Bureau of Indian Education
Residential Life Program
Behavioral Health Resource Manual

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2010

The mission of the Division of Residential Life programs is to provide a physically safe and nurturing living environment, supported with sufficient and appropriate resources conducive to growth and learning

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Chapter 1: Introduction

The Belief

"The dorm program to be effective must support, strengthen and supplement classroom instruction. The dormitory staff must take the place of the home in encouraging each child to achieve his/her maximum capacity. The dorm staff must provide the experiences, which children get in a good home environment. The dormitory environment is importantly related to each child's educational growth and emotional adjustment". (H. Thompson, Chief of the Branch of Education, Bureau of Indian Affairs. *Indian Education*, Volume 22, February 15, 1959.)

The Challenge

Within the Bureau of Indian Education (BIE), there are approximately 7,000 Native American children and youth residing in the 66 dormitories with around 1,200 adults working in these homeliving programs. These 1,200 staff members are responsible for supervision, food service, recreation, cultural programs and activities, behavioral health services, safety, wellness, counseling, tutoring and collaborating with schools.

The overriding challenge for all involved with homeliving programs, i.e., students, school/dorm staff, families, tribes, and BIE is to provide a "home away from home" that supports the educational, social, behavioral, cultural, and physical development of each individual child/youth.

An Approach

In 2005, the Bureau of Indian Affairs (BIA) published the final regulations for Homeliving Programs (Dormitories). These regulations address a variety of

requirements related to staffing, programs, safety, recreation, student rights, and behavioral health services. These program standards are part of the comprehensive No Child Left Behind (NCLB) federal education act.

The Purpose

The purpose of this document is to address only the regulations pertaining to the behavioral health services. The manual includes a variety of strategies, models, and resources to assist homeliving staff and behavioral health professionals in responding to social, emotional and behavioral needs of Native American children/youth.

Role of Homeliving Staff

In order to maximize the information in the *Behavior Health Services Manual,* it is recommended that all homeliving program staff:

- Understand that a behavioral health program is required for all BIE funded dormitories, per Federal Regulations.
- Focus on the age range and developmental level of students in the homeliving setting.
- Identify the social, emotional, and behavior needs of the students.
- Collaborate with all resources available from the schools, dorm, tribe(s), communities, and BIE to provide and evaluate behavioral health services.

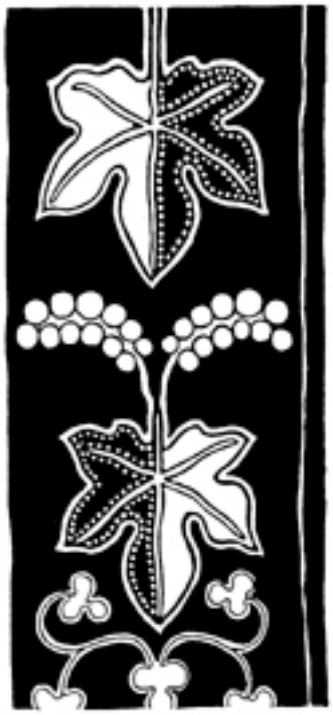
What are the regulations related to the required behavioral health services?

(25 CFR, Part 36 §36.70, §§36.79 – 36.90, and §36.101)

What terms do I need to know? (§36.70)

The following definitions apply to the homeliving regulations:

Behavioral health professional means a State licensed or State certified Social Worker, School Counselor, Drug and Alcohol Counselor, School Psychologist, or School Psychometrist responsible for coordinating a broad range of needs including:



- Support groups.
- Individual counseling.
- Crisis intervention.
- Preventative activities.
- Coordination of referrals and outside services with appropriate providers.

Behavioral Health Program means a homeliving based service designed to decrease barriers to learning and increase positive, personal well-being by:

- Providing early intervention services, coordinating crisis intervention, and prevention services.
- Promoting a positive social and emotional environment.
- Reducing the incidence of problems, and
- Referring students with behavioral needs that require professional medical care to an appropriate residential care facility.

Behavioral Health Services means the services provided by a school/dorm behavioral health program as defined in these regulations.

What are the homeliving behavioral professional staff/student ratio requirements? (§36.79)

Behavioral health professional(s) is necessary in homeliving programs to address issues, such as abuse, neglect, trauma, cultural conflict, and lack of school success. Each homeliving program must provide a minimum of one half-time behavioral health professional for every 50 students.

- The program may fill the staff requirements by using contract services, other agencies (including the Indian Health Service) or private/nonprofit volunteer service organizations.
- For purposes of this section, a one half-time behavioral health professional is one that works for the homeliving program a minimum of 20 hours per week.
- For purposes of this section, in instances where the behavioral health services are obtained through other programs, the behavioral health professional must be available at the request of the homeliving programs.

If a school or dormitory has separated boys' and girls' homeliving programs, may the same behavioral professional be used for each program? (§36.80)

Yes, a program may use the same behavioral professional for both boys' and girls' programs. However, behavioral health staffing requirements are based on the combined enrollment during the homeliving count period.

May a homeliving program use support staff or teachers to meet behavioral health staffing requirements? (§36.81)

No, a homeliving program must not use support staff or teachers to meet behavioral health staffing requirements. The only exception is if the individual support staff employee or teacher has the appropriate behavioral health license or certification.

May behavioral health professional(s) provide services during the academic school day? (§36.82)

Behavioral health professional(s) must average at least 75% of their work hours with students in their dormitories. These work hours must occur outside of the academic school day, except in emergency situations as deemed by the administrative head of the homeliving program or designee. The purpose of this requirement is to maximize contact time with students in their homeliving setting.

How many hours can a student be taken out of the academic setting to receive behavioral health services? (§36.63)

A student may spend no more than 5 hours per week out of the academic setting to receive behavioral health services from the homeliving behavioral health professional(s), except for emergency situations.

Can a program hire or contract or acquire by other means behavioral health professionals to meet staffing requirements? (§36.84)

A program may hire or contract behavioral health professionals to meet staffing requirements or acquire such services by other means such as through a Memorandum of Understanding with other programs.

- At least one individual must be a licensed or certified school counselor or a social worker that is licensed/certified to practice at the location where the services are provided.
- For additional staffing, other individuals with appropriate certifications or licenses are acceptable to meet staffing requirements.

Are there staff training requirements? (§36.86)

- All homeliving program staff as well as all employees that supervise students participating in homeliving services and activities must have the appropriate certification or licensing requirements up to date and on file.

Programs must provide annual and continuous professional training and development appropriate to the certification and licensing requirements.

All homeliving program staff, as well as all employees who supervise students participating in homeliving services and activities, must receive annual training in the following topics before the first day of student occupancy for the year.

REQUIRED TOPICS BEFORE THE IST DAY OF STUDENT OCCUPANCY:

- First aid/safety/emergency & crisis preparedness
- CPR – automated external defibrillator
- Student checkout policy
- Confidentiality (Health Information Privacy Act and the Family Education Right to Privacy Act)
- Medication administration
- Student rights
- Child abuse reporting requirements and protection procedures

Homeliving staff as well as all employees that supervises students participating in homeliving services and activities must be given the following training annually:

- De-escalation/conflict resolution
- Substance abuse issues
- Ethics
- Parenting skills/child care
- Special education and working with students with disabilities
- Student supervision skills
- Child development (recognition of various stages of development in the student population)
- Basic counseling skills
- Continuity of Operations Plan (COOP)

What are the program requirements for behavioral health services? *(§36.91)*

The homeliving health program must make available the following services:

- ☐ Behavioral health screening/assessment.
- ☐ Diagnosis.
- ☐ Treatment plan.
- ☐ Treatment and placement.
- ☐ Evaluation.
- ☐ Record of services (if applicable) in coordination with the student's Individual Education Plan (IEP).

REMINDER: AN IEP IS A PLAN DEVELOPED BY A TEAM (STUDENT, PARENT(S), EDUCATORS, DORMITORY STAFF MEMBERS, AND OTHERS). THE PLAN IS DESIGNED TO HELP THE CHILD/YOUTH MAKE PROGRESS AND BE SUCCESSFUL IN SCHOOL AND IN LIFE, AND MEET THE CHALLENGES RELATED TO HIS/HER DISABILITY.

- Each homeliving behavioral health program must have written procedures for dealing with emergency behavioral health care issues.
- Parents or guardians may opt out of any non-emergency behavioral health services by submitting a written request.
- Parents or guardians must be consulted before a child is prescribed behavioral health.
- Medication in a non-emergency situation.

How often must students who have been separated for emergency health or behavioral health reasons be supervised? (§36.101)

Students who have been separated for emergency behavioral or health reasons must be supervised as frequently and as closely as the circumstances and protocols require. No student will be left unsupervised for any period until such factors as the student's health based on a medical assessment, the safety of the student, and any other applicable guidance for dealing with behavior or health emergencies are considered.

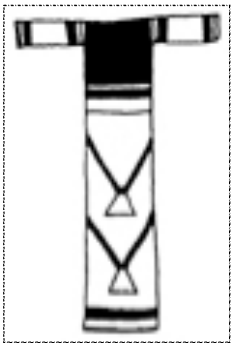
With the regulations in mind, let us take a look at the typical indicators of Native American children and youth who might need social, behavior and emotional supports.

Who are the Native American children and youth that need behavioral health services?

Native American children and youth who need some level of behavioral, emotional and social support usually have many of the following characteristics and risk factors:

- History of abuse and neglect.
- Significant school truancy, academic challenges and retention issues.
- Emotional and behavioral challenges in many settings (school, home, community and peer relationships).
- Low socio-economic status.
- Substance abuse issues.
- Family history of problem behavior, conflict, substance abuse, neglect, etc.
- Early and persistent antisocial behavior.
- Negative peer influence.

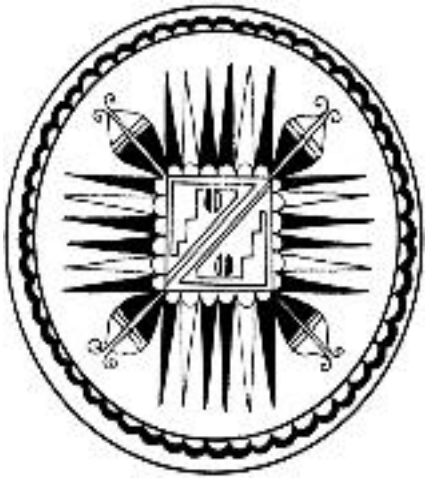
What do we know about children and youth who need additional and comprehensive behavioral health services?



1. Current data estimates at least 11 million children and youth in the US have a diagnosable mental, emotional or behavioral health disorder.
2. An extremely high number of youth that have a mental, emotional or behavioral disorder also have a substance abuse addiction.
3. Mental disorders in children and youth include a broad range of behavioral and emotional disorders that require a menu of treatments and services. There is no " one size that fits all".
4. There is limited communication, collaboration and coordination of services among families, schools, and community providers when addressing children and youth behavioral health needs.
5. Information from Indian Country Child Trauma Center, Center on Child Abuse and Neglect, University of Oklahoma reports the following:
    - Compared to their peers, Native American children/youth are at 2.5 times a greater risk of experiencing trauma.
    - Native American children/youth have higher rates of mental health and substance abuse problems than other ethnic groups.
    - 10 – 30% of Native American children/youth have depression
    - 50% of Native American youth in treatment for substance abuse have significant untreated psychiatric challenges and issues.

What do we know about Native American children and youth living in BIE funded Residential Programs?

In June 2005, the *National Status of Residential Life Report* was completed (authors – G & G Communications). The report included data and information from a survey of BIE funded residential programs. The data was from the 2003 – 2004 school year. Results from the residential life report relate to the need for behavioral health services for many students living in dormitories.



- 30% of students did not receive adequate parental supervision.
- 20% of students had been rejected or neglected within the family unit.
- 23% of students were from dysfunctional home settings.
- 18% of students were from homes with alcohol and/or one or both parents use drugs.
- 59% of students were from single parent homes.
- 20% of students were from homes where their well-being was imperiled due to family behavior problems.
- 15% of students had behavior problems too difficult for solution by the family or local resources.

What are the challenges and problems Native American children and youth who live in BIA funded dormitory settings?

The National Status of Residential Life Report included social, behavioral and emotional challenges and problems as reported by students themselves. These include:

% of students reporting this area	Social, Behavioral and Emotional Challenges and Problems
53%	Problems with completing school work and accepting responsibility
20%	Alcohol and drug abuse issues
16%	Peer socialization problems
13%	Problems with following rules
14%	Difficulty adjusting to dorm life
18%	Family problems at home
15%	Behavior problems
9%	Low self esteem

Another related report on behavioral health issues of Native American children and youth residing in BIE funded homeliving programs was prepared by the American Academy of Child and Adolescent Psychiatry – Native American Child Committee (Eli Breger, MD and Michael Storck, MD – Co-Chairs). This 2009 report identified a continuum of social, behavioral and health care challenges that impact the well being of Native American children and youth in residential life programs. Challenges and problems identified include:

- Leaving their home and school.
- Change in peer group.
- Separation from positive anchors to community and kinship.
- Exposure to new toxic peer behaviors such as substance abuse.
- Major shifts in dietary and daily living habits.

