counted or put into numerical form.
Readiness	A condition or state in which it is possible for a person to engage in a given learning activity; in education, the skills that are prerequisite to success in a formal classroom setting, including oral language, listening, perceptual-motor development, visual-perceptual development, reading readiness, social-emotional development, and number readiness.
Regular Education	All education not included under Special Education; sometimes referred to as General Education.
Reliability	The extent to which test scores are consistent; the degree to which the test scores are dependable or relatively free from random errors of measurement. Reliability is usually expressed in the form of a reliability coefficient or as the standard error of measurement derived from it.
Right Track	A screening program for all North Dakota children, birth to three years of age. Initial Right Track screenings are provided at no cost and can provide: Developmental Screenings; Ideas on stimulating a child's development; and Information and referrals to local, state, and national organizations.
RTI	RTI is a process for monitoring student progress and using the data to make decisions about instructional needs and modifications. This process is useful in making decisions about early intervening services, and information from this process can be used as part of the process for determination of a learning disability.

School-wide PBS (Positive Behavioral Support)	School-wide Positive behavior support (SW-PBS) is comprised of a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior with all students. It involves a systematic approach to set clear behavioral expectations within a supportive environment that teaches and reinforces the desired behaviors. SW-PBS is not a specific “model” but a compilation of effective practices, interventions, and systems change strategies that have a long history of empirical support and development and individually have been demonstrated to be empirically effective and efficient. Operationally defined and valued outcomes for all students are emphasized, along with research-validated practices, interventions, strategies, and curriculum to achieve goals and outcomes.
Screening	The process of examining children and youth to identify those who are at risk of failure without further intervention.
Socio-emotional	The way an individual communicates emotions to others, in order to fulfill their basic psychological needs.
Special Education	Individually designed instruction and related services provided to students with disabilities, ages 3 to 21.
Standardized tests	Tests which have norms reflecting a larger population (usually these are age or grade based norms reflecting the performance of children throughout the country on the same tests).
System of Care	A process of partnering an array of service agencies and families, who work together to provide individualized care and supports designed to help children and families achieve safety, stability and permanency in their home and community. Systems of care bring together a variety of community participants in an effort to extend resources and provide services designed to meet the needs of the child/youth and the family.
Test–retest reliability	A measure of the correlation between the scores of the same people on the same test given on two different occasions.
Validity	The extent to which a test does the job for which it is intended. The term validity has different connotations for different types of tests and, therefore, different kinds of validity evidence are appropriate for each.
Vocational Rehabilitation (RSA – Rehabilitation Services Administration)	Federally funded program that provides training and employment services to individuals with disabilities so they can become and remain employed.
Wraparound	A philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes. The process is based upon individualized, strength-based, needs-driven planning and service delivery. The process allows for providing a network of services to a child and family in the natural home, school and community environment. Parent-driven individualized service plans, creative use of resources, and natural environments are the common attributes, which characterize service systems based on wraparound.
YASI	A risk assessment process used by juvenile probation professionals. The assessment contains highly relevant assessment content and profiles the factors that are critical to promoting positive outcomes for juvenile probation clients. The instrument is applicable for juveniles placed on informal and formal probation. A computer tool assists in the collection and scoring of the data and uses the assessment results to develop plans for serving the youth who are assessed.