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Behavior Education Plan: Elementary Intervention & Disciplinary Response Decision-Making Process

Determine Decision-Making Authority

- Determine key facts
- The behavior is represented in the BEP and the school has jurisdiction to respond.
- Is the behavior level 2 (or higher)? (If not, address with referring staff member)
- Does the student have an IEP, 504 Plan or Behavior Support Plan?
  - If so, involve appropriate staff such as student’s Case Manager

Determine Response Level

“When a specific student behavior does not change using the lowest identified level of intervention and/or discipline, the next level may be used.” (p. 20)

“If the behavior is assigned 2 or more response levels, the lowest level should be used first.” (p. 21)

- Conduct thorough investigation that includes meeting with student
- Consider factors in progressive use of intervention & discipline (see box)

- Consider the student’s disciplinary record including the nature of prior behavior, the number of prior instances of behavior, the intervention and consequences applied, etc.
  - Has the student demonstrated the behavior before?
  - If so, has the student been provided with a documented intervention and the time necessary to change their behavior?
- Consider the nature, severity and scope of the behavior
  - To what extent did the behavior disrupt learning/safety?

Determine disciplinary response, if appropriate

“Every reasonable effort should be made to correct inappropriate student behavior using interventions and the least severe disciplinary responses possible.” (p. 20)

- Level 2–4: A disciplinary response may be appropriate when the student’s behavior creates a risk to safety
- Level 5: Required suspension and recommendation for expulsion
  - For all disciplinary responses, consider factors in progressive use of discipline (see box).

Factors in Progressive Use of Intervention & Discipline

- The student’s age, maturity and understanding of the impact of their behavior
- The student’s willingness to repair the harm caused by the behavior
- The student’s disciplinary record including the nature of prior behavior, the number of prior instances of behavior, the intervention and consequences applied, etc.
- The nature, severity and scope of behavior
- The circumstances and context in which the behavior occurred
- The student’s individualized education plan (IEP) or 504 plan, if applicable

Appendix 1

Develop / select an intervention that:
- Addresses the need(s) underlying the behavior
- Considers environmental context, cultural background and potential changes to support positive behavior
- Teaches any lagging skills to support the student in understanding what they could have done differently in the same situation and learning social strategies and skills to use in the future
- Provides an opportunity for the student to repair harm and maintain/regain dignity

Use Appendix A: Interventions by Behavior & Response Level
Behavior Education Plan: Middle & High Intervention & Disciplinary Response Decision-Making Process

Determine Decision-Making Authority

- Determine key facts
- The behavior is represented in the BEP and the school has jurisdiction to respond.
- Is the behavior level 2 (or higher)? (If not, address with referring staff member)
- Does the student have an IEP, 504 Plan or Behavior Support Plan?
  - If so, involve appropriate staff such as student’s Case Manager

Determine Response Level

“When a specific student behavior does not change using the lowest identified level of intervention and/or discipline, the next level may be used.” (p. 20)

“IF the behavior is assigned 2 or more response levels, the lowest level should be used first.” (p. 21)

- Conduct thorough investigation that includes meeting with student
- Consider factors in progressive use of intervention & discipline (see box)
- Consider the student’s disciplinary record including the nature of prior behavior, the number of prior instances of behavior, the intervention and consequences applied, etc.
  - Has the student demonstrated the behavior before?
  - If so, has the student been provided with a documented intervention and the time necessary to change their behavior?
- Consider the nature, severity and scope of the behavior
  - To what extent did the behavior disrupt learning/safety?

Determine Intervention

Develop / select an intervention that:
- Addresses the need(s) underlying the behavior
- Considers environmental context, cultural background and potential changes to support positive behavior
- Teaches any lagging skills to support the student in understanding what they could have done differently in the same situation and learning social strategies and skills to use in the future
- Provides an opportunity for the student to repair harm and maintain/regain dignity

Factors in Progressive Use of Intervention & Discipline

The student’s age, maturity and understanding of the impact of their behavior

The student’s willingness to repair the harm caused by the behavior

The student’s disciplinary record including the nature of prior behavior, the number of prior instances of behavior, the intervention and consequences applied, etc.

The nature, severity and scope of behavior

The circumstances and context in which the behavior occurred

The student’s individualized education plan (IEP) or 504 plan, if applicable

Determine disciplinary response, if appropriate

“Every reasonable effort should be made to correct inappropriate student behavior using interventions and the least severe disciplinary responses possible.” (p. 20)

- Level 2: A disciplinary response may be appropriate when the student’s behavior creates a risk to safety
- Level 3-5: A disciplinary response is required
- For all disciplinary responses, consider factors in progressive use of discipline (see box)
Responding to Behavior in the Classroom

When do I need to document level 1 behaviors and interventions?

When a behavior occurs...

Redirect the behavior in the current setting, unless a safety concern
- Nonverbal cues
- Fix-it on the Spot
- Loss of privilege

Redirecting teacher language
- Take a Break (TAB)

If the behavior continues, increase the level of the redirection
- Fix-it on the Spot
- Loss of privilege
- Quick Conference

- TAB
- Buddy room/TAB Out
- Call Behavior Response Team

If behavior continues, call for behavior support to come to the classroom

Document when universal (school-wide) practices and routine classroom supports/response strategies are not sufficient in supporting the student’s behavior and ANY of the following are true:

- Student demonstrates a pattern of behavior
- Student demonstrates level 1 behaviors with increased frequency, duration and intensity
- Student’s behavior requires additional support from a staff member (who responds to the classroom)

Document the behavior as at least a Level 1 if additional support was needed
# Routine Strategies to Respond to Behavior in the Classroom

<table>
<thead>
<tr>
<th>Tools</th>
<th>When to use</th>
<th>How to use</th>
</tr>
</thead>
</table>
| **Reminding Teacher Language** | • When you and the students feel calm.  
• Use proactively when planning ahead for a transition, skill, or experience that might be difficult for students.  
• Use reactively just when behavior is beginning to go off track. | • Base reminders on clearly established expectations  
• Reminders can be phrased as a question or a statement  
  o "What do you need to be doing right now?"  
  o "What can you do to solve the problem?"  
  o "Show me a kind way to talk to your partner"  
  o "Think about what will help you concentrate."  
• Can use reminders proactively or reactively  
• Keep reminders brief |
| **Redirecting Teacher Language** | When students are...  
• Doing something dangerous to themselves or others  
• Too emotional to remember expectations and think reasonably about what they’re suppose to be doing  
• Otherwise too deeply invested in their off-track behavior to correct themselves | • Be direct and specific  
  o "David, hands in your lap."  
• Name the desired behavior  
  o "All eyes on Miranda"  
• Be brief  
  o "Books closed. Eyes and ears on me"  
• Set firm limits  
• Make a statement, don’t ask a question |
| **Non-Verbal Cues** | When a student is...  
• Losing attention and focus  
• Not following a minor expectation | • Review your expectations  
• Select appropriate cues  
• Use Interactive Modeling to teach to students  
• Establish non-verbal cues for individual students if needed  
• Be consistent |

Examples of non-verbal cues: Signal for silence, proximity, finger to lips for silence, eye contact and shaking head no, pointing to an agenda or activity, miming correct activity (opening a book, etc.), smile, OK sign, and thumbs up.
<table>
<thead>
<tr>
<th>Tools</th>
<th>When to use</th>
<th>How to use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fix-Its/Reparation:</td>
<td>• When children’s mistakes result from simple carelessness, impulsivity or forgetfulness.</td>
<td>• In a simple case, provide brief, straight-forward directions</td>
</tr>
<tr>
<td></td>
<td>• Not appropriate when children are very upset or losing self-control. A fix-it may be used once</td>
<td>○ “Ana, get paper towel from the sink and clean up the milk please.”</td>
</tr>
<tr>
<td></td>
<td>the student is calm.</td>
<td>• Can be written or verbal, formal or informal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The best fix-its are student-generated</td>
</tr>
<tr>
<td>Take A Break (TAB)</td>
<td>When students are ... • Making small disturbances like saying negative remarks, picking or</td>
<td>• Explain the purpose to children</td>
</tr>
<tr>
<td></td>
<td>poking, whispering to a friend while a classmate is talking</td>
<td>○ “TAB is for someone who has made a mistake or broken a rule. It lets that person regain</td>
</tr>
<tr>
<td></td>
<td>• Having a difficult time regulating or beginning to lose control</td>
<td>control. TAB is not a punishment.”</td>
</tr>
<tr>
<td></td>
<td>TAB is an opportunity to help children learn and practice self-control</td>
<td>• Establish one or two specific places in the room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Keep TAB brief and clarify who decides when it’s over</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use a calm voice and few words</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use TAB democratically. It is important for students to see everyone uses TAB.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remember that TAB doesn’t work for all children</td>
</tr>
<tr>
<td>Loss of Privilege</td>
<td>When students ... • Tell a lie</td>
<td>• The loss of privilege should be connected to the incident.</td>
</tr>
<tr>
<td></td>
<td>• Act or speak in ways that show disregard for other’s rights or feelings</td>
<td>• Make sure the loss of privilege is temporary.</td>
</tr>
<tr>
<td></td>
<td>• Act in ways that show disregard for materials</td>
<td>• Loss of privilege is NOT a punishment. As adults it is our job to show this with our words</td>
</tr>
<tr>
<td></td>
<td>Adults are in charge of giving children privileges and of temporarily removing privileges that</td>
<td>and actions by providing supervision and support of the repairing process.</td>
</tr>
<tr>
<td></td>
<td>children have trouble managing. To help children succeed, we need to make sure the degree of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>privilege we offer matches what the children are ready to take on.</td>
<td></td>
</tr>
</tbody>
</table>

Examples of Loss of Privilege:

- A child leaves the room to go to the bathroom, fools around in the bathroom, and doesn’t return in a reasonable period of time. “You’re not taking care of yourself in the bathroom, so you won’t be able to go by yourself for the next two days. You will have to wait until a teacher is free to go with you.”
- To play games or avoid a task, a student says her work is done when it isn’t. “I must be able to believe what you say, or trust you to follow routines for finished work. You will have to show me your finished work every day this week.”
- A child cheats when playing games. “When you don’t follow the game rules, you make the game less fun for others. You will need to leave the game today and try again another time.” Students are also encouraged to stop a game if there is cheating and say, “If you continue to break the game rules, I don’t want to play with you.”
# Behavior T-Chart: Elementary

All Level 1 behaviors can progress to Level 2 when repeated or intensified.