- Re-experiencing the generational trauma of parents' and grandparents' boarding school experiences leading to feelings of loss, separation and alienation.
    - Many youth are "sent away" from unstable homes where the parents and parent-figures themselves did not live with family during their youth and as such had limited positive modeling of parenting skills.
- Establishing relationships with health care providers, therapists, teachers, dorm counselors, etc. in mid-childhood and early adolescence.
- Establishing new ties (if available) with tribal and cultural-identity supports and traditional healing practices.

What can homeliving programs do to address social, emotional and behavioral needs of Native American children and youth living in the dormitory setting?

There is no one single, isolated or proven technique that will address the range of possible social, emotional and behavior needs of Native American children and youth. Schools and dorms that are more effective in addressing the needs of their students develop interventions, services and programs based on *System of Care* principles.

An example of this is the mission statement of the United States Department of Health and Human Services – Substance Abuse and Mental Health Services Administration

(SAMHSA) Child, Adolescent and Family Branch. The mission statement of SAMHSA's Child Adolescent and Family Branch:

> *"Systems of care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around these principles: child-centered, family-driven, strength-based, and culturally competent with interagency collaboration."*

What role does culture play in the provision of behavioral health services?

Incorporating cultural strengths, practices and traditions into behavioral health services is very important and beneficial for Native American children and youth. Culturally appropriate practices may include, but are not limited to:

- Sweat lodge.
- Tribal healing rituals.
- Medicine wheel.
- Purification rituals, i.e. smudging.
- Mentoring and talking circles.
- Involvement in cultural activities, pow-wows, drumming, dancing.
- Storytelling.

In the following sections of the manual, are a variety of strategies, interventions, best practices, resources and templates that will assist homeliving programs in addressing the social, emotional and behavioral health needs of students living in residential settings.

Chapter 2: Development of Behavioral Health Programs within the Dormitory Setting

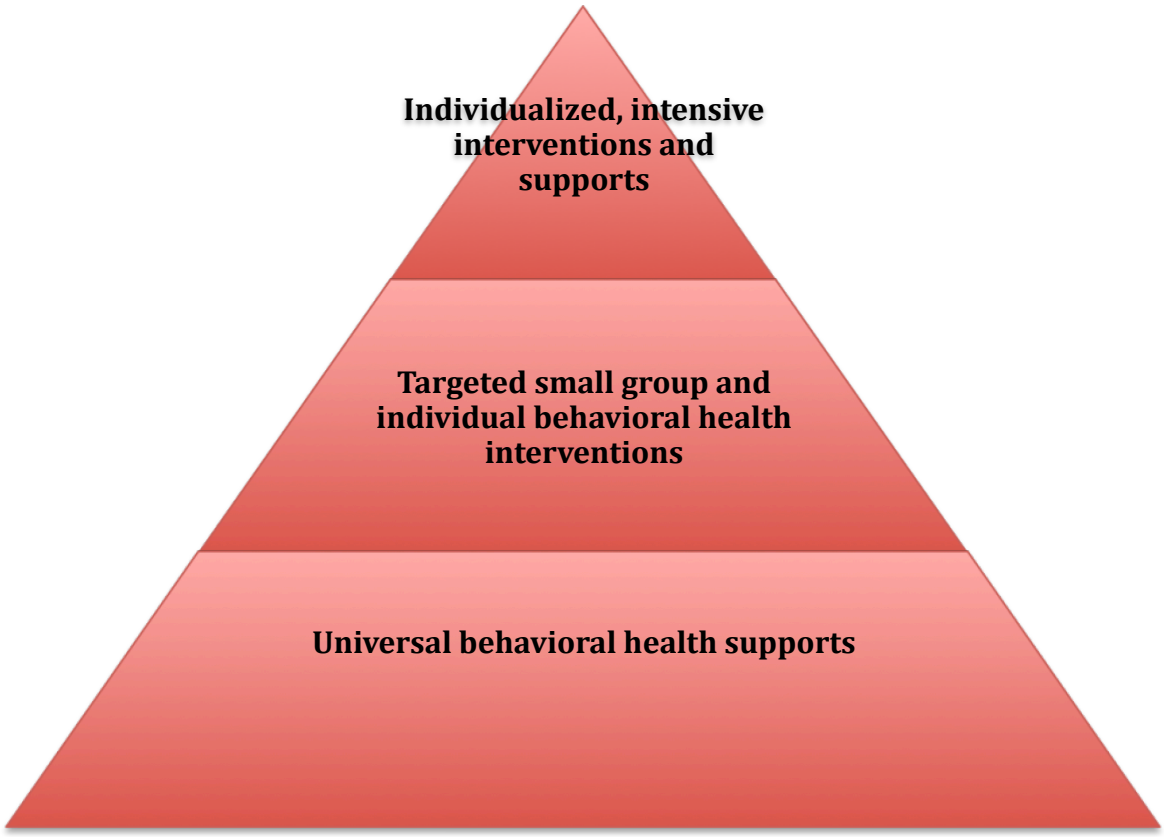
The federal regulations for BIE residential life programs defines Behavioral Health Programs as homeliving based services designed to decrease barriers to learning and increase positive, personal well-being by:

- Providing early intervention services, coordinating crisis intervention, and prevention services.
- Promoting a positive social and emotional environment.
- Reducing the incidence of problems.
- Utilizing a process for the referral of students with behavioral needs that require professional mental health supports to an appropriate residential care facility.

For most dorms, trying to develop a behavioral health program can be a daunting task due to size, limited staff, funding, location and age range of students. However, all dorms must develop and implement a behavioral health program.

A multi-tiered model is recommended as a framework for developing a behavioral health program. Many BIE funded schools, in addressing education and behavioral challenges of students, are utilizing this approach. Also, a multi-tiered approach is used in many mental and behavioral health systems. This method allows homeliving programs to develop a continuum of services to meet the needs of all students.

Multi-tiered Model



Tier 1 – Universal: Programs that support the social and emotional development of all students; the focus at this level is prevention.

Tier 2 – Targeted: Targeted behavioral health prevention and intervention activities for small groups and individuals

Tier 3 – Intensive: Individual therapeutic interventions based on a treatment plan

Adapted from a *Toward a Shared Agenda – Mental Health, Schools and Families Working Together for All Children and Youth*

Tier 1 – Universal:

This tier includes a focus on the social, emotional and behavioral development of all students in the dormitory setting. These activities and supports can be coordinated with school, community and homeliving staff and are proactive and preventative and emphasize the development of appropriate behavior/skills. Examples include, but are not limited to:

- System-wide behavior and social skills development.
- Character education.
- Counseling and guidance curriculum and activities.
- Support groups.
- Cultural activities.
- Parent – student involvement.
- Learning activities related to such areas as wellness, substance abuse, positive relationships, sex education, suicide, conflict resolution, bullying, abuse.
- Screenings.

Tier 2: Targeted Individual and Small Group Behavioral Health Services and Interventions

This tier focuses on personalizing behavioral health activities and services to meet specific areas of concern for individuals or small groups with a similar concern/issue. Examples include, but are not limited to:

- Providing more comprehensive screenings and assessments.
- Parent – student involvement.
- Individual counseling.

- Support groups.
- Development and implementation of individual intervention plans.
- Development of behavior plans and contracts.
- Specific skill development in dealing with violence reduction, bullying, anger management, substance abuse, peer mediation, trauma, etc.
- Referral to behavioral health professionals for consultation.
- Cultural based interventions.

Tier 3 – Individualized, Intensive Behavioral Health Interventions

The focus of this tier is on the provision of services for students who have critical behavioral and emotional needs that typically require individualized therapeutic interventions and follow along. In some situations, homeliving staff will collaborate with outside providers to facilitate a referral to a residential treatment/care facility. Examples include, but are not limited to:

- Referral for assessment and diagnosis.
- Development and implementation of a treatment plan.
- Referral to a residential treatment and care facility.
- Crisis intervention plan and services.
- Parent and student involvement.
- Linkages with the BIE Residential Educational Placement Program (REPP).
- Development of a reintegration plan if student is to return to the homeliving program.
- Cultural based and evidence based interventions and treatment.

Staff from several BIE Homeliving Programs have suggested utilization of the American School Counselor Association (ASCA) Framework for School Counseling as an excellent method for assuring effective and thorough services for all Native American children

throughout all tiers. Information about the ASCA school counseling framework, processes and tools can be found on the ASCA website. The website is noted in the Appendix 3, page 84.

This program has four components. They are:

- Foundation: beliefs, philosophy and mission
- Delivery system: guidance curriculum, individual student planning and responsive services, and systems support

- Management system: agreements (re: program, time, staffing), advisory council, use of data, and action plan.
  ASCA recommends 80% of counselor time spent in direct contact service with students – with the remaining time spread out within the rest of the components.
- Accountability: a focus on collecting and using data to evaluate the program.

Chapter 3: Identifying Behavioral Health Needs, Services and Interventions for Individual Students

In order to provide, timely, and effective behavioral health services, homeliving programs must have procedures for identifying the needs of their students. The procedures are based on the age range of the students, the number of students enrolled, and the behavioral health staff and resources available within the homeliving program, school and/or community.

A recommended process for determining individual behavioral health needs and services is displayed on the following page.

Process for Identifying Behavioral Health Needs of Students

1. Review student and family information (application, social-family history, academic/school progress, past behavioral health services & outcomes); interview student and family; follow up as needed for additional information and/or clarification.
2. Determine appropriate screening tool(s) and process.
3. Conduct screening.
4. Analyze and interpret screening data, and identify needs. From this, one of the following will be determined:
    - The student doesn't have any behavioral health needs – and will receive basic (tier 1) behavioral health supports, i.e. preventative and supportive.
    - Specific needs are identified through the screening – the student will receive individualized behavioral health services from the homeliving staff.
    - The student requires more formal assessment, followed by diagnosis and a formal treatment plan.

        - The treatment plan is developed; the needs are too complex and the student requires additional behavioral health supports (the homeliving program contracts with the additional supports & services) or the student is referred and placed in a residential care facility.

Guidelines for Improving this Process – Things to Keep in Mind

1. Gather as much information related to behavior health through the application process for enrollment in the school/dorm. In Appendix 1 are examples of student information to collect.
2. Ask for previous school information; pay close attention to information related to students with disabilities, those with history of truancy, behavior problems, etc.
3. Conduct behavioral health screening as soon as possible (**within 2 weeks of enrollment)**.

4. Link with outside behavioral health specialists (psychologist, social worker, therapist, etc.) if needed, for formal diagnosis, development of treatment plan, implementation assistance, and consultation.
5. For individuals with serious, complex behavioral health needs, refer to residential treatment facility. Use of the BIE's Residential Educational Placement Program (REPP) is appropriate. Contact numbers for Bureau of Indian Education REPP are:
    - Donna Eagle Staff Jetty, Education Specialist – 701-854-3625
    - Bertha Muskett, Education Specialist – 505-786-6006.
    - Gloria Yepa, Supervisory Education Specialist – 505-563-5264.
6. Obtain parental consent prior to screening and delivery of specialized behavioral health services based on local policies and procedures. Parents may opt out of any non-emergency behavioral health service by completing a form. See sample of this form on the next page.
7. School and dorm collaborate and coordinate efforts, services and resources.
8. Annually, evaluate and monitor this process to see if there are any changes needed.

Participation in Non-Emergency Behavioral Health Services

School/Dormitory**:**

Name of Student:

Date of Birth:

I/we give consent that the above named child/youth can participate in all non-emergency behavioral health services provided by the school/dormitory staff.

Signature of Parent/Guardian and Date

_____

Valid until: _____

Chapter 4: Coordination of Services to Meet Behavioral Health Needs

The Federal regulations for homeliving programs provide direction in addressing social, emotional and behavioral needs of Native American children and youth. Residential staff and behavioral health professional are required to provide, facilitate and coordinate a range of supports/services including:

- Support groups.
- Individual counseling.
- Crisis intervention.
- Preventative activities.
- Coordination of referrals and outside services with appropriate providers.

Linkages with service providers could include behavior specialists from other tribal/community providers, such as social workers, school psychologists, therapists, school/agency counselors, and substance abuse counselors.

This section will address the following areas:

- Rationale for coordinating services.
- Best practices in coordination of services between dormitory, school, community and outside agencies/providers.

There are currently 66 residential programs funded by the BIE serving approximately 7,000 Native American children and youth. The grade ranges include:

K – 5	K - 8	1 - 12	6 – 8
K – 6	K - 9	4 - 12	7 - 12
K - 7	K - 12	5 - 8	9 - 12

The total number of Native American children within residential life programs ranges from under 50 to over 300. The number and type of staff employed in each setting is directly related to the number of students and the funding generated from this count. The school/staff ratios are found in the Homeliving Program regulations (25 CFR, Part 36.79). To address the social, emotional and behavioral needs of the students, the majority of residential programs must link with other school, community and tribal providers due to fiscal, staffing and location challenges. This becomes imperative when formal diagnosis, treatment and therapy is required.

The purpose of a coordination service-planning model is to create a connection between school/dorm, and student/family, to appropriate behavioral health services.

There are many positive outcomes for Native American children, youth, families, and agencies involved in a coordinated system of service delivery. Outcomes include:

- Increased efficiency and effectiveness of supports and services.
- Provision of comprehensive services that are culturally-based.
- Sustained interagency coordination, communication and problem solving.
- Maximization of limited fiscal resources and personnel.
- Enhanced child, youth and family quality of life, resulting in improved outcomes of education and employment.
- Compliance with federal, state and tribal legal requirements.

1. Resource Mapping
2. Interagency Behavioral Health Support Team
3. Linkages with Special Education
4. Referral Feedback

Residential programs that have established coordination of service planning models have identified four critical components:

Component 1: Resource Mapping

Resource mapping is a term used to describe a process for identifying services that exist in a community/geographical region to address a specific need(s), such as behavioral health service providers. Appropriate residential staff and school staff (if possible) collaborate to develop the resource map. Information on the resource map includes community service providers, school/dormitory behavioral health professionals, contact and referral information, and services provided. Included here is a sample of a resource mapping tool/template.

Behavioral Health Services Resource Mapping Template

Local/Regional Service Provider	Services Provided	Contact Information	Referral Process

Component 2: Interagency Behavioral Health Support Team

The purpose of an interagency behavioral health support team is working together to address emotional and behavioral challenges of all Native American children and youth. This team supports the development of a continuum of culturally based services including:

- Preventative strategies.
- Diagnosis and treatment planning.
- Treatment.
- Case management.
- Crisis intervention plans.
- Educating parents, staff, and students.

- Identification of barriers.
- Traditional healing.
- Referral procedures.
- Funding.
- Service coordination – system level.

An example of an interagency behavioral health support team planning form follows.

Interagency Behavioral Health Support Team Planning Template

Member Name	Agency	Title

Tasks We Will Work On – Check All That Apply	
Potential Behavioral Health Services	**Team Activities – Needed to Implement Services**
☐ Preventative Strategies	
☐ Diagnosis & Treatment Planning	
☐ Treatment	
☐ Case Management	
☐ Crisis Intervention Plans	
☐ Educating Parents, Staff & Students	
☐ Identification of Barriers	

Tasks We Will Work On – Check All That Apply	
Potential Behavioral Health Services	**Team Activities – Needed to Implement Services**
☐ Traditional Healing	
☐ Referral Procedures	
☐ Funding	
☐ Service Coordination at System Level (Agency to Agency)	

Component 3: Linkages with Special Education

The third component is working closely with special education staff for students who are receiving special education services. The federal IDEA legislation allows students eligible for special education to receive a menu of supports and services based on needs as determined by the Individual Education Program (IEP) team. These supports and services are described within each student's IEP. Services and supports related to behavioral health might include: functional behavior assessment (FBA), behavior improvement plan (BIP), counseling, social skill development, psychological assessment, parent training, etc.

Recommendations for collaboration between the residential life program and special education are:

- Identify students in the dormitory who are receiving special education services.
- Participate in the development and implementation (as appropriate) of the student's IEP.
- Coordinate and collaborate with the school and special education staff in the delivery of behavioral health services and in supporting the student's IEP goals and/or behavioral improvement plans.
- Assure that the student's behavioral health goals and those of special education are compatible and address all environments.

REMINDER: AN IEP IS A PLAN DEVELOPED BY A TEAM (STUDENT, PARENT(S), EDUCATORS, DORMITORY STAFF MEMBERS, AND OTHERS). THE PLAN IS DESIGNED TO HELP THE CHILD/YOUTH MAKE PROGRESS AND BE SUCCESSFUL IN SCHOOL AND IN LIFE, AND MEET THE CHALLENGES RELATED TO HIS/HER DISABILITY.

FYI: FBA STANDS FOR "FUNCTIONAL BEHAVIOR ASSESSMENT". IT IS AN INDIVIDUALIZED ASSESSMENT OF THE STUDENT TO IDENTIFY REASON(S) FOR A STUDENT'S INAPPROPRIATE BEHAVIOR AND RECOMMENDATIONS FOR A BEHAVIOR IMPROVEMENT PLAN (BIP).

FYI: BIP STANDS FOR "BEHAVIOR IMPROVEMENT PLAN". A TEAM, USUALLY INCLUDING SCHOOL AND DORM STAFF, PARENTS AND STUDENT, DEVELOPS THE BIP. THE INDIVIDUALIZED PLAN IS DESIGNED TO ASSIST THE STUDENT TO DECREASE INAPPROPRIATE BEHAVIOR AND INCREASE APPROPRIATE BEHAVIOR.

Component 4: Referral Feedback Process

Often when residential staff makes a referral to a community or tribal provider, there can be quite a delay in getting information regarding the status of the referral. In some cases, the referral is misplaced, delayed due to lengthy intake procedures, subject to a long waiting list, etc. The goal is to have as brief a time as possible between the referral and the initiation of the services. A sample behavioral health services referral feedback template follows. This form is to be completed by the service provider and given to the dormitory and school so staff members are aware of the current status, and what to expect in the future.

Behavioral Health Services Referral Feedback Template

Note: This form is to be completed by the service provider.

Name of Student _____

Date of Birth _____

School/Dorm Name _____

Location _____

Status of Referral

1. Intake process not completed ☐
2. Evaluation in progress ☐
3. Treatment plan has been developed and implemented ☐
4. Student/family refused services ☐

Additional Comments:

Signature of Service Provider:

Date:

Appendix 1: Helpful Forms for Homeliving Programs

Included in this section are a variety of useful forms for homeliving program use. The forms included are samples that can be used "as is" or they can be modified to create forms more appropriate and applicable to the specific homeliving program. It is recommended that this type of information be collected during the school/dorm application process or as needed. They are:

1. **Student Information Packet**

   This is information that should be collected during the school/dorm application process or within the first two weeks of enrollment. This information helps to determine the specific behavioral health services (if any) the student may need.

2. **Student Reintegration Plan**

   ✎ FYI: A REINTEGRATION PLAN IS A WRITTEN PLAN THAT IS DEVELOPED BY A TEAM TO HELP THE STUDENT MAKE A SMOOTH TRANSITION BACK FROM THE RESIDENTIAL TREATMENT FACILITY TO THE DORM/SCHOOL. ACTIVITIES AND SERVICES OUTLINED IN THE PLAN HELP THE DORM/SCHOOL PREPARE FOR THE RETURN OF THE STUDENT.

   In order to assure a smooth and effective transition from the residential treatment facility to the school/dormitory, a plan called "reintegration plan" is recommended. The school, dorm, residential treatment facility, student, and parent(s) can complete this plan.

3. **Individual Student Crisis Management Plan**

   This plan is recommended for any student who is at high risk for very aggressive/violent or self-injurious behavior. A team including school, dorm, student and parent(s) should complete it.

4. Eufaula Dormitory Assessment and Evaluation

This form is an example of an assessment and evaluation protocol and form, which can be used as is or adapted. Information about the SASSI screening tool is included in the screening tool appendices.

Section I: Student Information Packet

Educational History

School/Dormitory: _____

Student Name: _____
Date: _____

Check boxes to indicate previous and current educational placements, if known.

Kind of Placement (check all that apply)	Previous	Current
Regular Classroom	❑	❑
Regular Classroom with in-class support and/or accommodations	❑	❑
Special Education Classroom/Resource Room	❑	❑
Alternative School	❑	❑
Day Treatment Program	❑	❑
Residential School and Dorm	❑	❑
Home and/or Hospital-based Instruction	❑	❑
Not in school – suspended	❑	❑
Not in school – expelled	❑	❑
Other (describe):	❑	❑
Please describe proposed educational placement and recommended facility, if known:		

Note: This information should be collected during intake/application process.

Section II: Student Information Packet

Living Situation History

School/Dormitory: _____

Student Name: _____
Date: _____

Check boxes to indicate previous and current living situations, if known.

Type (check all that apply)	Previous	Current
Independent Living	❑	❑
Both Parents	❑	❑
One Parent (indicate Mother or Father):	❑	❑
Shared Parenting	❑	❑
Adoptive Home	❑	❑
Relatives	❑	❑
Foster Care	❑	❑
Group Home	❑	❑
Emergency Shelter	❑	❑
Residential Treatment (non drug/alcohol)	❑	❑
Drug/Alcohol Residential Treatment Program	❑	❑
Medical Hospital	❑	❑
Psychiatric Hospital	☐	☐
Juvenile Detention Facility	☐	☐
Correctional Facility	☐	☐
Other (describe)	☐	☐
Other (describe)	☐	☐

Section III: Student Information Packet

Behavioral Issues

School/Dormitory: _____

Student Name: _____
Date: _____ Please complete the checklist below.

In the last year, has the child or youth exhibited any of the behaviors listed below to a marked/substantial degree when compared to others in his/her age group? If yes, check those that apply.		
☐ Confused/strange ideas	☐ Impulsive	☐ Extreme sadness
☐ Inappropriate/bizarre behavior	☐ Runs away	☐ Anxiety
☐ Inappropriate emotional reactions	☐ Anti-social acts	☐ Maladaptive dependence
☐ Inappropriate attention	☐ Fire setting/fire play	☐ Somatic complaints
☐ Hyperactivity	☐ Refusal to accept limits	☐ Bladder/bowel difficulties
☐ Verbal aggression	☐ Self-injurious behavior	☐ Persistent school refusal
☐ Aggression towards people	☐ Suicidal thoughts	☐ School suspension
☐ Aggression towards property	☐ Suicidal behavior	☐ Avoidance of social contact
☐ Inappropriate sexual activity	☐ Stealing	☐ Serious sleep disturbance
☐ Extreme withdrawal from family	☐ Animal cruelty	☐ Problems with the law
☐ Substance abuse	☐ Eating disorder	☐ Experienced trauma
☐ Other (describe):		
Feel free to expand upon the above behavioral issues and the settings in which they occur:		

Section IV: Student Information Packet

History of Services and Service Providers

School/Dormitory: _____

Student Name: _____

Date: _____

Services History	Agency (if known)	Previous	Current
Outpatient Psychological Assessment		❑	❑
Behavior Support Services		❑	❑
Case Management/Service Coordination		❑	❑
Individual Psychotherapy		❑	❑
Counseling		❑	❑
Medication (Psychiatric)		❑	❑
Substance Abuse Treatment		❑	❑
Traumatic Brain Injury Services		❑	❑
Deaf/Hard of Hearing Services		❑	❑
Other (describe):		❑	❑
Other (describe):		❑	❑

Section V: Student Information Packet

Behavioral and Mental Health Information

School/Dormitory: _____

Student Name: _____
Date: _____

Note: All related documentation, such as treatment plans and summaries should be reviewed once parent consent is obtained.

A. Mental Health Status (if available)

DSM IV Diagnosis	Code	Date	Provided by:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
List medications currently taken:			

Risk Factors (check all that apply)

Substantiated victim of: ☐ physical abuse ☐ neglect ☐ sexual abuse ☐ emotional abuse	
☐ Adjudicated sex offender	☐ Substantial perpetrator of sexual abuse
☐ Other adjudication (describe):	☐ Other risk factors (describe):

Source: Adapted from BIE Residential Educational Placement Program forms

Student Reintegration Plan From Residential Treatment Back to Dorm/School Setting

School/Dormitory: _____

Student Name: _____
Date: _____

Describe the components of the reintegration plan in order to assure a smooth and effective transition from the residential facility to the child/youth's dormitory/school.

Date of Plan:_____Plan status: ☐ New ☐ Continued ☐ Revised

1. Skills/supports the student needs in order to be reintegrated into the dorm and school setting.

2. Supports/services the dorm/school needs to adequately program for the student once they return from the residential treatment/care facility:

3. Other agencies which should be involved in this reintegration effort:

4. Person(s) responsible for coordinating the reintegration plan:

5. Target date for student's reintegration:

6. Other pertinent information related to the student's successful reintegration:

Source: Adapted from BIE Residential Educational Placement Program forms

Individual Student Crisis Management Plan

School/Dormitory: _____

Student Name: _____

Date: _____

Situation (triggers/stressors) which may trigger a crisis:
Coping strategies (Describe skills, strategies, to prevent, reduce or de-escalate the crisis for the child/youth:
Describe how the crisis (if one occurs) should be managed:
What should not be done?
Key support people to contact – include names, relationship and contact information:

Note: This plan is recommended for any student who is at high risk for very aggressive/violent or self-injurious behavior. A team including school, dorm, student and parent(s) should complete it.

Source: Adapted from BIE Residential Educational Placement forms

EUFAULA Dormitory Assessment and Evaluation

DATE:
NAME:
DOB:
FLOOR:

IDENTIFYING PROBLEM:

SOURCE OF INFORMATION:

PRESENTING PROBLEM:

REASON PLACED AT DORMITORY:

FAMILY HISTORY:

SOCIAL HISTORY:

EDUCATIONAL LEVEL/HISTORY:

MEDICAL AND PSYCHOLOGICAL HISTORY:

LEGAL HISTORY:

IMPRESSION DURING INTAKE:

SASSI RESULTS:

ART THERAPY TECHNIQUE:

INTERVIEW BEHAVIOR:

DIAGNOSTIC IMPRESSIONS:

INDICATORS SUGGESTED IN ART:

AXIS:

RECOMMENDATIONS:

Appendix 2: Useful Screening Tools and Information

Included in this section are listings of various screening tools and information about where to read more about them and/or obtain them. The screening tools are appropriate for use by the residential program's behavioral health specialist.