<table>
<thead>
<tr>
<th>Level 1 Behaviors</th>
<th>Level 2 – 5 Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cheating</td>
<td>• Alcohol, drugs &amp; tobacco</td>
</tr>
<tr>
<td>• Defiance of authority</td>
<td>• Bullying &amp; harassment</td>
</tr>
<tr>
<td>• Taunting, baiting, inciting a fight or disruption</td>
<td>• Cheating in group of 3 or more</td>
</tr>
<tr>
<td>• Throwing objects</td>
<td>• Volatile acts</td>
</tr>
<tr>
<td>• Property damage or theft under $50</td>
<td>• Property damage or theft over $50</td>
</tr>
<tr>
<td>• Toy weapon without threats or intimidation</td>
<td>• Toy weapon with threats or intimidation</td>
</tr>
<tr>
<td>• Forgery</td>
<td>• Weapons, fireworks, smoke bombs, etc</td>
</tr>
<tr>
<td>• Gambling</td>
<td>• Setting a fire</td>
</tr>
<tr>
<td>• Dress code violation</td>
<td>• False alarms</td>
</tr>
<tr>
<td>• Swearing, obscene gestures, put-downs</td>
<td>• Bomb threat</td>
</tr>
<tr>
<td>• Threats without concern of bodily harm</td>
<td>• Physical attack against a student</td>
</tr>
<tr>
<td>• Inappropriate physical contact (non-sexual, not bullying)</td>
<td>• Fighting</td>
</tr>
<tr>
<td>• Touching intimate parts of another person (gr K-3 only)</td>
<td>• Physical force against an adult</td>
</tr>
<tr>
<td>• Inappropriate use of technology</td>
<td>• Touching intimate parts of another person (gr 4-5)</td>
</tr>
<tr>
<td>• Indecent exposure (gr K-3 only)</td>
<td>• Sexual contact</td>
</tr>
<tr>
<td>• Removing another students’ clothing (gr K-3 only)</td>
<td>• Indecent exposure (gr 4-5)</td>
</tr>
<tr>
<td>• Making or distributing recordings of another person without consent</td>
<td>• Removing another students’ clothing (gr 4-5)</td>
</tr>
<tr>
<td>• Pornographic material</td>
<td>• Nude images of students or staff</td>
</tr>
<tr>
<td>• Use of non-educationally required device, electronic or not</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6

Behavior T-Chart: Secondary

All Level 1 behaviors can progress to Level 2 when repeated or intensified.

<table>
<thead>
<tr>
<th>Level 1 Behaviors</th>
<th>Level 2 – 5 Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cheating</td>
<td>• Alcohol &amp; drugs</td>
</tr>
<tr>
<td>• Defiance of authority</td>
<td>• Bullying &amp; harassment</td>
</tr>
<tr>
<td>• Taunting, baiting, inciting a fight or disruption</td>
<td>• Cheating in group of 3 or more</td>
</tr>
<tr>
<td>• Throwing objects – does not make contact with a person</td>
<td>• Volatile acts</td>
</tr>
<tr>
<td>• Property damage or theft under $50</td>
<td>• Throwing objects – makes contact with a person</td>
</tr>
<tr>
<td>• Toy weapon without threats or intimidation</td>
<td>• Property damage or theft over $50</td>
</tr>
<tr>
<td>• Forgery</td>
<td>• Toy weapon with threats or intimidation</td>
</tr>
<tr>
<td>• Gambling</td>
<td>• Setting a fire</td>
</tr>
<tr>
<td>• Dress code violation</td>
<td>• False alarms</td>
</tr>
<tr>
<td>• Swearing, obscene gestures, put-downs</td>
<td>• Bomb threat</td>
</tr>
<tr>
<td>• Threats without concern of bodily harm</td>
<td>• Inappropriate physical contact</td>
</tr>
<tr>
<td>• Making or distributing recordings of another person without consent</td>
<td>• Physical attack against a student</td>
</tr>
<tr>
<td>• Use of non-educationally required device, electronic or not</td>
<td>• (non-sexual, not bullying)</td>
</tr>
<tr>
<td></td>
<td>• Fighting</td>
</tr>
<tr>
<td></td>
<td>• Physical force against an adult</td>
</tr>
<tr>
<td></td>
<td>• Touching intimate parts of another person</td>
</tr>
<tr>
<td></td>
<td>• Sexual contact</td>
</tr>
<tr>
<td></td>
<td>• Inappropriate use of technology</td>
</tr>
<tr>
<td></td>
<td>• Indecent exposure</td>
</tr>
<tr>
<td></td>
<td>• Removing another students’ clothing</td>
</tr>
<tr>
<td></td>
<td>• Pornographic material</td>
</tr>
</tbody>
</table>


# Behavior Documentation Form

Student: ___________________ Homeroom Teacher: ___________ Referred By: ___________
(staff member requesting additional support)

Time: _______ Date: _______ Location of Event: ________________

**DETAILS:**

<table>
<thead>
<tr>
<th>Supports Attempted for Today’s Behavior</th>
<th>Communication Family contact required at Levels 2-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Reteach</td>
<td>☐ I will contact family</td>
</tr>
<tr>
<td>☐ Remind / Redirect</td>
<td>☐ Let’s check in before family contact is made</td>
</tr>
<tr>
<td>☐ Take A Break</td>
<td>☐ Follow family communication plan</td>
</tr>
<tr>
<td>☐ Loss of Privilege</td>
<td>☐ I would like to debrief</td>
</tr>
<tr>
<td>☐ Buddy Room / TAB Out</td>
<td>Times that work for me: _____________________</td>
</tr>
</tbody>
</table>

**Resolution:** Behavior Response Staff Use Only

<table>
<thead>
<tr>
<th>Intervention Used / Recommended: ___________________</th>
<th>Disciplinary Response: ___________________ (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Student Returned to Class: ___________</td>
<td>Behavior Admin Staff Name: ____________________</td>
</tr>
<tr>
<td>(Behavior Responder)</td>
<td></td>
</tr>
</tbody>
</table>

**DETAILS:**

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Appendix 8

Planning Spaces

According to the Behavior Education Plan, a planning room is “an alternative classroom within the school building where a student can work with staff to calm down, reflect on his/her behavior and develop a plan to make different choices when they return to class.”

Planning spaces may look different depending on school or level. As with any behavior intervention, the intent in using a planning space is to protect the dignity of the child in distress, while maintaining a learning environment for others. The use of a planning space is a more restrictive step than the use TAB Out and Back or a Buddy Room. Planning space is NOT intended to be a destination that children are sent to as a punitive measure.

Planning space is any space in which designated staff provide the time, space and support to help a child calm, reflect, and plan for their return to the learning environment. Planning spaces may include the hallway, a classroom that is not in use, the office space of the responding staff, or a designated room. When a student demonstrates a frequent need for a place to process behavior incidents, it is important to consider putting proactive strategies in place that might reduce the frequency of these behaviors occurring. A Brief Functional Behavior Assessment is a helpful tool in supporting staff to analyze the behavior and the context in which it occurs in order to intervene proactively as appropriate. It may also be beneficial to create a protocol that outlines a response plan for the student including staff members involved that the student may have a relationships with and a consistent processing location so the student knows what to expect.

Schools vary in their use of planning room and/or spaces. It is important to consider the potential unintended consequences of designated a room as the “planning room.” When parameters are too loose regarding the programming or processing that occurs in a planning room, this often evolves into a room which houses students rather than preparing them to return to the learning environment. A consistent room also requires consistent staffing, which may or may not be the most efficient use of resources. Regardless of whether schools use a planning room or space(s), it is important to document the use of the space in order to identify trends regarding student that are accessing the space in order to:

- Identify students that are in need of additional support and intervention
- Ensure the room/space is not contributing to or reinforcing racial disparities

Anytime a student accesses a planning room/space, it must be documented as a level 2 behavior or higher, depending on the type of behavior and student’s behavioral and intervention record during the current year. It is not a level 1 behavior as the student is missing significant instructional time and requires the support of an additional staff member. Schools need to determine who is responsible for documenting and monitoring the use of planning spaces.
Use of Planning Spaces

A planning space might be useful in the following situations:

- **Response to behavior**: For situations in which students are unable to re-engage after a less restrictive intervention (i.e. in-classroom support, buddy room), a planning space may be used to help the student calm down, process events, and make a plan for the future.

- **Self-referral**: A student may request use of an alternative space to calm down or reset. Individual student plans might outline specific circumstances for when they have access to an alternative space. If a student is accessing an alternative space regularly, a plan or protocol should be established.

- **In-School Suspension**: A planning space may be used as a productive space for ISS. Please see the “Parameters for Use of In-School Suspension” for a full description.

- **Transitions from alternative environments**: When transitioning from being out of school (out of school suspension, residential placement, alternative program, etc.), a planning space may be used to support students in re-integrating. An effective protocol to use to support this transition is a circle process.
Some students benefit from additional regulation supports in school. These supports can increase student availability for academic learning. Regulation supports can be used proactively, as an early intervention, or in response to a behavior incident. These breaks might be written into a student’s Behavior Support Plan (BSP) or IEP, but they can be used by any student with or without a plan who might benefit. Some indicators that a student might benefit from regulation breaks are:

- Emotional upset (overwhelmed, frustration, anxiety, anger)
- Low frustration tolerance, low flexibility
- Increased activity, distractibility
- Tired, ‘spaced out’, sedentary, dissociative
- Shut down (May appear to be noncompliant)
- Sensory sensitivity to:
  - Clothing fabrics, labels, tags, etc.
  - Light touch or unexpected touch
  - Sounds (volume or frequency)
  - Lights or patterns

**Proactive Regulation Breaks**

Proactive breaks may be scheduled for students when there is a pattern of behavior or upset, preventing behavior incidents from occurring.

**Early Intervention Regulation Breaks**

Regulation breaks can be used as an early intervention at the first signs of student dysregulation in order to prevent escalation. Early intervention breaks interrupt patterns and cycles of behavior, allowing students to apply positive coping skills.

**Proactive and Early Intervention Regulation Break Considerations:**

- **Location:** Regulation breaks can occur in a variety of places in the school, depending on the needs of the student. When possible, the least restrictive environment should be used. Possible locations include:
Classroom: Create time and space for proactive breaks with sensory materials.

Hallway: Movement activities while walking in the hallway can provide a change of pace without going all the way to a designated space.