Contents of this Appendix:

Strength Based Screening and Assessment Tool

This following information is to be collected through an interview format between student/family and homeliving staff.

Interview Topics for Child/Youth	**Interviewer Comments**
Interests/skills	
Activities in which student has participated	
Significant accomplishment (what is really important to him/her)	
Strengths (academic, social, artistic, creative, cultural, etc.)	
Ways of relaxing and having fun	
Ways of calming down when upset or angry	

Interview Topics for Child/Youth	Interviewer Comments
Closest adults within family and reasons	
Goals for future	
Other	

Parents/Family Member Interview Topics:	**Interviewer Comments**
Jobs, interests, skills of members in family	
Accomplishments of family	
Strengths of family	
Ways of relaxing and having fun as a family	
Ways family (and individual family members) calm down when upset or angry	
Supportive aspects of family	

Parents/Family Member Interview Topics:	**Interviewer Comments**
Supports outside of the family	
Religious affiliations or practices	
Goals for child/youth and family	
Other	

Adapted from Guidelines for Best Practice in Child and Adolescent Mental Health Services, 2005

Summary of Free Assessment Measures

There are a number of assessment measures for behavioral health professionals that are available for free online. Below is a list of recommended tools that can be used in school/dorm behavioral health programs to help assess symptoms of behavioral health issues (e.g. depression, anxiety, ADHD). Also included below are measures to assess school/dorm climate that may also be useful for school/dorm mental health and behavioral health programs/services. **The behavioral health specialist should be the person who conducts and/or facilitates the use of these tools and processes in this listing.**

1. Child Dissociative Checklist (CDC) Version 3

The CDC is a 20-item parent/adult observer report measure of dissociative behaviors for children ages 5 to12. A score of more than 12 warrants additional evaluation. The measure can be accessed at http://www.energyhealing.net/dissoc.htm

2. Narrative Description of Child's Impairment – Home and School Versions

This measure asks parents and teachers to describe the child's primary problem and how this problem has affected functioning with peers, relationship with parents/teacher, academic progress, self-esteem and overall family/classroom functioning. Both the home and school versions can be accessed at

http://ccf.buffalo.edu/resources_downloads.php#GR

3. Parent Version of the Young Mania Rating Scale

This 11- item scale, used for assessing children and adolescents ages 5-17, was adapted from the clinician version of the Young Mania Rating Scale. Parents are asked to rate the severity of manic symptoms and can also be useful in measuring the impact of interventions. The scale takes about 5 minutes to complete. Teachers can also complete the P-YMRS, substituting the word "student" in each item where the word "child" appears. The P-YMRS can be accessed at

http://www.bpkids.org/site/PageServer?pagename=lrn_08_20_03

4. Self-Report for Childhood Anxiety Related Disorders (SCARED)

This measure is designed to screen for anxiety disorders in children ages eight and above. It consists of 41 items that measure general anxiety, separation anxiety, social phobia, school phobia, and physical symptoms of anxiety. Both child self-report and parent report versions of SCARED are available. The child version can be found at http://www.nationwidechildrens.org/Search (search for "SCARED child version" and "SCARED parent version").

5. Strength and Difficulties Questionnaire (SDQ)

The SDQ is a brief behavioral screening questionnaire for children and adolescents ages 3-16. There are several versions of the SDQ including a parent form, a teacher form, a modified form for parents and teachers of nursery school children, and a self-report form for youth aged 11-16. Each form is comprised of 25 items that assess the following 5 domains: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behavior. There is an impact supplement that can also be added to the measures that includes questions about whether the respondent thinks the child has a problem, and if so, enquires further about the chronicity, distress, social impairment and burden to others caused by this problem. These measures can be accessed at http://www.sdqinfo.com/ba2.html.

6. Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

The Y-BOCS is a 40-item measure used by clinicians to assess obsessive-compulsive symptoms in adolescents ages 15 and over. The Y-BOCS rating scale is a gradated scale to measure the severity of OCD symptoms, and can be repeated to measure treatments and interventions. A version of the Y-BOCS is available at

www.brainphysics.com

Source: Adapted from *Summary of Free Assessment Measures*, Center for School Mental Health – University of Maryland, 2008

Evidence-Based Screening Tools

The screening tools listed below are in the public domain and universally available. Scoring and administration information is not electronically available for all of the tools listed from the Center for Children and Families at the University of Buffalo. These tools are not designed to diagnose psychological disorders. However, significant scores on any of these tools may warrant a referral to a qualified professional for a full assessment. **The behavioral health specialist should be the person who conducts and/or facilitates the use of these tools and processes in this listing.**

1. Center of Epidemiological Studies Depression Scale for Children (CES-DC)

The CES-DS is a 20-item self-report depression inventory. Questions focus on how the individual may have felt or acted over the past week. Scores range from 0-60 with a score of 15 or higher being significant of depressive symptoms in children and adolescents.

http://www.brightfutures.org/search/index.html (search "ces-dc").

2. Pediatric Symptom Checklist (PSC)

The PSC is a 35-item self-screen used to identify cognitive, emotional, and behavioral problems in children and adolescents. There are two versions: parent and child. The items on each of the checklists are parallel, i.e., they ask about the same cognitive, emotional or behavioral problems. The parent checklist can be administered regarding children as young as four years old. The youth checklist can be administered to adolescents beginning at age 11 years. Scores may range from 0-70 on both checklists. A score of 28 or higher on the parent checklist indicates psychological impairment for children ages 6-16 years. For children ages 4 and 5 years, the cutoff score on the parent checklist is 24 or higher. The cutoff score for the youth checklist is 30 or higher. If the youth leaves more than four items blank, the response is not considered valid.

http://www.brightfutures.org/search/index.html (search "psc")

3. Spence Children's Anxiety Scale (SCAS)

The SCAS is a 44-item, self-administered tool used to assess anxiety symptoms consistent with the dimensions of anxiety disorder outlined in DSM-IV. These dimensions are generalized anxiety, panic/agoraphobia, social phobia, separation anxiety, obsessive-compulsive disorder, and physical injury fears. The SCAS can be used with children, including preschoolers, and adolescents. There are three versions: child, parent (to be used in conjunction with the children's scale), and parent (preschool child). The items on each of the child and parent (child) scales are parallel, i.e., they ask about the same problems related to anxiety, with the exception of the six, positively worded filler items on the child scale. The website includes extensive materials, including administration, scoring, and research articles.

http://www.scaswebsite.com/

4. CRAFFT Screening Tool

The CRAFFT is a behavioral health-screening tool for use with children and adolescents through age 20. The acronym is derived from key words in each of a series of 6 questions developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously. It is meant to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. This tool is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents.

www.ceasar-boston.org/

5. Child and Adolescent Needs and Strengths (CANS-MH)

The CANS-MH is a comprehensive, 41-item assessment of psychological and social factors for use with children and adolescents with mental, emotional, or behavioral problems that can be administered in approximately 10 minutes. Domains assessed include general symptomology, risk behaviors, developmental functioning, personal/interpersonal functioning, and family functioning. The CANS is designed for

use at two levels: 1) the individual child and family and 2) the system of care. The CANS provides information regarding the child and family's service needs for use during system planning and/or quality assurance monitoring.

http://www.praedfoundation.org/About%20the%20CANS.html

6. CAGE Questionnaire

The CAGE Questionnaire is an internationally used, brief assessment instrument for identifying alcoholics. The acronym comes from key words in each of the four yes-no questions. Two or more affirmative responses are indicative of alcohol dependence. Available information does not indicate if this scale is appropriate for children and/or youth. Consequently, behavioral health professionals should use this tool along with other measures.

http://pubs.niaaa.nih.gov/publications/inscage.htm

7. BASC-2 (Behavior Assessment System for Children, Second Edition)

The BASC is a comprehensive set of rating scales and forms aimed at helping teachers; parents and other service providers understand the behaviors and emotions of children and adolescents. It is also very useful in developing functional behavior assessments, behavior improvement plans and individualized education programs.

www.pearsonassessments.com

8. Beck Depression Inventory (BDI)

The Beck Depression Inventory is a 21-question multiple-choice self-report inventory. It is a widely used instrument for measuring the severity of depression. The questionnaire is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex. The BDI is widely used as an assessment tool by health care professionals and researchers in a variety of settings.

www.pearsonassessments.com

9. Global Appraisal of Individual Needs (GAIN)

The GAIN is a series of measures (screening tool, assessment battery and follow-up assessment battery). In its 99 scales and subscales, it is designed to measure the recency, breadth, and frequency of problems related to substance abuse.

http://www.chestnut.org/li/gain/

10. Resiliency Scales for Children and Adolescents – A Profile of Personal Strengths (RSCA)

The RSCA measures three areas of perceived strength and/or vulnerability related to psychological resilience. The Scales may be used for screening for preventions programs and for referral.

www.pearsonassessments.com

11. Profile of Student Life: Attitudes and Behaviors

This attitudes and behaviors survey not only measures the 40 Developmental assets, it also assesses risk behaviors, thriving indicators, and deficits.

http://www.search-institute.org/survey-services/surveys/attitudes-behaviors

12. Teen Screen Primary Care – National Center for Mental Health Checkups at Columbia University

Teen Screen Primary Care provides free evidence-based screening tools to medical providers. The screening tools help providers determine if their adolescent patients are suffering from depression, anxiety or other conditions. It also ascertains if they are at risk for suicide.

www.teenscreen.org

13. Substance Abuse Subtle Screening Inventory (SASSI)

The SASSI is a brief self-report measure (with separate versions for adolescents and adults). The adolescent SASSI is designed to identify individuals who have a high probability of having a substance use disorder, including both substance abuse and substance dependence www.sassi.com

Center for Children and Families, University of Buffalo Resources

The Center for Children and Families has a variety of tools available to download that assess for behaviors that are related to Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). However, the scoring and administration information is not available for all of these resources. See below.

http://ccf.buffalo.edu/resources_downloads.php

- **Parent/Teacher Disruptive Behavior Disorder Rating Scale** – The 45-item questionnaire is to be completed by the parent and teacher to help determine symptoms of ADHD, oppositional/defiant disorder and conduct disorder. Scoring information is included.
- **Impairment Rating Scales** – This narrative scale is to be completed by the parent and teacher to describe child's behavioral problems and need for treatment. Means, standard deviations, and score distribution are available.
- **Clinical Intake Interview** – This is an extensive interview outline to be administered to parents/guardians.
- **Disruptive Behavior Disorders Structured Interview** – This semi-structured interview consists of DSM-IV symptoms of ADHD, ODD and CD with situational and severity probes.
- **Teacher Behavioral Practices Interview** – This tool assesses teachers' use of and success with classroom management procedures and behavioral interventions, both at the class-wide level and for a targeted child.

- **Teacher Classroom Management Practices Rating Scale** – This checklist assesses 1) teachers' use of and success with behavioral practices in the classroom, and 2) use of non-evidence-based practices for ADHD in the classroom context.

- **Parent Behavior Management Practices Rating Scale** – This checklist assesses 1) parents' use of and success with behavioral practices in the home, and 2) use of non-evidence-based practices for ADHD.

Source: Adapted from *Evidence-Based Screening Tools*, Wisconsin Department of Public Instruction – Student Services, Prevention and Wellness

Psychosocial Screening Overview & Results Chart – Pine Ridge School

Dr. Candace Fleming, University of Colorado, shares the following concerning the psychosocial guide:

The psychosocial guide was developed over the last two decades as a tool to screen for major needs and strengths. The actual questions that are asked are age-appropriate for the child or youth (Grades 1-12). The interviewers have been individuals with masters and doctoral training but the screening was not developed to diagnose the children and youth. The outcome has been to describe the concerns that the youth share with the interviewers and the school staff uses that to reach out to those who appear to be in distress. Sometimes the screening is a false positive, that is, the youth conveys information that suggests distress or risk, but upon a closer look and discussion with parents, teachers, and others, the situation appears less worrisome. There have been enough times that the screening has identified true distress that we have been content to continue to 'throw the net far' knowing that not everyone who gets in the net is experiencing great challenges.

The chart (social screening and results) shows the definitions we have developed over the years for a rating from '1' to '5'. The data within the chart shows how the current screening ratings can be described within gender and age groups. In the past, support groups have been formed using the results so that the counselor and staff time can be efficiently used to share knowledge about common issues raised by the children and youth.

2009 MENTAL HEALTH AND SOCIAL SCREENING RESULTS Residential Program, Pine Ridge School					
	Levels of Intervention				
Children and Youth Were Screened	**[1] Immediate crisis intervention needed; danger to self or others; possibility of abuse or neglect.**	**[2] Needs intervention soon because of acute symptoms or intense situation.**	**[3] Intervention would be helpful in stabilizing a very problematic or unhealthy situation; intervention soon may prevent a crisis.**	**[4] Intervention with educational objective may be helpful and may reduce risk factors and prevent a problematic situation.**	**[5] No immediate intervention needed but supporting resiliency factors in youth would be beneficial.**
Girls: 13	6	1	3	1	2
Boys: 15	2	0	7	4	2
Total: 28	8	1	10	5	4
Grade 2			M		
Grade 3					
Grade 4			M, M		
Grade 5	F, M		M, F		
Grade 6	F			F	
Grade 7	F	F		M	F
Grade 8				M	
Grade 9	F		M, M, M		M
Grade 10	M, F		F	M	
Grade 11	F		F		F, M
Grade 12				M	
Screening Team consisted of 5 pre-doctoral psychology interns from the University of Colorado School of Medicine. Supervision provided by Candace M. Fleming, PhD, Associate Professor, University of Colorado Denver.					