Student services staff office

OT / PT space

Regulation room: A space intended specifically for regulation breaks with regulation materials available.

Planning room

Available Staff: A wide range of staff with any amount of experience can provide regulation breaks, but choosing one or two consistent staff members for a specific student’s breaks can help build a routine and create relational trust. OT and PT staff may be able to provide valuable expertise on sensory activities that other staff can implement. Classroom teachers can be taught to provide regulation breaks for students, allowing them to be seamlessly incorporated into the school day.

Frequency & Duration: Consider the frequency of problem behaviors when deciding how often to provide proactive sensory breaks. Two breaks each day could significantly improve the functioning of a student, reducing reactive behavior referrals, and ultimately increasing student instructional minutes in class.

Documentation: If a behavior responder provides proactive regulation breaks, whether it be Level 1 or Levels 2-5, it must be documented as per the regular guidelines.

Fading: If a student has shown progress using proactive regulation breaks, consider how breaks may be faded over time

- reduce the length of the breaks
- decrease the number of breaks per day or per week
- change breaks from an external space back to the classroom
- shift the staff member providing breaks from a support staff member to the classroom teacher.

Reactive Regulation Breaks

Students in distress may need time and regulation activities in order to calm down before processing behavior incidents. Regulation activities and tools may be used throughout the recovery process to help a student gain and maintain a calm state of regulation. Once calm, a student is more able to process, problem-solve and participate in restorative practices.
Appendix 10

Interventions by Behavior & Response Level is an online resource.
Visit www.mmsd.org/bep.

Appendix 11

Behavior & Social Emotional Interventions is an online resource.
Visit www.mmsd.org/bep.
Next time I will:

- Say stop!
- Deep breath, count to 10
- Listen
- Ignore it
- Keep hands to self
- Walk away

Did I apologize?  
- Yes  
- Not yet

How will I fix it?

- Write a letter
- Draw a picture
- Fix what I broke
- Be a helper
- Share

Draw a picture:

Student Signature: ____________________  
Teacher signature: ____________________
Plan de solución

Nombre: ______________________     Fecha:_____________________

¿Qué sucedió?

- Pelear
- Desobedecer
- No hacer el trabajo
- Burlarse, molestar/intimidar
- Hacer ruido
- Romper algo
- Lastimar a alguien

¿Quién más?

- Solo yo
- Un maestro
- Otro estudiante
- Un grupo de estudiantes

Me sentía:

- Triste
- Enojado
- Avergonzado
- Feliz
- Asustado
- Cansado
- Confundido
La próxima vez voy a:

Retirarme

Mantener las manos quietas

Ignorar

Obedecer

Decir ¡PARA!

Respirar profundamente y contar hasta 10

¿Me disculpé?

Sí

Todavía no

¿Cómo lo voy a solucionar?

Compartiré

Ayudaré

Repararé lo que rompí

Escribiré una carta

Haré un dibujo

¿Cómo lo voy a solucionar?

Haz un dibujo:

Firma del estudiante: ______________________

Firma del maestro: ______________________
Fix-It Plan

Name:____________________________  Date:______________

What happened?
________________________________________________________________________
________________________________________________________________________

How did my actions affect others?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I was feeling:
________________________________________________________________________
________________________________________________________________________

Next time I will:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How will I fix it?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Did I apologize?  □ Yes  □ Not yet

I’m sorry for…  Next time I will…  I will fix it by…  Do you forgive me?

Student  Signature:_____________________________  Teacher  Signature:_____________________________

Behavior Education Plan Toolkit | 2014-15  56
Plan de solución

Nombre: ____________________________  Fecha: ______________

¿Qué sucedió?

____________________________________________________________________________

____________________________________________________________________________

¿Cómo lo voy a solucionar?

____________________________________________________________________________

____________________________________________________________________________

¿Me disculpé?  [ ] Sí  [ ] Todavía no

Lamento mucho…  La próxima vez voy a…
Lo solucionaré de la siguiente manera…  ¿Me perdonas?

Firma del estudiante: ____________________________  Firma del maestro: ____________________________
Appendix 16

Home-School Communication System

This system is designed to ensure that staff and parents/guardians are “on the same page” with respect to student behavior at home and at school. The goal is for ongoing, meaningful sharing of information and may include a communication notebook, daily emails, etc.

When utilizing a home-school communication system as an intervention, the following parameters and strategies should be considered to determine when this might be an effective intervention.

Types of home-school communication:

Phone call (voicemail, conversation)

Written (email, paper, notebook, text)

In person (unscheduled, check in, conference)

Reasons for home-school communication:

Attendance

Engagement

Behavior Concern

Celebration

Progress report / update

Specific Behavior Reinforcement

Proactive vs. Reactive

Examples (ie: attendance: proactive - welcome!; reactive - “we missed you”)

Parameters:

Scripts:

Other Considerations:
Elementary

Behavior Contract

Student Name:______________  Teacher Name:______________

**Agreement:** (Include specific behavior and time period.)

I can ______________________________________

_________________________________________________

_______________________________________________

I can earn _______________________________________

If I do not follow the agreement ______________________

_________________________________________________

Date of Agreement: ______________

Date to revisit this plan: _____________

Student Signature: ____________________

Teacher Signature: ____________________

Parent/Guardian Signature: ______________

Parent/Guardian Comments: ______________

---

Date family notified of contract: ______________

Contacted by: ________________________

Contact Method:

☐ Phone

☐ Email

☐ Signature on form

---
Middle School

Behavior Contract

Student Name: ___________________________ Date of Agreement: _________________

Staff Member Name: ___________________________

Agreement:
I can ______________________________________________________________________
____________________________________________________________________________
For the period of ______________________________________________________________________
If I follow this contract, I understand I will earn _________________________________
If I do not follow the agreement, I understand I will have to accept _____________
____________________________________________________________________________
Bonus opportunities: _________________________________

Date to revisit this plan: _________________

Student Signature: ___________________________
Staff Member Signature: ___________________________

Parent/Guardian Signature: ___________________________
Parent/Guardian Comments: ___________________________

Date family notified of contract: _________________
Contacted by: ___________________________
Contact Method:
☐ Phone
☐ Email
☐ Signature on form

Appendix 18
Appendix 19

RESTORATIVE CIRCLE AGREEMENT

Date of Incident ________________
Date of Circle _________________
Date of Follow-up Circle __________

Type of Circle
- Attendance/tardy
- Behavior
  - Bullying/Harassment
  - Classroom/Disruption
  - Conflict--specify type (peer, staff/student, etc.) _____________________
  - Fight
  - Vandalism
- Support
- Other __________________________

Participants

<table>
<thead>
<tr>
<th>Name, role (referred student, parent, school staff, supporter, community worker, Circle Keeper)</th>
<th>I agree to maintain confidentiality (initial)</th>
<th>I support the agreement (initial)</th>
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Briefly describe the situation, including who has been harmed/affected (either directly or indirectly).

________________________________________________________________________________________
___________________________________________________________ _____________________________
________________________________________________________________________ ________________
_________________________________________________________ _______________________________
_________________________________________________________ _______________________________
______________________________________________________ _____________________________________

Behavior Education Plan Toolkit | 2014-15
Agreement: How will harm be repaired, or how will the situation be made better? Be specific about who will do what.

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

Measurable Goal (e.g., improved attendance, conflict will not escalate to fight, no more office referrals) Be specific.

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

Person assigned to monitor follow-through, schedule follow-up Circle, and determine whether goal was met ________________________________

Notes from Follow-up Circle

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________ 

_________________________________________________________________________________
Restorative Practices

INTRODUCTION

Restorative justice, rooted in values such as interconnectedness, respect, and responsibility, holds that wrong-doing is more fundamentally a violation of relationships than of rules or laws. Restorative practices grow out of this philosophy, and are particular approaches to addressing a range of challenging issues. The objectives of restorative approaches where there has been wrong-doing include reparation of harm, and addressing the needs of victims, offenders, and the community. Restorative practices, including restorative Circles, are inclusive and collaborative rather than authoritarian and punitive, and utilize a structured process to create opportunities to develop understanding, empathy, and problem-solving through open and honest dialogue. This approach builds and strengthens relationships, and encourages students to become aware of the impact of their behavior, understand the obligation to take responsibility for their actions, and take steps toward making things right. Circles can also be used to build community, and as a framework for addressing a wide variety of topics in addition to challenging behaviors. Research shows that restorative practices create more positive and equitable outcomes for students and school communities than traditional punitive systems of discipline.

Training in Circle facilitation is highly recommended prior to facilitating Circles or using the following tools.

BASIC CIRCLE OUTLINE

Opening

- Welcome and statement of purpose
  
  Name the purpose of the Circle, including the following in situations of wrong-doing or conflict:
  - To talk openly about _________ (name the situation)
  - To talk about who has been harmed/affected by it, and how
  - To repair any harm that has been done
  - To move forward positively and peacefully

- Introduce Circle process and talking piece
  - A Circle is a special way for a group of people to talk about something, often something that is hard, or when there is a problem to resolve.
  - In a Circle everyone involved in the situation is included, everyone is equal, and respected, and everyone is asked to be open and honest.
  - The talking piece gives everyone an equal chance to talk, and to listen.
  - Circle Keeper asks a question then passes the talking piece around the Circle and each person has a chance to respond (talking piece goes in order, with no interrupting or “cross-talk.”)
● Introductions and relationship-building round

How this is done and how much time is spent on it depends in part on the prior relationships of participants.

- With the talking piece, have each person introduce him/herself, share his/her relationship to the key participants (if that is not known or they are from outside of school), and respond to a low-risk question about him/herself.

● Guidelines

How this is done and how much time is spent on it depends in part on the prior relationships of participants, and on the nature of the situation—the more serious or contentious the situation, the more time must be spent on guidelines, and the more important it is that participants generate guidelines themselves rather than simply agree to guidelines put before them.

- Remind participants of the values of Circle (e.g., inclusion, equality, respect, honesty). CK can place values circles in the middle of the Circle, talking about them briefly.
- “So that we can have an open, honest conversation where each of us feels that inclusion and respect, we’re going to take some time to think about what would help.”
- Explain that guidelines are based on the values, and are the expectations for how people will participate in the Circle.
- CK can name guidelines, talk about a couple, and place them in the Circle (e.g., respecting the talking piece, listening with an open mind, confidentiality, phones/electronics off and away), and ask if anyone has a guideline to add. OR
- Have group generate guidelines, write them down and place in Circle.
- Either way, go around the circle and get each person’s agreement to follow the guidelines during Circle.
- Sign Confidentiality Agreement
- If a participant or the group begins to have trouble following guidelines, gently remind them of the guidelines and their agreement to follow them. If this continues, you may need to stop the Circle. Values and guidelines are fundamental to the process, and if the group cannot adhere to them, the Circle should not take place at that time.