Pine Ridge School Psychosocial Screening

PART I

Student Name:_____Date of Birth:_____

First Name: Middle Name: Last Name:

Lakota or English

Nickname: _____ Gender: Male or Female

Current Grade:____ Age:____

Name(s) of Parent/Guardian the Student Lives With: _____

Address: _____

Home Tel:_____

Relationship of Above Person(s) to Student: ___Parent(s)
___Grandparent(s) ___Other Family ___Non Family

Names/Ages of Siblings:

"Show me where you live on this map."

Tell me about your mother and father.

Is mother living? ___Yes; ___No; ___Don't Know

Is father living? ___Yes; ___No; ___Don't Know

Are parents living together? ___Yes; ___No; ___Don't Know

Is mother employed? ___Yes; ___No; ___Don't Know

Is father employed? ___Yes; ___No; ___Don't Know

Ask the student to draw a picture of his family doing something together (kinetic family drawing):

Ask student to rate his/her relationship with parents/guardians:

Mother:	___Very Good; ___Good; ___Poor; ___Not Applicable
Father:	___Very Good; ___Good; ___Poor; ___Not Applicable
Mother figure:	___Very Good; ___Good; ___Poor; ___Not Applicable
Father figure:	___Very Good; ___Good; ___Poor; ___Not Applicable

If any relationship is poor, describe:

Rate the relationship of this student with siblings/cousins:

___Very Good; ___Good; ___Poor; ___Not Applicable

If any relationship is poor, describe:

ACADEMIC FACTORS:

Everyone is smart in some ways. Some of us are smart in how our body works, like running fast. Some of us are smart in drawing or painting pictures. Some of us are smart in reading or doing arithmetic. Some of are smart in knowing a lot about music. Some of us are smart in being a good friend or listening to others in a respectful way.

What are the ways you show you are smart in school?

What are the ways you struggle in school?

If the teachers could see how you are smart during your out-of-school-time, what would they see?

What do you like best about school?

If you had the power to change this school, what would you make different?

Do you plan to go to college? ___Yes; ___No; ___Don't Know

Career Aspirations:

Activities/Interests/Hobbies:

PEER RELATIONSHIPS:

Do you currently have a friend or two with whom you can talk about important matters? ___Yes; ___No; ___Don't Know

For students 6-12th Grades:

Do you date? _Yes; _No If yes, what is that like? Are you sexually active?

For students 6-12th Grades:

Do the friends of the student date? ___Yes; ___No

If the student could change things about his/her friendships, what would he/she change?

SELF ESTEEM ISSUES:

Think about the person who knows you best.

What would he or she say is terrific about you?

What would he or she say is something you need to improve?

If you had three wishes, what would they be?

PART II

RATINGS FOR THE FOLLOWING PART OF THE INTERVIEW

[+] Child / Youth is experiencing some of the behaviors (thoughts, feelings, actions) associated with the area of concern

[-] Child / Youth is not experiencing any of the behaviors associated with the area of concern

[Not ?] Questions were not asked about the area of concern

[R/O] Child / Youth is experiencing 1 or 2 of the symptoms or behaviors associated with the disorder or area of concern, and a more thorough evaluation should be attempted. Also, the responses of the child/youth do not match other information and a more thorough evaluation may help to understand the needs of the child/youth.

1. Current Physical Health Issues:

___ Respiratory: _____

___ Cardiac: _____

___ Mus/Skel: _____

___ Derm: _____

___ Puberty: _____

___ Vision: _____

___ Oral Health: _____

___ Hearing: _____

___ Other: _____

2. Current Medications:

___ List: _____

3. Family Health: Is anyone in your family sick?

4. Grieving and Bereavement

Describe any recent deaths and losses (past year) that have occurred in this student's family and social circle and how the youth has grieved:

5. Feelings Disorders:

___ Major Depressive Disorder

___ Bipolar Disorder

___ Dysthymic Disorder

In the past month, have you felt sad or lonely? Have you cried easily or often? Do you have trouble going to sleep or staying asleep?

6. Harm to Self and Others:

___ Suicide Ideation, Past 2 months

___ Suicide Ideation, Present (within past two weeks)

___ Suicide Attempt(s), Ever

Actions Taken by Interviewer if active suicidal ideation or recent attempt (past 2 wks):

Have you EVER tried to hurt yourself without wanting to die (cutting)?
__Yes; __No; __Don't Know

Have you EVER thought of killing yourself?

__Yes; __No; __Don't Know

Have you thought of killing yourself in the past month?

__Yes; __No; __Don't Know

Have you EVER attempted to kill yourself?

__Yes; __No; __Don't Know

Have you attempted to kill yourself in the past month?

__Yes; __No; __Don't Know

Has anyone close to you EVER attempted to kill himself or herself?

__Yes; __No; __Don't Know

7. Harm to Others:

___ Bullying Behavior, Past 2 months

___ Intent to seriously hurt another physically, Present (within past two weeks)

Actions Taken by Interviewer if severe violent ideation or recent violence toward another (past 2 wks):

8. Anxiety:

___ Generalized Anxiety Disorder

___ Panic Disorder

___ PTSD

Everyone worries once in a while. In the six months, tell me what has been worrying you.

9. Thought Disorders

___ Schizophrenia

10. Eating Disorders

___Anorexia Nervosa

___Bulimia Nervosa

11. Substance Use Disorders (Past 3 months)

___Alcohol
___Drugs
___Tobacco

Do you use use alcohol? __Yes; __No; __Don't Know

How old were you when you first used alcohol? _____

Do you use use drugs? __Yes; __No; __Don't Know

How old were you when you first used drugs? _____

Do you use tobacco in a non-ceremonial way? __Yes; __No; __Don't Know

Have you ever had treatment in a clinic or hospital for using alcohol and/or drugs?

__Yes; __No; __Don't Know

If yes, "Tell me what that was like for you: What helped you the most?"_

Does anyone close to you use alcohol or drugs in an unhealthy or unsafe way?

__Yes; __No; __Don't Know

If yes, "Tell me what that is like for you."

12. Disruptive Behavior Disorders:

___ Attention Deficit/Hyperactive Disorder

___ Oppositional Defiant Disorder

___ Conduct Disorder

Describe any conduct or legal problems experienced by this student in the past 1-2 years:

13. Other Concerns

___ Physical or Sexual Abuse of Student

___ Neglect of Student

Actions taken by interviewer:

___ Other Psychosocial and Environmental Problems

___ Issues Related to Cultural Identity:

Have you ever talked to a counselor at school or somewhere else?

___Yes; ___No; ___Don'tKnow

What was that like?

Would this student like to talk to a counselor soon? ___Yes; ___No; ___Don't Know

Tell me about some event that is coming up for you.

Thank you for sharing about yourself and the people in your life here at school and at home.

Do you have any questions you would like to ask me?

RECOMMENDATIONS:

1:

2:

_____Date:_____

Signature of Examiner Printed Name of Examiner

Name _____._____Date:_____

Signature of Supervisor

Printed Name of Supervisor

Suicide Assessment Form

STUDENT:_____ DATE:_____

REFERRAL SOURCE:_____

Circumstances Preceding Referral:

Stressors/Precipitants from Student's Perspective:

Ideation

When did student begin to consider suicide?

How often does student think about suicide? _____times per hour/day/week

What does the student say to him/herself when thinking about suicide?

Current Plan

___ yes ___ considering means/vague ___ no

S*pecify:* Time frame_____ Place_____

Means_____

Access to means_____

Self-mutilating behavior?_____

Intent

___ denies ___ endorses ___ unclear/passive ___ evasive

In client's own words, how serious is s/he about enacting suicidal gestures?

Attitude Toward Living/Dying

___ wants to live, gives tangible reasons

___ is not sure, comparable reasons for living and reasons for dying

___ wants to die, sees no reasons for living

Describe:

Presence of Hope

___ believes things can/will be better in future

___ does not believe things can improve

Describe any things client is looking forward to in immediate/distant future:
(e.g., romantic interest's phone call tonight, cousin's baptism tomorrow, camping trip, 10th birthday in one month)

Past Ideation and Attempt/s

When?_____

Frequency?_____ Plan?_____

History of attempts or risky/self-harmful behavior:

Judgment/Impulsivity

___ believes can control own actions

___ afraid s/he will be driven to do something

___ augmenting factors? *(check)*
- __ regular drug/alcohol use
- __ occasional drug/alcohol use
- __ hx. impulse control problems (e.g., ADHD, mania)
- __ hx. thought problems or low functioning (cognitive)

Risk and Mitigating Factors

Risk	Mitigating
Frequent/intrusive ideation___ Planfulness ___ Access to lethal means ___ Clear intent ___ Bias toward death ___ Hopelessness ___ Feels isolated ___ Present suicidal gestures or self-mutilation ___ History of suicidal ideation ___ History of attempt/self-harm ___ Family history of suicide ___ History of friend's suicide/contagion ___ Poor judgment (can include poor/immature understanding of death) ___ Impulsive behavior ___	Supportive family ___ Friends/social network available ___ Supervision by parent/trusted adult ___ Activities/plans in near future ___ Hope regarding future ___ Feels valued by friends/family ___ Willing to contract for safety ___ No history of self-harmful behavior ___

Immediate Intervention Procedures *Check all that are applicable:*

___ School principal was notified. Date:_____ Time:_____
___ Parent/s was notified. Date:_____ Time:_____
___ Certified letter mailed because parent could not be contacted. Date:_____
___ Meeting with parent/s arranged. Date:_____ Time:_____
___ Student given hotline number:
___ Student linked with other staff for additional support:
___ Student encouraged (how) to use support network:
___ Additional safeguards to prevent access to lethal means:
___ Student referred to outside agency:
___ Outside agency notified:
___ Student escorted to/met at ER. Date:_____ Time:_____

Hospital:_____ Inpatient? __ yes __no
___ Safety plan established via written *Contract for Safety* (see attached)
- __ Student able to explain positive aspects of living/express hope/future orientation.
- __ Student has person/s or agency/ies can contact if does not feel safe.
- __ Student understands steps to take if does not feel safe.
- __ Student willing to sign document.

Follow-Up
___ Clinician will phone student/guardian
___ Clinician will meet with student/guardian
___ Clinician will contact agency: Date:_____

Case Disposition: *when situation is stabilized*

_____ _____
Clinician Signature/Degree Date

Source: Developed by the University of Maryland – School Mental Health Program 2008

Center for Epidemiological Studies – Depression Scale for Children (CES-DC)

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Each response to an item is scored as follows:

- 0 = "Not At All"
- 1 = "A Little"
- 2 = "Some"
- 3 = "A Lot"

However, items 4, 8, 12, and 16 are phrased positively, and thus are scored in the opposite order:

- 3 = "Not At All"
- 2 = "A Little"
- 1 = "Some"
- 0 = "A Lot"

Higher CES-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. That is, scores over 15 can be indicative of significant levels of depressive symptoms. Remember that screening for depression can be complex and is only an initial step. Further evaluation is required for children and adolescents identified through a screening process. Further evaluation is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.

REFERENCES

Weissman MM, Orvaschel H, Padian N. 1980. Children's symptom and social functioning self report scales: Comparison of mothers' and children's reports. *Journal of Nervous Mental* Disorders 168(12):736–740. Faulstich ME, Carey MP, Ruggiero L, et al. 1986

The CES-DC scale follows.

CES-DC – Depression Scale for Children				
During the Past Week	**Not at all**	**A Little**	**Some**	**A Lot**
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating. I wasn't very hungry.				
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.				
4. I feel like I was just as good as the other kids.				
5. I feel like I couldn't pay attention to what I was doing.				
6. I felt down and unhappy.				
7. I felt like I was too tired to do things.				
8. I felt like something good was going to happen.				
9. I felt like things I did before didn't work out right.				
10. I felt scared.				
11. I didn't sleep as well as I usually sleep.				
12. I was happy.				
13. I was more quiet than usual.				
14. I felt lonely, like I didn't have any friends.				
15. I felt like kids I know were not friendly or that they didn't want to be with me.				
16. I had a good time.				
17. I felt like crying.				
18. I felt sad.				
19. I felt people didn't like me.				
20. It was hard to get started doing things.				

Number _____
Score _____

Source: Bright Futures * Tools for Professionals, Georgetown University

Rosenberg Self-Esteem Scale

The Rosenberg self-esteem scale was developed by Morris Rosenberg, Ph.D. (deceased) in 1965. (Reference: Society and The adolescent Self-Image. Princeton, N.J.: Princeton University Press.) The scale can be used to assess global self-esteem and it is one of the most widely used self-esteem tests among psychologists and sociologists.

The scale is a ten-item Likert scale with items answered on a four-point scale - from strongly agrees to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and seniors from 10 randomly selected schools in New York State.

Instructions: Below is a list of statements dealing with your general feelings about yourself.
If you strongly agree, circle SA. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.

Feeling Statement	Strongly Agree SA	Agree A	Disagree D	Strongly Disagree SD
On the whole, I am satisfied with myself.				
At times, I think I am no good at all.				
I feel that I have a number of good qualities.				
I am able to do things as well as most other people.				
I feel I do not have much to be proud of.				
I certainly feel useless at times.				
I feel that I'm a person of worth, at least on an equal plane with others.				
I wish I could have more respect for myself.				
All in all, I am inclined to feel that I am a failure.				
I take a positive attitude toward myself.				

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score, the higher the self-esteem. Scores below 15 suggest low self-esteem.

Appendix 3: Resources for Behavioral Health Prevention and Intervention Services

Included in this section are resources related to curriculum, products, children and youth books and websites tools useful in prevention and intervention strategies. They are:

1. Resources for Behavioral Health Services Curriculum and Services.
2. Behavioral Health Products.
3. Children and Youth Books Related to Social, Emotional and Behavioral Topics.
4. Websites Related to Behavioral Health.

Resources for Behavioral Health Curriculum and Services

Once you get to the Internet site, you will need to use the search tool on the web page to find the specific product.

Project/Material Name	Target Population	Description	Focus
Promoting Alternative Thinking Strategies (PATHS) www.channing-bete.com	Grades Pre-K to 5th	❍ Taught 3 times per week/20 to 30 minutes per day ❍ Developmentally based lessons, materials and instructions	❍ Social and emotional competence ❍ Aggression ❍ Behavior problems
Stop & Think Social Skills Program www.projectachieve.info	Grades Pre-K to 8	❍ Involves 5 components: teaching steps of skill, modeling, role play, feedback and applying skill	❍ Practical skills to help students manage their own behavior ❍ Ignoring ❍ Accepting consequences
Steps to Respect www.cfchildren.org/programs/str/overview	Grades 3 – 6	❍ 11 skill building lessons and 2 literature unit selections ❍ 20 – 30 minute lessons	❍ Recognize and refuse bullying ❍ Maintain friendships ❍ Resolve conflicts
Second Step www.cfchildren.org/programs/str/overview	Grades Pre-K to 9	❍ Pre-K to 5 are taught 20 – 25 lessons ❍ 6 –9 are taught 8 lessons	❍ Anger management ❍ Social skills ❍ Decision making ❍ Choosing positive goals ❍ Reducing impulsivity
Cognitive Behavioral Interventions for Trauma in	Age 10-15	❍ 10 group sessions with 6 -8 students	❍ Education about reactions to trauma ❍ Relaxation

Project/Material Name	Target Population	Description	Focus
Schools (CBITS) www.sopriswest.com		per group ❍ One time per week for 1 hour	❍ Social problem solving
Lion's Quest Skills for Adolescence www.lions-quest.org/curriculum	Grades 6 – 8	❍ 102 skills building lessons ❍ Service learning included	❍ Positive contributions to community ❍ Effective communication ❍ Resist negative peer pressure
All Stars www.allstarsprevention.com/programs.asp	Age 11 – 14	❍ 13 lessons, 45 minutes ❍ Weekly basis	❍ Developing positive ideals ❍ Building strong personal commitments ❍ Increasing positive parental attentiveness
SMARTteam (Students Managing Anger and Resolution Together) www.lmssite.com/	Age 11 – 15	❍ Multi-media, computer based ❍ Games, graphics, simulations, cartoons, and interactive interviews	❍ Violence prevention
I Can Problem-Solve www.researchpress.com	Grades Pre-K - 6	❍ Pre – K 59 lessons ❍ K – 3 83 lessons ❍ 4 – 6 77 lessons	❍ Violence prevention ❍ Resolving interpersonal problems
Coping Cat C.A.T. Project www.amazon.com	Age 8 – 13 Age 14 - 17	❍ Groups for 16 sessions	❍ Recognizing and analyzing anxious feelings ❍ Coping with anxiety-provoking situations
Positive Action www.positiveaction.net	Age 5 – 18	❍ Based on Thoughts-Action-Feelings Circle ❍ Contains instructor's manual and scripted 15 minute lessons	❍ Positive actions for the physical, intellectual, social and emotional areas of self

Project/Material Name	Target Population	Description	Focus
		❍ Student activity books & journals	
PREPaRE Curriculum www.nasponline.org/prepare/curriculum.aspx	Grades 7 – 12	❍ 10 course length interventions	❍ Stress reduction ❍ Reducing aggression ❍ Reducing prejudice
EQUIP Program www.researchpress.com		❍ 3 part intervention method	❍ Anger management ❍ Pro-social skills ❍
Aggression Replacement Training (ART) www.researchpress.com	Age 12- 17	❍ Groups – 1 hour, 3 times per week	❍ Pro-social skills ❍ Anger management ❍ Moral reasoning
CARE (Care, Assess, Respond, Empower) www.reconnectingyouth.com	Age 13 – 17	❍ Begins with suicide assessment ❍ Motivational counseling and social support intervention	❍ Suicide prevention for high-risk youth
Life Skills Training www.lifeskillstraining.com	Age 8 – 14	❍ 3 components ❍ Can be taught in school or after-school settings	❍ Self esteem ❍ Confidence ❍ Coping skills ❍ Substance abuse
Project ALERT www.projectalert.com	Age 12 - 14	❍ 11 lessons – one time per week ❍ 2 year curriculum ❍ Small group activities, role play, real life videos	❍ Substance abuse prevention
Teaching Students to be Peacemakers	K – 12	❍ 20 segments – 30 minutes long	❍ Conflict resolution

Project/Material Name	Target Population	Description	Focus
www.co-operation.org/pages/materials.html			
Girls Circle www.girlscircle.com	Age 9 – 18	❍ Circles are held weekly for 1 ½ to 2 hours ❍ Girls take turns talking and listening to one another about their concerns and interests ❍ Role play, journaling, collage, clay, etc.	❍ Resiliency practices
Success in Stages: Build Respect, Stop Bullying www.samhsa.gov	Grades K – 12	❍ Series of small group activities and lessons	❍ Bullying
PENN Resiliency Program www.ppc.sas.upenn.edu/prpsum.htm	Grades 4 – 8	❍ 12 lessons – 90 minutes or 18 – 24 – 60 minutes ❍ Skits, role play, short stories, cartoons	❍ Resilience
TRIBE: Conflict Resolution Curriculum for High School Mediation Network of North Carolina www.mnnc.org	Grades 9 - 12	❍ Spiral bound paper back	❍ Conflict resolution
Elementary, Middle, and High School Guidance Curriculum	Grades K - 12	❍ Can be addressed in school or in an	❍ Covers a wide range of skills & topics related to academic, personal-social skills and

Project/Material Name	Target Population	Description	Focus
Activity books (Based on the American School Counselor Association Model) www.hyalite.biz		alternative setting	career areas
Flirting or Hurting www.wcwonline.org	Grades 6 – 12	❍ Easy to adapt curriculum ❍ Includes discussion and activities ❍ Role plays	❍ Student to student sexual harassment in schools
In Touch With Teens Curriculum www.peaceoverviolence.org	Grades 7 – 12	❍ 8 Units	❍ Sexual harassment prevention ❍ Power and control ❍ Healthy relationships ❍ Dating violence
The Youth Relationships Manual: A Group Approach with Adolescents for the Prevention of Woman Abuse and the Promotion of Healthy Relationships www.amazon.com	Grade 7 – 12	❍ 18 session group training	❍ Relationship violence prevention training
It Ain't Love Olmos Productions www.transformingcommunities.org/tctatsite/tools/tit_aint_love.html	Grades 7 - 12	❍ Video and study guide ❍ Strong language advisory	❍ Teen dating violence
Violence Prevention Curriculum for Adolescents www.amazon.com	Grades 7 – 12	❍ 10 sessions	❍ Awareness of homicide and associated factors, positive ways to deal with hostility, disputes – how they begin and how they escalate, alternatives to fighting

Project/Material Name	Target Population	Description	Focus
Native Stand www.ncsddc.org/2505.xml	Grades 7 - 12	❍	❍ Comprehensive curriculum training peer educator ❍ Promotes healthy decision making
American Indian Life Skills Development/Zuni Life Skills Development http://uwpress.wisc.edu/books/0129.htm	Age 15 – 24	❍ 28 – 56 lessons	❍ Building self esteem ❍ Increasing communication and problem solving skills ❍ Eliminating self destructive behavior

Children/Youth Books Related to Social, Emotional and Behavioral Topics

When children are experiencing difficulties in their daily lives, reading about characters with similar problems can help them cope. Most of the books in this list are fiction; there are a few non-fiction books focusing on techniques and skill building. Purchase information can be obtained by using a "search" tool on your computer, such as Google. Type in the name of the book and author to find out where to purchase the book. Check with your school's library – they may have some of these books or may be interested in collaborating in the purchase.

- Alexander, Claire. *Lucy and the Bully*. Ages 3-10.
- Alexander, Martha. *Move Over, Twerp*. Ages 4-8.
- Anderson, Hans Christian. *The Ugly Duckling.*
- Anholt, Laurence. *Camille and the Sunflowers.* Grades 1 – 4.
- Applegate, Katherine. *Home of the Brave*. Ages 9-14.
- Bang, Molly. *Tiger's Fall.* Ages 8 – 12l
- Bateman, Teresa. *The Bully Blockers Club*. Ages 5-10.
- Berenstain, Stan and Jan. *The Berenstain Bears and the Bully.* Ages 4-8.
- Berenstain, Stan and Jan. *The Berenstain Bears and Too Much Teasing.* Ages 4-8.
- Berry, Joy. *Being Bullied*. Ages 4-6.
- Blanco, Jodee. *Please Stop Laughing at Me: One Woman's Inspirational Story*. Ages 12 to adult.
- Blanco, Jodee. *Please Stop Laughing at Us: One Survivor's Extraordinary Quest to Prevent School Bullying.* Ages 12-adult.
- Blume, Judy. *Blubber*. Ages 8-12.
- Bomberge, Jane. *Benny Gets a Bully Ache.* Ages 4-8.
- Bosch, Carl. *Bully on the Bus.* Ages 6-12.
- Brown, Marc. *Arthur's April Fool*. Ages 6-10.
- Bruchac, Joseph. *Bearwalker*. Ages 10-15.
- Carlson, Nancy. *Loudmouth George and the Sixth Grade Bully.* Ages 4-8.
- Carey, Janet Lee. *Wenny Has Wings.* Grades 4 – 6.
- Clifton, Lucille. *My Friend Jacob.* Grades 1 – 4.
- Cohen-Posey, Kate. *How to Handle Bullies, Teasers and Other Meanies: A Book that Takes the Nuisance Out of Name Calling and Other Nonsense.* Ages 9+
- Coughlin, Denise. *Dragon in my Pocket.*
- Curtis, Jamie Lee. *Today I Feel Silly and Other Moods That Make My Day.* Ages 4 – 8.
- Dane, Marion Bauer. *On My Honor.* Grades 4 - 6
- *Dissed-Respect: The Impact of Bullying.* Center for Diversity (CDPI) of Plattsburgh State University and Mountain Lake PBS' Media Lab, 2006. Ages 5-15.
- *Don't Laugh at Me*. Video featuring Peter Yarrow of Peter, Paul, and Mary, who

talks about bullying and sings a song about it. Operation Respect. Ages 6-15.