● Opening Ceremony

Purpose is to mark the time and space and process of the Circle as something different.

- Begin with a quote or poem related to the situation being addressed in the Circle.
- May do a round (with talking piece) asking each person to share a thought related to the quote/poem.

Restorative questions see sample questions below

- Story-telling/empathy-building (one question)
- Situational questions (several questions)

Agreement when appropriate to situation

- May suspend talking piece to brainstorm possible solutions and agreements (write down). OR
- Do a round asking each person what they think would be helpful (start with central participants, and pay special attention to what they believe would be helpful), then
- Ask each person what they are willing do to (write on Agreement Form)
Closing

- Quote or poem  OR
- A word to describe how they’re feeling about the situation now, or how they feel about the Circle process.

CIRCLE TEMPLATE

Opening

- Welcome and statement of purpose
- Introduce Circle process and talking piece
- Introductions and relationship-building round
- Guidelines
- Opening ceremony

Restorative questions

(Story-telling/empathy-building round--one question)

(Situational questions)

Agreement

Closing

RESTORATIVE QUESTIONS

The purpose of restorative questions is typically to explore:

- the situation--what happened/is happening
- how people feel about the situation
- who has been harmed/impacted, and in what ways
Story-telling/empathy-building questions

The purpose of story-telling/empathy-building questions is to build empathy and understanding by demonstrating that many members of a community have faced similar situations, have made mistakes and can learn from them, and to learn from the experiences of others. Care must be taken in eliciting stories that are relevant and meaningful, and at the same time appropriate for sharing with students. The Circle Keeper should explain and model this. Some examples of questions:

Conflict

● Talk about a time when you handled a conflict in a positive way.
● Share a time when you experienced a conflict with someone, and something you learned from it.
● Share a time when handled a conflict poorly, and what you wished you had done.

Bullying/harassment

● Share a time you saw someone being treated badly, possibly because of way they were different, and how it made you (or the other person) feel.
● Share a time when you were treated badly, and how it made you feel.
● Share a time when you treated someone badly, and why you think you did that.

Attendance and tardiness

● Talk about a situation where you struggle to be on time, and who you think is affected by that.

Support

● Share a time (in general terms) when you needed extra support. What is something you needed, and how did you get it?

Re-engagement

● Share a time (in general terms) when you were making a big transition. What did you need?
● Share a time (general) when you did something you later regretted/that got you in trouble. What did you learn from that? What do you wish you had done differently? What did you need in order to take responsibility for your mistake?
Incident with staff member

- Share a time (general) when you did something you later regretted/that got you in trouble. What did you learn from it? What do you wish you had done differently? What did you need in order to take responsibility for your mistake?

**Situational questions**

Sometimes it will be helpful to do a second round with the same question to allow people to go deeper, or to give another opportunity to speak to someone who has passed the first time.

**Conflict example questions**

- What is happening between _________ and _________, and how do you feel about it?
- What is your part in it?
- Who all has been affected/hurt by it, and how?
- What needs to happen to make things right, and let it go?

**Bullying/harassment example questions**

- How do you want to be treated by others?
- How do you feel when you are not treated this way?
- What is happening between _________ and _________?
- How does that make you feel (not think)? (hurt, angry, scared, powerful…)
- What is your part in the situation?
- Who all is impacted by it, and how?
- What do you need in this situation? (start will person being mistreated)
- What do you want people to know about you?
- What needs to happen to repair the harm that has been done?

**Attendance example questions**

- Why is it important to attend/be on time? (start with person of focus)
- What are the benefits of attending/being on time? (start with person of focus)
- What are some things that seem good about not attending/being on time? (person of focus only)
● Who all is impacted, and how, when you do not attend/get there on time? (all)
● What could help you/__(student)__ to attend/be on time? (all)
● What is a goal you have for yourself around attendance? (person of focus only)
● What might get in the way of reaching that goal? (start with person of focus)
● What strategies are you willing to try? (person of focus only)
● Is there anyone who could help who is not in the Circle? (all)

Support example questions
● What is happening with ____________?
● What are the challenges (or concerns)?
● What is getting in the way of ____________ being successful in school?
● What might help make things better?
● What do you need in order for things to be better? (only person of focus answers)
● What is each person willing to do to support ____________?

Re-engagement after extended absence example questions
● Name a strength of ________ (student) or something you appreciate about him/her.
● What concerns/worries do you have about coming back to school?
● What do you/does ____________ need in order to have a positive transition back to school?
● Who can help support you/ ____________?
● What would you like school staff to know about you/your situation?
● Who has been affected/harmed by this situation, and how? (if the absence from school was related to wrong-doing in school)
● What needs to be done to repair any harm that has been done?
● What is each person willing to do to support ____________ as he/she comes back to school?

Incident with staff member (including injury to staff) example questions
● What happened? How do you feel about what happened?
● Who do you think has been hurt/affected by this, and how? (the person who most obviously caused harm can include themselves as someone harmed, but encourage them to think beyond that, and to speak to their own harm last)

● What needs to be done to repair the harm? (ask the most obvious victim what they want/need first, before asking others what needs to be done)

Chronic behavior concerns example questions

● What are the concerns, from your perspective? (brief, factual, non-judging) (person of focus speaks first)

● What is your part in it?

● How do you feel about what is happening?

● Who is affected by it, and how?

● How would you like things to be (in the class, with the other person, etc.)?

● What do you want _________(the other person) to know about you?

● What are you willing to do differently?

● What might help you to turn this situation around?

MODIFIED CIRCLES

Certain situations could benefit from use of elements of Circle process (e.g., in a circle, talking piece, facilitator asking pre-selected questions to focus conversation restoratively, equal voice), but may not require all the elements and stages of a full Circle and can be limited to just a few questions. Examples of those situations, and sample questions follow.

Readmit after suspension

● Invite each person to talk briefly about the situation from their perspective.

● Who is impacted/harmed by this, and how?

● What needs to be done to make things right/repair the harm?

● What do you need to help you come back to school and get back on track?

● Who can help with that?

● What are you (each person in the Circle) able to do to help with that?

Expulsion Prevention Plan

● What happened/is happening? How do you feel about it?

● What were you thinking at the time?
- What happened as a result of your actions?
- What might be another/better way to handle it next time?
- Who all has been affected by this, and in what ways?
- What do you need to do in order to make things right with other people?
- How does/would getting suspended/expelled affect how you’re doing in school?
- What do you need in order for this not to happen again?
- What support do you need? What can I/we do to help you?
- What do you need to start doing, keep doing, or stop doing?

Welcoming a new student
- Share something you would like ____________ (new student) to know about our class/school.
- What is something you would like ____________ to know about you?
- Who are the people in our school that you can go to help?
- What is something you can do to help ____________ become comfortable in our class/school?

RESOURCES

Books

Discipline that Restores, Ron and Roxanne Claassen
The Little Book of Circle Processes, Kay Pranis
The Little Book of Restorative Discipline for Schools, Loraine Stutzman Amstutz and Judy Mullet
The Little Book of Restorative Justice, Howard Zehr
Peacemaking Circles & Urban Youth: Bringing Justice Home, Carolyn Boyes-Watson
Restorative Circles in Schools: Building Community and Enhancing Learning, Bob Costello, Joshua Wachtel, and Ted Wachtel
Safer Saner Schools: Restorative Practices in Education, edited by Ted Wachtel and Laura Mirsky

Articles

How Educators Can Eradicate Disparities in School Discipline: A Briefing Paper on School-Based Interventions

indiana.edu/~atlantic/wp-content/uploads/2014/03/Disparity_Interventions_Full_031214.pdf

Restorative Practices at the Elementary Level

https://dfes-sfusd-ca.schoolloop.com/restorative_practices

The Restorative Recovery School: Countering Chemical Dependency


Videos

Community Forward-Justice Circle (Chicago neighborhood center)

http://www.youtube.com/watch?v=0SipxJonUpo

Restorative Justice in Oakland Schools: Tier One, Community Building http://www.youtube.com/watch?v=RdKhcQrLD1w

Restorative Justice: It's Elementary!

https://www.youtube.com/watch?v=dUA1AVf1Sql
Appendix 21

MMSD Best Practice Guidelines: Individual Social Emotional Brief Assessments

Student Services staff, including psychologists, nurses, social workers, and counselors, are positioned to conduct brief assessments relative to their roles and core practices in schools working with students with behavioral concerns. This most often occurs in the context of collaborative problem-solving in Student Services Intervention Teams. Results of assessments may be used to design supports for learning, consult with teachers, and assist families seeking community resources.

Assessments included in this part are for the purposes of progress monitoring and/or determining appropriate instructional/behavioral strategies for curriculum implementation. Assessments may not be used to determine eligibility for special education and related services or whether a special education referral is warranted. If District staff suspect a student is demonstrating a disability the District must comply with all procedural safeguards set forth in the District’s Special Education or Section 504 policies and procedures.

The following brief assessments are easily accessible in the public domain. They are best used in concert with other data such as structured observations, teacher report, health office visits for somatic concerns, work completion, out of class time/behavioral referrals. It is important to keep in mind the following points:

- These assessments are not diagnostic.
- Consultation with other school-based Student Services staff, and the Student Services Leads for each discipline in Central Office, is available and encouraged.
- Parent permission is needed and documentation of assessment results should be kept solely in the professional files of the assessor.
- Sharing of data internally adheres to MMSD’s guidelines on confidentiality; a signed parental consent to release information (ROI) must be in place in order to share information with community providers.

For Concerns about Anxiety and Worry

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. The child and parent versions of the SCARED have moderate parent-child agreement and good internal consistency, test-retest reliability, and discriminate validity. Both child self-report and parent report versions of SCARED are available; scoring directions are at the bottom of the form.

Child Form

Parent Form


**For Concerns about Sadness, Worry, Depression**

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

This is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Higher CES-DC scores indicate increasing levels of depression. Scores over 15 can be indicative of significant levels of depressive symptoms. The CES-DC can be used with children and adolescents **ages 6-17**. It can be accessed below:


**For Concerns about Hyperactivity, Impulsivity, Inattention, Anxiety, Conduct**

*NICHQ Vanderbilt Assessment Scales*

The Vanderbilt Assessment Scale is a 55-item measure that can be completed by parents and teachers to assess for high frequencies of symptoms associated with ADHD. The scale also includes screening questions for commonly coexisting conditions, including oppositional defiant disorder, conduct disorder and anxiety disorders. The target population for this measure is children **ages 6 to 12**.

Parent Measure (long form)


Parent Follow-Up (short form; often used to monitor education plan/plan of care)


Teacher Measure (long form)


Follow Up (short form; often used to monitor education plan/plan of care)


Scoring Instructions

For Concerns about Relational & Conduct Difficulties, Hyperactivity, Inattention, Emotional Difficulties

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, inquires further about the chronicity, distress, social impairment and burden to others caused by this problem. [www.sdqinfo.org](http://www.sdqinfo.org)

The SDQs in English 50+ other languages: [http://www.sdqinfo.org/py/sdqinfo/b0.py](http://www.sdqinfo.org/py/sdqinfo/b0.py)
MMSD Procedures for Supporting Student with Alcohol and Other Drug (AOD) Behavioral Concerns: Summary Flow Chart

This summary draws on the MMSD Behavior Education Plan (BEP), MMSD Board of Education Policy 4235 “Alcohol and Other Drug Use/Abuse” (revised July 2014), MMSD’s Best Practices for Students Who Are Believed to Be Under the Influence of Intoxicants (developed July 2014), MMSD Board of Education Policy 4147 “Safety” including transportation for medical emergencies, and MMSD’s Health Services Guidelines for Alcohol Use/Misuse/Abuse. Refer to these documents for further details relative to decision-making.
Appendix 23

BEST PRACTICES AND SAFETY PROCEDURES FOR STUDENTS WHO ARE BELIEVED TO BE UNDER THE INFLUENCE OF INTOXICANTS

These procedures comprise the recommended protocol for all MMSD staff who participate in the investigation.

1. Notify an administrator/designee immediately anytime a student is believed to be under the influence of an intoxicant (alcohol or other drug) including:

   • while the student is at school during school hours
   • immediately before and after school
   • participating in any school-sponsored and supervised activity, including athletic events and field trips
   • under the direct supervision of a district employee or volunteer while involved in a school activity
   • while using district provided transportation (e.g., yellow buses)

2. The primary staff response should always be to ensure the health and safety of the student involved. If staff suspect a student is under the influence, they should maintain visual contact with the student and immediately report the incident to an administrator and request assistance. Unless it’s deemed critical to the student’s safety, avoid discussing the behavior in front of other students.

3. An administrator will take the lead and determine next steps. Generally, a student who is believed to be under the influence should be examined by the school nurse who’ll assess immediate physical needs. In addition, the nurse may consult with the administrator regarding the student’s intoxication. However, the nurse’s physical findings should not be used as the sole basis of deciding whether the student is under the influence. Based on all of the information gathered, the administrator makes the final decision.

4. Due to safety concerns, a staff member should maintain visual contact with the student at all times.

5. If the student is incapacitated, a call to parents and 911 for immediate medical assistance may be required. Incapacitation is defined as extreme physical debilitation as evidenced by one or more of the following:

   • Difficulty standing without assistance
   • Difficulty walking, staggering, falling
   • Inability to understand and coherently respond to questions
   • Dilation of eyes, flushed complexion
   • Presence of vomit, urination on clothing
   • Unconsciousness
   • Difficulty breathing

6. If the student is not incapacitated, but is suspected of being under the influence of alcohol or other drugs, an assessment will be made about the level of intoxication. In most cases, the administrator will be able to make a
reasonable determination based on their own observations and information gathered from the student. However, if the student denies having consumed any alcohol or used any drugs, consultation with the school nurse and ERO is recommended. In high schools, the ERO can utilize a Portable Breath Tester (PBT) to determine the level of alcohol the student has consumed. The assessment is more difficult if the student is suspected of being under the influence of other drugs. Again, consultation with the nurse is critical to determine the need for additional medical care and next steps.

7. **Additional information should be collected to determine if other students were involved and if any other risk factors or safety concerns exist.** Staff who initiated the report should be attentive to any chatter about the incident as students often talk about these incidences with peers.

8. **If drugs or alcohol are recovered from the student, place them in a secure location until the investigation is completed and a plan is in place.** All illegal drugs must be turned over to the police for disposal, but it doesn’t mean that the student should be arrested. Small amounts (e.g., one marijuana joint), should not result in criminal charges. However, larger amounts that indicate possession with intent to distribute (e.g., ten individually wrapped bags of marijuana) could result in charges. **When considering involving law enforcement (ERO or police), it is critical to communicate clearly in order to avoid unintended consequences for the student.** It is often helpful to contact the Safety Coordinator, Behavior Education Coordinator, and/or MMSD Legal office, to discuss the specifics of the situation.

9. **Surrender for Safety:** If a student voluntarily surrenders possession of an inappropriate items such as alcohol or drugs before being asked about the item or being discovered to be in possession and before anyone has been harmed by the inappropriate item, he/she will not be subjected to disciplinary consequences. Surrender for safety does not apply when a student is already under investigation for being under the influence.

10. **The options available to an administrator under the BEP will depend on the student’s level of intoxication and on the information available.** The response articulated in the Behavior Education Plan’s for level 2 behaviors is for the student to be supported through an intervention and /or administrative discipline of up to 1 day of in-school suspension. If there are health and safety concerns, parents should be contacted for transport home.

11. **The behavior and resulting interventions must be documented in the student’s electronic behavioral record.**


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July 2014
Appendix 24

MMSD HEALTH SERVICES

ALCOHOL AND OTHER DRUG USE/MISUSE/ABUSE

30.1020

Illnesses

MMSD Rev. 6/2014

No student shall possess, consume or be under the influence of alcohol and/or other drugs in the school, on school grounds, in motor vehicles used by school or at school sponsored events or activities on or off school grounds (Board Policy #4235).

Drug:

Alcohol and any substance, including prescription, non-prescription and illegal drugs, which produces physical, mental, or emotional behavior change in a person. Non-prescription drugs come under this Policy when a student abuses or misuses a non-prescription drug. Prescription drugs come under this Policy when a student misuses or abuses such prescription drugs; or when a student consumes, possesses, sells, gives away, or is under the influence of a prescribed drug that has been prescribed for someone other than such student.

Initial Management

1. Obtain objective data:

   a. Assess for a medical emergency (e.g., loss of consciousness, disorientation, ingestion of dangerous substances and/or unknown quantity, bizarre behavior, seizures, injury). If present, call 911 and be prepared to maintain airway and initiate CPR.

   b. Assess for impairment. Primary concern is for physical safety of student, not to determine if or what substances were used.

      1. General appearance (alert, responsive, sleepy, jaw clenching, sweating, tremors).

      2. Behavior / emotional status (relaxed, anxious, excited, depressed, agitated).

      3. Orientation to name, date, location. (What day is it?; What time of day is it?, What is the name of our school?; Who is your principal?)

      4. Motor coordination (falling, swaying, stumbling, unsteady).

      5. Speech (slow, slurred, rapid).
6. Note odor of breath, hands, clothing.

c. Assess temperature, pulse and respirations. Refer to school nurse for blood pressure and further assessment if indicated.

d. Assess for signs of injury.

e. Notify Administrator if not already done.

2. Obtain subjective data: Ask student, if possible, what happened or ask student’s friends who may have been present. Attempt to determine what substance has been ingested. If substance is known, call Poison Control (1-800-222-1222) for guidance.

3. Provide or supervise treatment/care: Two adults should be present, if possible.

a. Call or send for needed help.

1. (Dependent on assessment of situation) – School Student Services staff (Nurse, Social Worker, Psychologist, or Counselor) or administrator will contact student’s parents and/or guardian and follow Board Policy #4235 if medical emergency is not present.

   OR

2. Contact Madison Fire Rescue Squad (911) if medical emergency is present and student’s behavior is non-violent. Request transport to emergency room and follow Board Policy #4235.

   OR

3. Contact Madison Police Department (911) if student’s behavior is violent. Request transport to emergency room and follow Board Policy #4235.

4. While waiting for help to come:

   a) Monitor temperature and vital signs, keeping alert for respiratory problems.

   b) Maintain airway.

   c) Remain with student until he/she is under professional care or in legal guardian’s care.

Secondary Management

1. Document in Infinite Campus Health Office Visit.

2. Assure follow-up by AOD Team.
# Appendix 25
## The CRAFFT Screening Questions

### Part A

During the PAST 12 MONTHS, did you:  

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Drink any alcohol (more than a few sips)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Smoke any marijuana or hashish?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Use anything else to get high?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

*“anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”*

If the patient answered NO to ALL of the questions in Part A, ask the CAR question below only. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions below.

### Part B

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Do you ever FORGET things you did while using alcohol or drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Scoring:** Two or more yes answers in **Part B** suggest a serious problem and a need for further assessment.

---

**CONFIDENTIALITY NOTICE:**
The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

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Appendix 26

GAIN Short Screener (GAIN-SS)
Version [GVER]: GAIN-SS ver. 3.0

What is your name? a. ________________ b. __ c. ________________
(First name) (M.I.) (Last name)

What is today’s date? (MM/DD/YYYY) [____]/[____]/20[____]

The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can’t go on.

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.

<table>
<thead>
<tr>
<th></th>
<th>Past month</th>
<th>2 to 3 months ago</th>
<th>4 to 12 months ago</th>
<th>1+ years ago</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDScre 1. When was the last time that you had significant problems with...</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. becoming very distressed and upset when something reminded you of the past?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. thinking about ending your life or committing suicide?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDScre 2. When was the last time that you did the following things two or more times?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. lied or conned to get things you wanted or to avoid having to do something</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. had a hard time paying attention at school, work, or home</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. had a hard time listening to instructions at school, work, or home</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. had a hard time waiting for your turn</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. were a bully or threatened other people</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. started physical fights with other people</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. tried to win back your gambling losses by going back another day</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDScre 3. When was the last time that...</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. you used alcohol or other drugs weekly or more often?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?</td>
<td>4 3 2 1 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(Continued)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.