- Dreyer, Ann L. *After Elaine.* Grades 4 – 8.
- Duncan, Riana. *When Emily Woke Up Angry.* Ages 4 – 8.
- Estes, E. *The Hundred Dresses*. Ages 8-12.
- Fierstein, Harvey. *The Sissy Duckling*. Ages 4-9.
- Fitzhugh, Louise. *Harriet the Spy*. Ages 9-13.
- Franklin, Kristine L. *Lone Wolf.* Grades 4 – 7.
- Hazelden, Marianne Johnston. *Dealing with Bullying.* Ages 4-8.
- Heller, Janet Ruth. *How the Moon Regained Her Shape.* Ages 2-12.
- Henkes, Kevin. *Chrysanthemum*. Ages 4-8.
- Hiaasen, Carl. *Hoot*. Ages 8-13.
- Kaufman, Gershen, and Lev Raphael. *Stick Up for Yourself.* Ages 10+ (nonfiction).
- Keats, Erza Jack. *Peter's Chair.* Ages 4 – 8.
- LeShan, Eda. *When Kids Drive Kids Crazy: How to Get along with Your Friends and Enemies.* Ages 9-12. (Nonfiction)
- Lovell, Patty. *Stand Tall.*
- Ludwig, Trudy. *My Secret Bully*. Ages 7-12.
- Ludwig, Trudy. *Just Kidding*. Illus. Ages 7-12.
- MacDonald, Betty Bard. *"The Bully." Hello, Mrs. Piggle-Wiggle*. Ages 4-10.
- McDonald, Megan. *The Potato Man.* Grades 2 – 5.
- McCain, Becky Ray. *Nobody Knew What to Do: A Story about Bullying*. I. Ages 4-12.
- McCloud, Carol. *Have You Filled Your Bucket Today: A Guide for Daily Happiness for Kids.* Ages 4-8.
- Moser, Adolph. *Don't Feed the Monster on Tuesday*. Ages 4-10.
- O'Neill, Alexis. The Recess Queen. Ages 3-9.
- Paterson, Katherine. *The Flip Flop Girl.* Grades 4 – 6.
- Payne, Lauren Murphy. *We Can Get Along: A Child's Book of Choices.* Grades Pre-K – 3.
- Rochman, H., and D. McCampbell. *Who Do You Think You Are?* Ages 12+
- Romain, Trevor. *Bullies Are a Pain in the Brain*. Ages 8-14. (Nonfiction)
- Seskin, Steve, and Allen Shamblin. *Don't Laugh at Me.* Illus. Ages 5-12.
- Thomas, Pat. *Stop Picking on Me: A First Look at Bullying*. Ages 4-8. (Nonfiction)
- Ure, Jean. *Skinny Melon and Me.* Ages 9 – 14.
- Walker, A. *Finding the Greenstone*. Ages 6-12.
- Webster-Doyle, Terrence. *Why Is Everybody Always Picking on Me?: A Guide to Understanding Bullies for Young People.* Ages 8-12. (Nonfiction

Helpful Websites

(1) Adults and Children Together Against Violence
www.actagainstviolence.org/
(2) American Association of School Counselors
www.schoolcounselor.org/
(3) Center for the Prevention of School Violence
www.aasa.org
(4) Center for Social and Emotional Education
www.bullybust.org
(5) Center for the Study and Prevention of Violence
www.Colorado.EDU/cspv/index.html
(6) Center for School Mental Health
http://csmh.umaryland.edu/who/
(7) Center for Substance Abuse Prevention
www.prevention.samhsa.gov
(8) Indian Health Service
www.ihs.gov/MedicalPrograms/Behavioral
(9) Institute on Violent and Destructive Behavior
www.uoregon.edu/~ivdb/
(10) National Center for Conflict Resolution Education
www.nccre.org/
(11) National Child Traumatic Stress Network
www.nctsnet.org
(12) National Mental Health Association
www.nmha.org
(13) National Youth Violence Prevention Project
www.gucchd.georgetown.edu/
(14) National Youth Violence Prevention Resource Center
www.safeyouth.org/scripts/index.asp
(15) Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.org/
(16) Positive Behavioral Interventions and Supports
www.pbis.org/
(17) School Mental Health Organization
www.schoolmentalhealth.org
(18) Search Institute (Developmental Assets)
http://www.search-institute.org/developmental-assets
(19) Stop Bullying Now
www.stopbullyingnow.hrsa.gov/
(20) Substance Abuse and Mental Health Administration
www.samhsa.gov/

Appendix 4: Evaluation of Behavioral Health Programs and Services

In order to enhance the quality of behavioral health programs and services, routine and frequent evaluation measures are needed. In determining the effectiveness of behavioral health programs and services, three levels of information should be collected. They are:

- Data related to overall program components typically referred to as *quality indicators.*
- Information related to services provided to individual students and the effectiveness/results of preventative activities, screenings, assessment and treatment plans. This type of information can be gathered from students and families. This area is often referred to measurement of satisfaction.
- Data collected by service providers regarding number of referrals, evidence based and culturally based interventions used, positive case closings, etc.

Included in the remainder of this appendix are examples of tools that can be used for behavioral health program evaluation.

1. Behavioral Health Services Self-Assessment.
2. Youth Services Survey.
3. Youth Services Survey for Families.
4. How to Determine if your Dorm is Safe, Secure and Orderly.

Behavioral Health Services Self-Assessment

Quality Indicator - Philosophy	We're There…	Sort of….	Not even close….
1. We have a shared belief that providing behavioral health services is the responsibility of our homeliving program.			
2. We have a commitment to provide a welcoming, caring and supportive environment within our homeliving program.			
3. We understand the importance of collaborative efforts between school and residential staff to support the academic, social, cultural and emotional development of children/youth.			
4. We believe in the importance of a cultural-based approach to providing behavioral health services.			
5. We are committed to reaching out and linking with the community and tribe to support us in providing needed behavioral health services.			

Quality Indicator – Behavioral Health Services Program Components	We're there…	Not sure…	Not even close…If
1. We have in place a variety of preventative activities and strategies, which are implemented in the dorm (and school, as appropriate).			
2. We have a variety of methods in place in the dormitory, which promote healthy life styles.			
3. We provide education/training for students in the area of substance abuse, conflict resolution, resiliency, bullying, anger management, etc. (dorm, school and/or combination).			
4. We have behavior health professionals employed, contracted or available through an interagency agreement.			
5. We provide, or facilitate the following behavioral health services: ➢ Screenings ➢ Support groups ➢ Individual and small group counseling ➢ Crisis intervention ➢ Treatment			

Quality Indicator – Behavioral Health Services Program Components	We're there…	Not sure…	Not even close…If
➢ Referrals to community service providers			
6. Our behavioral health services (contracted or our own staff) are available to work with children and youth in the evenings and weekends.			
7. We have procedures that allow for the identification of emotional and behavioral needs in a timely manner.			
8. We have developed a behavioral health resource map, which identifies all community and tribal behavioral health resources and service providers.			
9. We have linked with all appropriate community and tribal providers and meet on a regular basis.			
10. We incorporate evidence-based and culturally based practices in our preventative, screening, assessment, counseling, and other intervention and treatment services.			

Quality Indicator – Assessment	We're There…	Sort of…	Not even close…
1. We ensure that families, and students (as appropriate) are meaningfully involved in treatment planning and on-going therapy.			
2. We have developed and implemented several strategies to evaluate our behavioral health services and programs (related to our entire program/system and individually related to each student).			
3. We have procedures and policies in place to ensure that information is appropriately shared, consent obtained when needed, and student and family confidentiality is protected.			
4. We collect and review data related to student's emotional and behavioral issues, and intervention success.			
5. We obtain measures of satisfaction regarding our behavioral health services from students, staff (school and dorm), parents and community providers			

Youth Services Survey (YSS)

Please help our dormitory make services better by answering some questions about the services you received over the last 6 months. Your answers are confidential and will not influence the services you receive or how staff treats you. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statements below. Put an X in the box that best describes your answer. Thank you!

Questions	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services I received.					
2. I helped to choose my services.					
3. I helped to choose my treatment goals.					
4. The people helping me stuck with me no matter what.					
5. I felt I had someone to talk to when I was troubled.					
6. I participated in my own treatment.					
7. I received services that were right for me.					
8. The location of services was convenient.					
9. Services were available at times that were convenient for me.					
10. I got the help I wanted.					
11. I got as much help as I needed.					
12. Staff treated me with respect.					
13. Staff respected my family's religious, spiritual and cultural beliefs					
14. Staff spoke to me in a way that I understood.					
15. Staff were sensitive to my cultural/ethnic background.					
As a result of the services I received:					
16. I am better at handling daily life.					

Questions	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
17. I get along better with family members.					
18. I get along better with friends and other people.					
19. I am doing better in school and/or work.					
20. I am better able to cope when things go wrong.					
21. I am satisfied with my family life right now.					

22. What has been the most helpful thing about the services you received over the last 6 months?

23. What would improve the services here?

24. How long did you receive behavioral health services from the homeliving program?
    - ☐ Less than 1 month
    - ☐ 1 – 2 months
    - ☐ 3 – 5 months
    - ☐ 6 months to 1 year
    - ☐ More than 1 year

25. Are you still getting behavioral health services from the dorm?
    ☐ Yes ☐ No

26. When not living in the dorm, are you currently living with one or both parents?
    ☐ Yes ☐ No

27. Have you lived in any of the following places in the last 6 months? Check all that apply.

☐ With one or both parents
☐ With another family member
☐ Foster home
☐ Homeless shelter
☐ Group home
☐ Residential treatment center
☐ Hospital
☐ Jail or detention facility
☐ Correctional facility
☐ Homeless/on the streets
☐ Other, please describe:

28. In the last year, did you see a medical doctor or nurse for a health check up or because you were sick? Check one.

☐ Yes, in a clinic or office
☐ Yes, in a hospital emergency room
☐ No
☐ Don't remember

29. Are you on medication for emotional/behavioral problems?

☐ Yes ☐ No

If yes, did the doctor or nurse tell you what side effects to watch for?

☐ Yes ☐ No

30. In the last month, did you get arrested by the police? ☐ Yes ☐ No

31. In the last month, did you go to court for something you did?

☐ Yes ☐ No

32. How often were you absent from school during the last month?
    - ☐ 1 day or less
    - ☐ 2 days
    - ☐ 3 to 5 days
    - ☐ 6 to 10 days
    - ☐ More than 10 days
    - ☐ Don't remember

Please answer the following questions to let us know a little about you.

Gender: ☐ Male

☐ Female

Birth Date: _____

Today's Date: _____

Thanks for taking the time to answer these questions.

Adapted from *The Youth Services Survey, which* was developed as part of the State Indicator Project funded by the Center for Mental Health Services. Molly Brunk, Ph.D., 1999

Youth Services Survey For Families (YSS-F)

Please help our agency make services better by answering some questions about the services your child received **OVER THE LAST 6 MONTHS.** Your answers are confidential and will not influence the services you or your child receives. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statements below. Put a cross **(X)** in the box that best describes your answer. Thank you!!!

Questions	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services my child received.					
2. I helped to choose my services.					
3. I helped to choose my child's treatment goals.					
4. The people helping my child stuck with us no matter what.					
5. I felt my child had someone to talk to when he/she was troubled.					
6. I participated in my child's treatment.					
7. The services my child and/or family received were just right for us.					
8. The location of services was convenient for us.					
9. Services were available at times that were convenient for us.					
10. My family got the help we wanted for our child.					
11. My family got as much help, as we needed for my child.					
12. Staff treated me with respect.					
13. Staff respected my family's religious, spiritual and cultural beliefs					
14. Staff spoke to me in a way that I understood.					
15. Staff were sensitive to my cultural/ethnic background.					

Questions	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
As a result of the services my child and/or family received:					
16. My child is better at handling daily life.					
17. My child gets along better with family members.					
18. My child gets along better with friends and other people.					
19. My child is doing better in school and/or work.					
20. My child is better able to cope when things go wrong.					
21. I am satisfied with our family life right now.					

22. What has been the most helpful thing about the services you and your child received over the **last 6 months**?

23. What would improve the services here?

Please answer the following questions to let us know how your child is doing.

24. How long did your child receive services from this Center?

- ☐ a. Less than 1 month
- ☐ b. 1 -2 month
- ☐ c. 3-5 months
- ☐ d. 6 months to 1 year
- ☐ e. More than 1 year

25. Is your child still getting services from this Center? ☐ Yes ☐ No

26. Is your child currently living with you? ☐ Yes ☐ No

27. Has your child lived in any of the following places in the **last 6 months**? (CHECK ALL THAT APPLY)

- ☐ a. With one or both parents
- ☐ b. With another family member
- ☐ c. Foster home
- ☐ g. Group home
- ☐ h. Residential treatment center
- ☐ i. Hospital

☐ d. Therapeutic foster home
☐ e. Crisis Shelter
☐ f. Homeless shelter
☐ j. Local jail or detention facility
☐ k. State correctional facility
☐ l. Runaway/homeless/on the streets
☐ m. Other (describe): _____

28. In the last year, did your child see a medical doctor (or nurse) for a health check up or because he/she was sick? (Check one)

☐ Yes, in a clinic or office ☐ Yes, but only in a hospital emergency room ☐ No ☐ Do not remember

29. Is your child on medication for emotional/behavioral problems? ☐ Yes ☐ No
29a. If yes, did the doctor or nurse tell you and/or your child what side effects to watch for? ☐ Yes ☐ No

30. In the last month, did your child get arrested by the police? ☐ Yes ☐ No

31. In the last month, did your child go to court for something he/she did? ☐ Yes ☐ No

32. How often was your child absent from school during the last month?

☐ 1 day or less
☐ 2 days
☐ 3 to 5 days
☐ 6 to 10 days
☐ More than 10 days
☐ Not applicable/ not in school
☐ Do not remember

Please answer the following questions to let us know a little about your child.

Child's Race: (Check two if needed)
____ American Indian/Alaskan Native ____ White (Caucasian) ____ Black (African American)
____ Asian/Pacific Islander ____ Other: Describe _____
____

Are either of the child's parents Spanish/Hispanic/Latino? _____ Yes ____ No
Child's Birth Date: __

Child's Gender: ____ Male ____ Female

Does your child have Medicaid insurance? _____ Yes _____ No

Thank you for taking the time to answer these questions!