<table>
<thead>
<tr>
<th></th>
<th>Past month</th>
<th>2 to 3 months ago</th>
<th>4 to 12 months ago</th>
<th>1+ years ago</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVSr 4. When was the last time that you...</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>a. had a disagreement in which you pushed, grabbed, or shoved someone?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>b. took something from a store without paying for it?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>c. sold, distributed, or helped to make illegal drugs?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>d. drove a vehicle while under the influence of alcohol or illegal drugs?</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>e. purposely damaged or destroyed property that did not belong to you?</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (Please describe) 1 0

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

7. How old are you today? Age

7a. How many minutes did it take you to complete this survey? Minutes

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gaincc.org

8. Site ID: Site name v.
9. Staff ID: Staff name v.
10. Client ID: Comment v.
11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered
13. Referral: MH SA ANG Other 14. Referral codes:

<table>
<thead>
<tr>
<th>Screener</th>
<th>Items</th>
<th>Past month (4)</th>
<th>Past 90 days (4, 3)</th>
<th>Past year (4, 3, 2)</th>
<th>Ever (4, 3, 2, 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDSr</td>
<td>1a - 1f</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDSr</td>
<td>2a - 2g</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDSr</td>
<td>3a - 3e</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVSr</td>
<td>4a - 4e</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDsr</td>
<td>1a - 4e</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Procedure Summary: Student in Need of Screening for Alcohol and Other Drug (AOD) Concerns

There are two primary routes for students receiving an AOD assessment from a trained Student Services staff member including a) suspicion of possible use based on changes in behavior over time, and 2) suspicion of being under the influence of alcohol or drugs at school.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Tools/Contact Information/Resources</th>
<th>Who does this?</th>
<th>Comments</th>
<th>Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a.</td>
<td>Respond to staff, student, and parent concerns about possible AOD use and related problems</td>
<td>Referral Form submitted to Student Services AOD Team chairperson</td>
<td>Everyone; all staff members</td>
<td>Teacher education needed relative to behaviors that may indicate use of AOD over time (e.g., decreased attendance, grades, etc.)</td>
</tr>
<tr>
<td>1b.</td>
<td>Refer to Principal and School Nurse for acute health concerns thought to be related to alcohol or drug use</td>
<td>Best Practices and Safety Procedures for Investigations Involving Students Who Are Believed To Be Under the Influences of Intoxicants --MMUSD Health Services Guideline for Alcohol and Other Drug Use --Procedures for Responding to Student AOD concerns</td>
<td>Everyone; all staff members</td>
<td>Triage by the school nurse for acute health and safety needs is critical. When a referral for medical care is not indicated, determination of level of use is made by the principal or designee in consultation with the school nurse and others.</td>
</tr>
<tr>
<td>2.</td>
<td>Interview student to assess risk</td>
<td>**CRAFFT &amp; GAIN-SS</td>
<td>Student Services staff trained in AOD assessment</td>
<td>Consult with other members of the Student Services AOD Team as needed.</td>
</tr>
<tr>
<td>3.</td>
<td>Contact parent/guardian as needed and secure Release of Information (ROI)</td>
<td>Follow state statutes relative to confidentiality</td>
<td>Student Services staff trained in AOD assessment</td>
<td>Voluntary disclosures by a student of use of alcohol and other drugs by the student or other students to pupil services professionals or other educators in the school designated by the school board as being part of</td>
</tr>
</tbody>
</table>
the school district’s alcohol and other drug program may not be disclosed, unless 1) the student gives consent in writing, 2) there is serious and imminent danger, or 3) a report must be made for suspected child maltreatment under Ch. 48. Reference: Wis. Stat. sec. 118.126

<table>
<thead>
<tr>
<th>4.</th>
<th>Refer to Community Resources</th>
<th>University of Wisconsin Hospital and Clinics’ Adolescent Alcohol/Drug Assessment Intervention Program (UWHC-AADAIP) Mental Health &amp; AOD Resource List</th>
<th>Student Services staff trained in AOD assessment</th>
<th>Ensure adequate communication with community resource, family and school in order to develop a meaningful plan of support at school</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Develop plan for follow-up and monitoring</td>
<td>GAIN-SS Follow Up tool</td>
<td>Student Services staff trained in AOD assessment</td>
<td></td>
</tr>
</tbody>
</table>

**Training in the use of these two screeners is necessary prior to using with students.**

**CRAFFT**
CRAFFT is a brief alcohol and drug screening test developed by Center for Adolescent Substance Abuse Research at Children's Hospital Boston. The test is comprised of six questions and is designed specifically for use with adolescents. The tool is available in 12 additional languages including Spanish. The CRAFFT questions can be accessed in the public domain at: [http://www.ceasar-boston.org/CRAFFT/index.php](http://www.ceasar-boston.org/CRAFFT/index.php)

**Global Appraisal of Individual Needs – Short Screener (GAIN-SS)**
The GAIN-SS serves as a 3-5 minute, self- or staff administered screener for general populations to accurately identify clients who have one or more behavioral health disorders (e.g. internalizing or externalizing psychiatric disorders, substance use disorders, or crime/violence problems). Responses are given in terms of frequency of the problem in the past month, 2-12 months, more than a year, or never. The number of past-month symptoms is used as a measure of change; the number of past-year symptoms is used as a covariate to measure lifetime severity. This screener also rules out those not identified as having those behavioral health disorders, serves as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision, and it serves as a periodic measure of change over time in behavioral health. This 20-item instrument is available in English and Spanish. To access these measures and learn more about GAIN-SS: [http://www.gaincc.org/](http://www.gaincc.org/) [http://www.gaincc.org/GAINSS](http://www.gaincc.org/GAINSS)
Appendix 28

Nonsuicidal Self Injury Protocol: MMSD

IDENTIFYING NSSI

Nonsuicidal self-injury (NSSI) is the deliberate damaging of one’s own body tissue in the absence of any intent to die. It is commonly referred to as deliberate self-harm, self-mutilation, and “cutting”. Although most often not a suicidal gesture, it is statistically associated with suicide and can result in unanticipated severe harm or fatality. The absence of suicidal intent needs to be established for any self-injurious behavior.

Reports of NSSI span centuries; reported instances, however, have increased dramatically over the last 20 years. DSM-5 criteria for NSSI require 5 or more days of intentional self-inflicted damage to the surface of the body without suicidal intent within the past year. Persons also must engage in the self-injurious behavior with at least 1 of the following expectations: to seek relief from a negative feeling or cognitive state, to resolve an interpersonal difficulty, or to induce a positive state. The behavior must also be associated with 1 of the following criteria: interpersonal difficulty or negative feelings and thoughts (e.g., depression, anxiety), premeditation, and ruminating on (non-suicidal) self-injury. Socially sanctioned behaviors, like body piercing and tattooing, do not qualify for the diagnosis, nor do scab picking or nail biting.

Prevalence:

Studies report a lifetime prevalence ranging from 12 to 37.2 percent in secondary school populations, and an increasing prevalence in older elementary school students. The average age of onset in the U.S is 16 years, with the normally-distributed age of onset ranging from 10 to 24 years. (DSM-5, 2013). Self-injury occurs in both sexes; about 60-65% female and 35-40% male (Ross and Heath, 2002); males more frequently engage in the battery forms of NSSI such as self-bruising and breaking bones.

Of all youth reporting any NSSI, over three-quarters report more than one episode, and about one-quarter report a single episode. Even one episode of NSSI is significantly correlated with a history of trauma including abuse, and comorbid conditions such as depression, mood disorders, suicidality, obsessive-compulsive disorder (OCD), and eating disorders (ED).

Common reasons for self-injury:

- To displace emotional pain (sadness, anxiety) from the psyche to the body
- To distract from overwhelming emotion
- To reconnect from a feeling of emotional numbness with the reality of being alive to-
Self-injury is not just attention-seeking, just manipulation or just trivial. The depth of the physical injury does not necessarily reflect the depth of the emotional pain, and a careful assessment is vital.

**Signs and symptoms of self-injury:**

Signs and symptoms are sometimes absent or easy to miss. Arms, hands, and forearms opposite the dominant hand are common areas for injury and often bear the tell-tale signs of a self-injury history (e.g., a right-handed person will often injure his/her left arm). However, evidence of self-injurious acts can and do appear anywhere on the body. NSSI can include a variety of behaviors but is most commonly associated with:

- Intentional carving, cutting or scratching of the skin
- Subdermal tissue scratching
- Burning (including abrasions from ice or erasers)
- Ripping or pulling of the skin or hair
- Self-bruising

**Possible signs:**

- Inappropriate dress for the season, such as consistently wearing long sleeves or pants in warm weather
- Constant use of wrist bands/coverings
- Unwillingness to participate in events/activities which require less body coverage such as swimming or gym class
- Frequent bandages
- Odd/unexplainable paraphernalia (e.g., razor blades, thumb tacks, or other implements which could be used to cut or pound)
- Heightened signs of depression or anxiety
- Unexplained burns, cuts, scars, or other clusters of similar markings on the skin
- Secretive behavior including spending unusual amounts of time in isolated areas, e.g.,
PROTOCOL

Assessing NSSI

Concern that a student is showing signs of NSSI may come from observations of teachers & staff, peer disclosure, or self-disclosure. Referral to the school nurse is critical for any open or healing wounds. Unless the student is in obvious emotional crisis, kind and calm attention to assuring that all physical wounds are inspected and treated should precede additional conversation with the student about non-physical aspects of self-injury. The nurse will:

- Use a non-judgmental, matter-of-fact approach, setting the tone for trust and future communication. Avoid being over-sympathetic, shaming, or reacting with criticism or shock. An attitude of respectful curiosity is helpful.

- Note wound severity, implements used, location of injury, observed number of scars (see Rosen and Heard Rating System; Level 1 requires First Aid; Levels 2-4 requires referral for physical care)

- Deliver first aid, reinforcing the need for infection prevention.

- Possible questions:
  - Is this the first time you’ve injured yourself, or have there been others?
  - Where on your body do you typically injure yourself?
  - What do you typically use to injure?
  - What do you do to care for your wounds?
  - Have you ever hurt yourself more severely than intended?
  - Have your wounds ever become infected? Have you ever been to a health care provider because you were worried about a wound?

The school nurse and/or another Student Services staff member conducts an assessment to determine risk immediately following the physical assessment or soon after. A guiding principle for assessment is the importance of consulting with at least one other Student Services staff in the assessment process.

- While it is uncommon for actively self-injurious students to be suicidal, screening for suicidality is always indicated:
  - Have you ever had thoughts that you wanted to die?
  - Did you ever have a plan? If yes, “tell me more about that”.