Adapted from *The Youth Services Survey for Families, which* was developed as part of the State Indicator Project funded by the Center for Mental Health Services. Molly Brunk, Ph.D., 1999

Effectiveness of Services/Interventions Provided by Behavioral Health Provider – Self-Assessment

Name of Client: _____
Name of Provider: _____
Date: _____

Questions	Yes	No	Not Sure
1. Did I establish rapport with the individual?			
2. Did I show respect and care for the individual?			
3. Is the intervention/treatment meaningful and practical?			
4. Is the intervention/treatment evidence and culturally based?			
5. Did I collaborate and communicate with others as appropriate?			
6. Did I actively involve the individual, family and dorm/school staff members in the development, implementation and outcome/effectiveness evaluation of the intervention?			
7. My written reports are clear and comprehensive?			
8. Other:			

How to Determine if Your Dorm is Secure, Safe and Orderly

This chart may be useful in beginning the discussion about dormitory safety. The school/dorm's Continuity of Operations Plan (COOP) also focuses on these areas. For more information and resources in the area of school and dormitory safety, contact the BIE School Safety Specialists: Eric North – 505-563-5240 OR Desmond Jones – 928-871-5942.

A SECURE DORM	**SAFE DORM**	**ORDERLY DORM**
A "secure dorm" is one whose physical features, layout and policies and procedures are designed to minimize the impact of intrusions that might prevent the dorm from fulfilling its homeliving mission.	A "safe dorm" is one whose climate is free of fear. The perceptions, feelings, and behaviors of those who live in the dorm reveal that the dorm is a place where children, youth and staff members are comfortable and are able to go about their business without concern for their safety.	An "orderly dorm" is one characterized by a climate of respect. Children and youth relate to each other and staff members in acceptable ways. Expectations about what is acceptable behavior are clearly stated, and consequences for unacceptable behavior are known and applied when appropriate.
INDICATORS OF A SECURE DORM The existence and execution of a plan, policies, and procedures that address the "security" of the dorm. **Measures:** ➨ Number of trespassers ➨ Number of stealing incidents ➨ Number of firearms ➨ Number of weapons other than firearms ➨ Number of incidents of damage and destruction by children/youth to building and materials ➨ Substance abuse incidents	**INDICATORS OF A SAFE DORM** The existence and execution of a plan, policies, and procedures that address the "safety" of the dorm. **Measures:** ➨ Results from surveys of dorm students, staff members, parents, the community at-large ➨ Absenteeism from school ➨ Being gone from the dorm when school is in session	**INDICATORS OF AN ORDERLY DORM** The existence and execution of a plan, policies and procedures that address the "orderliness" of the dorm. **Measures:** ➨ Incident reports ➨ Number of suspensions
EVALUATING A DORM'S SECURITY To evaluate the "security" of a dorm, continuous assessments of the physical features, layout, staffing needs, and policies and procedures need to occur. Knowledge gained from these assessments needs to be incorporated into the safe dormitory plan and translated into action. Adjustments need to be made when appropriate.	**EVALUATING A DORM'S SAFETY** To evaluate the "safety" of a dorm, assessments of the safety concerns of all involved, through surveys, or other means, need to occur. Information from assessments is used in the creation of the safe dormitory plan so that safety concerns can be addressed. Continuous measurement of safety concerns takes place so that actions can be adjusted to address concerns.	**EVALUATING A DORM'S ORDERLINESS** To evaluate the "orderliness" of a dorm, assessments of the reasons for disorder need to occur. From these assessments, a code of conduct reflecting behavioral expectations can be established as part of the safe dorm plan. Review of the reasons for disorder should help establish the code of conduct. Adjustments to the code should be made based upon continuous review of the dorm's "orderliness."

Adapted from: Center for Mental Health in Schools at UCLA. (2007 Revision). Violence Prevention and Safe Schools. Los Angeles, CA: Author

Appendix 5: Residential Programs by Agency

Location Code	Name of School	Grades Served	# of Dorms
Billings			
D51N03-B	Blackfeet Boarding Dormitory **(P)**	1-12	1
Cheyenne River Agency			
D01N12-B	Cheyenne-Eagle Butte School	K-12	2
D01N14-G	Pierre Indian Learning Center	1-8	
Arizona Navajo Central (Chinle)			
D35N20-B	Chinle Boarding School	K-8	
D35N07-G	Lukachukai Community School	K-8	
D35N21-B	Many Farms High School	9-12	
D35N09-G	Nazlini Community School	K-6	
D35N10-G	Pinon Community School **(CP)**	K-12	
D35N12-G	Rough Rock Community School	K-12	
D35N06-G	Jeehdeeza Academy, Inc. (Low Mt)	K-5	7
Crow Creek/Lower Brule			
D14N04-G	Crow Creek Reservation High School	6-12	
D70N02-B**	Flandreau Indian School	9-12	2
New Mexico Navajo Central (Eastern Navajo Agency)			
D34N05-B	Chi-Chil'tah (Jones Community School)	K-7	
D34N24-B	Dzilth-Na-Dith-Hle CommunitySchool	9-12	
D34N0-G	Hanaa/dli School/Dorm (Huerfano) **(GP)**	K-12	
D34N10-B	Lake Valley Navajo School	K-8	
D34N12-B	Mariano Lake Community School	K-6	
D34N15-B	Pueblo Pintado Community School	K-8	
D34N23-B	Crownpoint (T'iists'oozi'bi'olta	K-8	
D34N20-B	Wingate Elementary School	K-8	
D34N21-B	Wingate High School	9-12	9

Location Code	Name of School	Grades Served	# of Dorms
Arizona Navajo South (Fort Defiance Agency)			
D36N03-G	Ch'ooshgai CommunitySchool (Chuska)	K-8	
D36N05-B	Crystal Boarding School	K-6	
D36N06-G	Dilcon Community School	K-8	
D36N08-G	Greasewood Springs Community School	K-8	
D36N09-G	Tiisyaatin Holbrook Dormitory **(GP)**	9-12	
D36N11-B	Hunter's Point Boarding School	K-5	
D36N19-B	Seba Dalkai Boarding School	K-8	
D36N24-G	Wide Ruins Community School	K-6	
D36N25-G	Winslow Residential Hall **(GP)**	7-12	9
Minneapolis Area			
D80N02-G**	Circle of Nations	5-8	1
New Mexico North (Northern Pueblos Agency)			
D25N33-G	Jicarilla Dormitory **(GP)**	1-12	
D25N32-G	Santa Fe Indian School	7-12	2
Oklahoma Area			
D03N02-G	Chickasaw Children's Village **(GP)**	1-12	
D07N02-G	Eufaula Dormitory **(GP)**	1-12	
D09N02-G	Jones Academy **(GP)**	1-12	
D01N02-B**	Riverside Indian School	4-12	
D08N02-G	Sequoyah High School	9-12	5
Arizona South (Papago/Pima Agency/Ft. Apache)			
D54N21-B	Santa Rosa Boarding School	K-8	
D52N21-G	Theodore Roosevelt School	6-8	2
Pine Ridge Agency			
D06N16-B	Pine Ridge School	K-12	1
Seattle (Portland Area)			
D02N02-B**	Chemawa Indian School	9-12	2
D03N03-G	Paschal Sherman Indian School	K-9	
Rosebud Agency			
D07N12-G	Marty Indian School	K-12	2
D07N10-G	Sicangu Owaye Oti (Rosebud D) **(GP)**	l-12	

Location Code	Name of School	Grades Served	# of Dorms
Sacramento Area			
D60N02-B**	Sherman Indian High School	9-12	1
New Mexico Navajo North (Shiprock Agency)			
D32N02-B	Aneth Community School	K-6	
D32N03-G	Aztec Dormitory **(GP)**	9-12	
D32N20-G	Navajo Preparatory School	9-12	
D32N06-B	Nenahnezad Community School	K-6	
D32N13-G	Shiprock Alternative Dormitory **(GP)**	9-12	
D32N10-B	T'iis Nazbas CS (Teecnospos)	K-8	
D32N11-B	Tohaali'CS (Toadlena)	K-8	7
South & Eastern States Agency			
D78N23-G	Choctaw Central High School	9-12	1
New Mexico South (Southern Pueblos Agency)			
D20N29-G	Pine Hills School	K-12	1
Arizona Navajo North (Western Navajo)			
D33N04-B	Dennehotso Boarding School	K-8	
D33N22-G	Greyhills Academy High School	9-12	
D33N05-G	KinLani Bordertown Dorm-Flagstaff**(GP)**	9-12	
D33N07-G	Kaibeto Boarding School	K-8	
D33N08-B	Kayenta Community School	K-8	
D33N09-G	Leupp School, Inc.	K-12	
D33N11-G	Nan Tsis'Ann CS-(Navajo Mt.)	K-8	
D33N14-G	Richfield Residental Hall **(GP)**	9-12	
D33N15-B	Rocky Ridge Boarding School	K-8	
D33N16-G	Shonto Preparatory School	K-8	
D33N19-B	Tuba City Boarding School	K-8	11
		TOTAL	**66**
** Off-reservation boarding schools--ORBS			

Appendix 6: Definitions

1. *24/7* – This term refers to "twenty four – seven". Students with intensive behavioral health needs may need residential treatment/care services, which are considered 24/7 or 24 hours, 7 days a week.
2. *Age of majority* – this means the legal age when a youth assumes the responsibilities of an adult. In most cases, the age of majority is 18 years of age.
3. *Behavioral Health Program* – is a home living based service focusing on decreasing barriers to learning and increasing positive, personal well-being of its students. The Bureau of Indian Education funds 66 homeliving programs, which are all required to implement a behavioral health program.
4. *Behavioral Health Professional* - is a State licensed or State certified Social Worker, School Counselor, Drug and Alcohol Counselor, School Psychologist, or School Psycometrist responsible for coordinating various behavioral health services at the dormitory, such as support groups and individual counseling.
5. *Behavior Intervention Plan (BIP)* – BIP stands for behavior improvement plan. A team, usually including school, and dorm staff, parents and the student, develops the BIP. The BIP is an individualized plan designed to assist the student to decrease inappropriate behavior and increase appropriate behavior.
6. *Bureau of Indian Affairs (BIA*) – this bureau is part of the Department of Interior.
7. *Bureau of Indian Education* – this bureau is the educational division within the Department of Interior.
8. *Confidentiality* – this term refers to the requirements of schools and dorms relating to the privacy of information relating to students and families.
9. *Continuity of Operations Plan (COOP)* – The COOP establishes outlines the procedures for schools/dorms to ensure that all essential functions and activities of the school and dorm are able to continue or be reactivated as quickly as possible during the full range of human-caused, natural, technological or national security emergences that have some reasonable likelihood of occurring.

10. *Critical incident report* – This is a Bureau of Indian Education report, which is required whenever a critical incident, such as weapon use, serious bodily injury, or death) occurs in the residential or school setting.
11. *Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV)* – this manual, published by the American Psychiatric Association, provides diagnostic criteria for mental disorders. Some students may have a DSM-IV diagnosis and related treatment plan.
12. *Disciplinary removal* – this usually means suspension, expulsion or other removal from school/dorm for disciplinary reasons.
13. *Family Educational Rights Privacy Act (FERPA)* – this is a federal law designed to protect the privacy of student records. Both schools and homeliving programs are bound by FERPA.
14. *Functional Behavior Assessment (FBA)* – this is an individualized assessment of a student to identify reasons for a student's inappropriate behavior and determine recommendations for a behavior improvement plan.
15. *Individual Crisis Management Plan* – This plan is recommended for any student who is at high risk for very aggressive/violent or self-injurious behavior. A team including school, dorm, student and parent(s) should complete it.
16. *Individual Education Program (IEP)* – is a plan developed by a team (students, parents, educators, dormitory staff members, and others). The plan is designed to help the child/youth make progress and be successful in school and in life, and meet the challenges related to his/or disability.
17. *Individuals with Disabilities Education Act (IDEA)* – this term refers to the federal law regarding special education services for children/youth (birth through the age of 21).
18. *Individual Education Program (IEP) Team* – this team is a group of individuals responsible for developing, reviewing and revising the IEP. The required team members are the parent of the student, a school administrator (or designee), a general and special education teacher, and a person who can interpret evaluation

information. Other individuals such as homeliving staff are often included as a part of this team as their input is helpful.

19. *Indian Health Service (IHS)* – this is a U.S. Department of Health and Human Services program for American Indians. The goal of the program is to assure that comprehensive and culturally acceptable persona and public health services are made available.
20. *In loco parentis* – this term means "in place of a parent".
21. *Manifestation Determination* – this term refers to a decision made by an IEP team to determine if: a special education student's conduct in question was caused by, or had a direct and substantial relationship to the student's disability OR if the conduct was a result of the school's failure to implement the IEP.
22. *Reintegration plan* – this is a written plan that is developed by a team to help the student make a smooth transition back from the residential treatment facility to the dorm/school. Activities and services outlined in the plan help the dorm and school prepare for the student's return and implement appropriate supports when the student returns.
23. *Residential Educational Placement Program (REPP)* – this is a Bureau of Indian Education program, which facilitates the placement, and funding for students with disabilities whose IEP team has determined that they are in need of residential educational placement and services.
24. *Residential treatment facility (RTC)* – this term refers to a facility that specialized in 24 hour a day mental health and substance abuse, care and treatment.
25. *Student with a disability* (also often referred to as a special education student) – means a child/youth who has been evaluated according to the evaluation and eligibility requirements of IDEA and has been determined to have a disability and is in need of special education services.
26. *Special education* – means specially designed instruction aimed at meeting the unique needs of the student with a disability.
27. *Treatment plan* – this term refers to the plan developed by the behavioral health specialist or residential treatment center after a formal mental health diagnosis.

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