The protocol for NSSI assessment is designed to ensure that students receive appropriate care and support, while also addressing the underlying emotional and psychological needs that may be contributing to self-harm behaviors. It is crucial for educators and school health professionals to approach these situations with a high degree of sensitivity and empathy, as well as a commitment to ensuring the safety and well-being of all students.
Did you ever act on that plan?

How about right now? Are you thinking about killing yourself at this moment? Today?

If “yes” to any of these questions, proceed or refer for a suicide risk assessment (SRA).

Interview questions should aim to assess:

- History
- Frequency
- Types of methods used
- Triggers
- Psychological purpose
- Disclosure (who knows)
- Help seeking and support

Assessment of Risk: General:

- LOW risk
  - Little history of self-injury
  - Manageable amount of external stress
  - Some positive coping skills
  - Some external supports

- HIGHER risk:
  - Frequent or long-standing NSSI practices
  - Use of high lethality methods
  - Chronic internal and external stress
  - Few positive supports or coping skills

Assessment of Risk: Stage Model of NSSI (Williams, 2012):

This model parallels the development of other addictive behaviors and allows deeper understanding of the behavior as well as designing interventions.

- Stage 1: No Self-Injurious Behavior – the lowest level of self-injury with no present of past self injury
Stage 2: Experimental NSSI – Stage 1 comprises the first act(s) of self-injurious behavior; this experience will help determine whether or not they choose to repeat this behavior. Adolescents in Stage 1 are not yet committed to NSSI as a coping behavior, nor have they taken on the identity of person who self-injures. This stage is one of experimentation with the behavior.

Stage 3: Encapsulation – Students in Stage 3 are no longer experimenting with or exploring NSSI. At this point, NSSI is not one of many coping strategies used but, rather, the primary (if not the only) method used to control negative feelings. NSSI happens regularly, and these adolescents may construct elaborate plans regarding how and when self-injury will occur. In this stage, urges strike at inconvenient times and become more difficult to control; the behavior becomes increasingly difficult to hid.

Stage 4: Pervasive Dysfunction—the final stage of NSSI behavior is characterized by constant self-injurious thoughts and actions. At Stage 4 the behavior is barely under an adolescent’s control. Such extreme behavior is found almost exclusively in clinical populations and is atypical of adolescents who engage in NSSI. Probability of suicidal thoughts and plans is higher in Stage 4 than Stage 3.

Action Steps and Referral

LOW risk: Ideally the student should be encouraged to call his or her parent/guardian to talk about what occurred. For older adolescents especially, if there is a high likelihood that parent/guardian contact will pose an additional risk to the student, delaying parent notification may be considered in consultation with other staff. Teaching strategies for using more positive coping mechanisms and a follow-up plan are indicated.

HIGHER risk: Parent/guardian involvement is indicated, engaging the student as an active participant. Unless the student is in severe crisis and unable to function, the decision to make parental contact should be discussed honestly and respectfully with the student. A meeting to discuss next steps should be scheduled as soon after the event as possible. Parent/guardian meetings provide an opportunity to answer questions, address parental concerns and dispel myths about NSSI that the parent might have. Additionally the meeting will allow for the following actions:

- Provide parent/guardian with community and web-based resources for understanding and effectively addressing NSSI.
- Plan for additional supports at school.
- Encourage and help family and student get outside community services
- Follow up in 1-2 week and no later than one month after the school detects a NSSI.

Attention to Social Contagion

Social contagion refers to the way in which a behavior can spread among members of a
group. To prevent social contagion in schools relative to NSSI:

- Reduce communication around self-injury by advising students who self-injure not to explicitly talk with other students about engaging in this behavior.
- Assist students in managing healing wounds and scars including keeping them covered.
- To not give student explicit information about NSSI, e.g., no school-wide assemblies.
- **Supports for students with NSSI MUST be done on an individual basis; it is not appropriate to treat self-injury with a group intervention targeting students who self-injure.**
- However, educating students about signs of distress in themselves and others, as well as teaching the use of positive coping skills, is useful. Including students who self-injure in a group with others who do not self-injure for this purpose may be a useful intervention.

**References:**


## Protocol Summary: Nonsuicidal Self-Injury (NSSI)

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Tools/Contact Information/Resources</th>
<th>Who does this?</th>
<th>Comments</th>
<th>Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respond to any show of signs and symptoms</td>
<td>Refer to Protocol and website resources for more detailed information on NSSI</td>
<td>All school staff should be aware of signs. Student Services staff</td>
<td>Referrals can come from school staff, peers, parents/guardians, or self-disclosure</td>
<td></td>
</tr>
<tr>
<td>2. Refer to School Nurse for assessment and treatment of wound</td>
<td>School Staff who has initial contact with student regarding NSSI concern</td>
<td>Accompany the student to the Health Office if being referred from elsewhere.</td>
<td>School Nurse will document assessment and care in IC Health Record</td>
<td></td>
</tr>
<tr>
<td>3. Interview student to assess risk</td>
<td>Interview questions and parameters in protocol</td>
<td>Student Services staff (nurse, social worker, psych, counselor) trained in assessing NSSI risk</td>
<td>Consultation with another Student Services team member is always indicated at some point in the assessment process</td>
<td>Document level of risk</td>
</tr>
<tr>
<td>4. Contact Parent/Guardian:</td>
<td>MMSD Release of Information form</td>
<td>Student Services staff trained in assessing NSSI risk</td>
<td>Contact CPS if contacting parent will exacerbate the situation Share with parent the results of risk assessment</td>
<td>Document parent/guardian contact and plan of care</td>
</tr>
<tr>
<td>--Request they come to school if risk high(er).</td>
<td>Mental Health &amp; AOD Resource List</td>
<td>Student Services staff trained in assessing NSSI risk</td>
<td>Arrange for mental health referral while parent/guardian still at school</td>
<td></td>
</tr>
<tr>
<td>--Request consent for release of information.</td>
<td>Mental/Behavioral Health Referral Guide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Refer to Community Mental Health Provider</td>
<td></td>
<td></td>
<td>Copy of forms and other documentation placed solely in Student Services staff member personal file; do not put in MMSD behavioral file.</td>
<td></td>
</tr>
<tr>
<td>6. Plan for follow-up and monitoring at school</td>
<td>Fact Sheets for Parents --Safety Planning Guidelines and template</td>
<td>Student Services staff trained in assessing NSSI risk --Involve principal or designee as needed</td>
<td>Involve student in creation of plan as fully as possible</td>
<td>Document plan including primary school contact person; community mental health providers.</td>
</tr>
</tbody>
</table>
MMSD Nonsuicidal Self Injury Protocol for Students: Flowchart

To aid in decision-making regarding the safety and care of students who may be engaging in self injury

Student show signs and symptoms of NSSI

Staff suspects Student self injury

Peer disclosure of student self injury

Self-disclosure and/or parent concern

School becomes aware of student self injury

School Nurse assesses and treats wounds for severe or life-threatening

Contact Emergency Services injuries

Student Services trained staff interviews student

LOW RISK: Teaching strategies for positive coping Mechanisms, contact parent(s) as indicated, monitor

HIGHER RISK: Parent involvement, provide resources and referral, plan for additional supports at school, follow-up in 1-2 weeks
Appendix 31

MMSD: Individual Short-Term Safety Plan Protocol

Purpose:
To establish and maintain consistent measures for school personnel to follow in cases when a student displays unsafe behavior AND is considered at risk for future unsafe behavior (i.e., threat to self or others including suicidal or homicidal ideation, nonsuicidal self-injury, firesetting, inappropriate sexual touching, court imposed safety plans, or returning from treatment with community imposed safety plans). An individual student safety plan is generally short-term and it, unlike a typical behavior plan, addresses specific behavior that is dangerous to the student and/or others.

Process:
1. Create a plan considering student need, as well as school schedules and resources:
   • Who will do what?
   • How will plan be monitored?
   • What is the review schedule (plans should be working documents that are reviewed regularly and modified as indicated by student behavior or information from a qualified mental health provider)
   • How will the decision be made to terminate the plan?

2. Student Services staff in collaboration with the Principal completes MMSD Individual Student Safety Plan using all available information (with participation of student, family, and relevant school personnel). If student safety needs are beyond the school’s ability to provide for, the Coordinator of School Safety should be contacted immediately; other key consultation contacts include the Assistant Superintendent and Director of the Office of Physical, Mental and Behavioral Health.

3. Plan will include (link to Individual Student Safety Plan):
   • Description of unsafe behaviors
   • Strategies that work and do not work for warning signs and triggers
   • Crisis Response Plan
   • Identification of specific behavior supports
   • Identification of safety team members and point person.
   • Develop schedule for reviewing the plan; minimum every two weeks

4. Point person shares plan with all persons responsible for carrying out the plan (including substitutes and others who may supervise the student) in order that everyone understands their role in ensuring the student’s safety.

5. Once Safety Plan is submitted online, the team will make a decision about whether the situation warrants a “flag” appear on the student’s IC record. The flag will have the following message: “Alert: Student has safety supervision plan.” Specific information will not be entered in this location. In most cases, a “flag” will be in the student’s best interest.

6. Unless otherwise specified, the plan will be terminated at the end of the school year.
INDIVIDUAL STUDENT SAFETY PLAN

An individual student safety plan, unlike a typical behavior plan, addresses specific behavior that is dangerous to the student and/or others.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Grade</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Special Education?</th>
<th>Yes</th>
<th>No</th>
<th>Case Manager:</th>
</tr>
</thead>
<tbody>
<tr>
<td>504 Plan?</td>
<td>Yes</td>
<td>No</td>
<td>Case Manager:</td>
</tr>
</tbody>
</table>

Contact Information

<table>
<thead>
<tr>
<th>Parent/Guardian:</th>
<th>Home Phone:</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell Phone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Contact:</td>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>

Places Student May Be if Missing During School Hours

<table>
<thead>
<tr>
<th>On School Grounds</th>
<th>Off School Grounds</th>
</tr>
</thead>
</table>

Medical Information

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Phone:</th>
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<table>
<thead>
<tr>
<th>Diagnoses:</th>
<th>Medications:</th>
<th>Allergies/Special Considerations:</th>
</tr>
</thead>
</table>

Description of Specific Unsafe Behaviors (why student requires a safety plan)

CRISIS RESPONSE PLAN

<table>
<thead>
<tr>
<th>What to do if student exhibits above described behavior</th>
<th>Who will do what/backup staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warning Signs/Triggers</td>
<td>Strategies That Work</td>
</tr>
<tr>
<td>------------------------</td>
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<td></td>
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</table>

**BEHAVIOR SUPPORTS**

What will staff, student, and family do to lessen the likelihood of unsafe behavior (i.e., supervision, transition planning, transportation to and from school, plan for unstructured time, closed campus, searches, etc.)? Who / Back-up person?

How will plan be monitored? Who/Back-up person?

How will decision be made to terminate the plan? Who/Back-up person?

**Current Agencies or Outside Professionals Involved**

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency</th>
<th>Phone</th>
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<tbody>
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<td>4.</td>
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</tbody>
</table>

**Student Safety Team Members**

<table>
<thead>
<tr>
<th>Name/Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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<td>4.</td>
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<tr>
<td>5.</td>
<td>Principal</td>
<td></td>
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<tr>
<td>6.</td>
<td>Safety Plan Coordinator</td>
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</tbody>
</table>

Next Review Date: (approximately two weeks from initiation of plan or last review date)
Appendix 33

MMSD Safety Planning for Students Who are Adjudicated
Plan Template & Meeting Agenda

Date(s):

School:

Student:

Plan prepared by: (name, title, phone number)

Present: (names/titles)
Principal
MMSD Safety and Security Coordinator
Name of parent/guardian if in attendance
List others

Purpose of Meeting(s):
To develop a safety plan that balances the student’s right to privacy and access to educational programming with the safety needs of the school and community.

Background Information:

Court Order:
List conditions of court order that are pertinent to the safety plan, e.g., no contact orders.

Safety Plan Considerations:

1. Course Selection & Scheduling:

2. Supervision during classes and non-structured times (e.g., recess, bathroom use, passing times, evacuations):

4. Restricted access to information: It is the school district’s legal responsibility to restrict access to the information shared during this safety planning meeting. Releases of Information are obtained and filed.

5. Sharing of plan with (Student):

6. Termination of Court Order and Supervision: (Date court supervision is scheduled to end)
Appendix 34

Suicide Risk Assessment Protocol: MMSD

IDENTIFYING SUICIDAL BEHAVIOR

Suicidal behavior includes a student’s stated or unstated thoughts about causing intentional self-injury or death (suicidal ideation) and acts that cause intentional injury (suicide attempts) or death (suicide). Suicide is the third leading cause of death in teens. Five to 10% of high school students make attempts every year. Nonsuicidal self-injury is not necessarily indicative of suicidality.

Suicide is a complicated human behavior. Here is what is important to know:

- There is no typical suicide victim
- There are no absolute reasons for suicide
- Suicide is always multi-dimensional
- Preventing suicide must involve many approaches and requires team work
- Most suicidal people do not want to die; they just want to end their pain
- Ambivalence almost always exists until the moment of death

(From: The Wisconsin Components of School-Based Suicide Prevention, Intervention, Postvention Model.)

RISK FACTORS VERSUS WARNING SIGNS

Risk factors are epidemiologically derived, often distant in time and unchangeable. They may mean nothing. Warning signs are behavioral signs of precipitating conditions in an individual. They are observable and current. Risk factors make warning signs more ominous.

RISK FACTORS FOR SUICIDE: There are no formal ways to weigh the significance of risk factors in an individual. Risk factors are stressful events, situations, or conditions that exist in a person’s life that may increase the likelihood of attempting or dying by suicide.

- Previous suicide attempt
- Access to lethal means (firearms, poisons, prescription medications, alcohol & other substances)
- Mental illness (depression, anxiety, mood disorder, personality disorder, schizophrenia)
- Impulsively aggressive response to stress
- Low frustration tolerance
● Alcohol and other substance use disorders
● Serious medical/physical illness
● Hopelessness
● Family history of suicide or recent suicide in school
● LGBTQ youth
● History of abuse, trauma, interpersonal violence
● Perceived lack of social support; lack of affiliation, especially lack of meaningful adult connection
● Family violence/stress/dysfunction
● Rejection by peers, loneliness
● Bullying (both perpetrators & victims)
● Low self-esteem

WARNING SIGNS FOR SUICIDE: Warning signs are the changes in a person’s behaviors, feelings, and beliefs about oneself that indicate risk. Never take warning signs lightly.

● Suicidal threats in the form of direct and/or indirect statements
● Suicidal intention including notes and pre-planning (giving away possessions)
● Decline in quality of school work
● Increased alcohol or drug use
● Preoccupation with death
● Changes in behavior, appearance, thoughts &/or feelings
● Talking about feeling trapped or unbearable pain
● Talking about being a burden to others
● Acting anxious or agitated; behaving recklessly
● Sleeping too little or too much
● Displaying sudden improvement after a period of being very sad and withdrawn. This may mean that a decision has been made to escape all problems by ending one’s life.

PROTECTIVE FACTORS FOR SUICIDE: Protective factors are the positive conditions and person-
al and social resources that promote resiliency and reduce the potential for youth suicide. It is important to understand that protective factors do not prevent suicide.

- **Individual Characteristics & Behaviors**
  - Psychological or emotional well-being, positive mood
  - Emotional intelligence: the ability to perceive, integrate into thoughts, understand and manage one’s emotions
  - Adaptable temperament
  - Internal locus of control
  - Strong problem-solving skills
  - Coping skills, including conflict resolution and nonviolent handling of disputes
  - Positive self-esteem
  - Frequent vigorous physical activity or participation in sports
  - Spiritual faith or regular church attendance
  - Cultural and religious beliefs that affirm life and discourage suicide
  - Resilience: ongoing or continuous sense of hope in the face of adversity
  - Frustration tolerance and emotional regulation
  - Body image, care, and protection

- **Family and Other Social Support**
  - Family support and connectedness to family, closeness to or strong relationship with parents, and parental involvement
  - Close friends or family members, a caring adult, and social support
  - Parental pro-social norms, that is, youth know that parents disapprove of antisocial behavior
  - Family support for school

- **School**
  - Positive school experiences
  - Part of a close school community
- Safe environment at school
- Adequate or better academic achievement
- A sense of connectedness to school
- A respect for the cultures of all students

**GENERAL GUIDELINES / INITIAL STEPS**

If you are concerned about a student or observe warning signs: ACT

- Acknowledge the student’s feelings
- Show Care/Concern
- Tell a member of the school student services team/designated crisis team member

Everyone in school must take suicidal behavior seriously and should know who to contact if he or she has a concern. Youth who feel suicidal may not seek help directly. Anyone who has a concern should take immediate action to inform the school administrator and/or the designated Student Services crisis team member. **Take immediate action. Never leave the student alone.**

During time with the student prior to connection with the Student Services crisis team member:

- Remain calm.
- Provide constant supervision. Do not leave the youth alone.
- Focus on your concern for his or her wellbeing and avoid being accusatory.
- Listen.
- Reassure that there is help and that he or she will not feel like this forever.
- Do not judge.
- Remove means for self-harm.

**SUICIDE RISK ASSESSMENTS (OVERVIEW)**

Suicide risk assessment is the process of determining an individual’s level of risk, i.e., low, medium, or high. Suicide risk assessments require training, and utilize a combination of evidence-based data and clinical impressions to determine risk. In the school setting, assessments should be accomplished by key trained support staff (social worker, psychologist, nurse, and counselor) in consultation with other knowledgeable staff and the parents.

Positive response to two questions warrants further assessment:

- Have you ever felt that life is not worth living?
● Have you ever felt like you wanted to kill yourself?

The protocol includes provisions for:

● Assessing suicide risk: See Suicide Risk Assessment Form; Student Safety Plan

● Notifying parents/guardians (unless this will exacerbate the situation—refer to CPS); advise parents to restrict lethal means (guns, alcohol, etc.)

● Referring to a mental health service provider: See Notification of Student Suicide Risk to Mental Health Provider Form; Flow Sheet

● Developing plan for follow-up and monitoring at school

● Documenting the process

“No Self Harm Contracts” are not evidenced based. Although they may be useful in expressing concern for the student and gaining assessment information, they more often lead to false reassurance.

Confidentiality is not an issue in emergency situation. When a student is believed to be suicidal or has expressed suicidal thoughts, school officials may determine that an articulable and significant threat to the health or safety of the student exists and that such a disclosure to appropriate parties is warranted under this exception (Department of Education, 2010).

DOCUMENTATION:

Assessment & Plan should be the largest part of a note. Show evidence that you have consulted with others and interpreted the information; include comments. Document what you have learned from the student using competent, clinical judgment. Keep all documentation solely in personal file.

FOLLOW-UP AND MONITORING AT SCHOOL

A re-entry meeting that includes student, parent/guardian, and primary school contacts is needed to create a plan to provide a support system at school and minimize stressors for the student. Purposeful and timely communication between the family, school and mental health providers is imperative, based on a well-outlined school plan and necessary signed releases to share information. Important factors in a student-centered plan include:

- Identifying a student school support team, include administrator in planning
- Identifying a case manager or primary contact person
- Identifying key community mental health provider and instructions for how to contact from school if needed
- Development of a communication plan between home, school and community
- Development of a plan for teacher collaboration to enhance their support of student
Consider the need for shortened day or altered class schedule

Identify and document plans for student observation and check-in’s

Identify and implement emotional and educational supports (school groups, extracurriculars)

REFERENCES

Alexandria City Public Schools. Suicide Prevention / Intervention Guidelines, December 2013


eSchool Care: Suicide Overview and Care at School section of the Mental Health module https://www.eschoolcare.org/


Mays, D. Safe Communities Suicide Risk Symposium. PowerPoint presentation, 2007


Substance Abuse and Mental Health Services Administration (SAMHSA) Preventing Suicide: A Toolkit For High Schools, 2012

## Protocol Summary: Student with Suicidal Ideation or Threat of Harm

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Tools/Contact Information/Resources</th>
<th>Who does this?</th>
<th>Comments</th>
<th>Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Take any threat seriously and respond immediately.</td>
<td>Inform Student Services staff member (psychologist, social worker, nurse, counselor) &amp; administrator</td>
<td>Everyone; all school staff</td>
<td>• Do not leave student alone. • Personally escort student to Student Services staff, or if necessary, clear other students from the area and call for assistance.</td>
<td></td>
</tr>
<tr>
<td>2. Interview student to assess urgency/risk</td>
<td>Suicide Risk Assessment Form, Student Safety Plan</td>
<td>Student Services staff member trained in SRA</td>
<td>• Always consult with at least one other student services professional.</td>
<td>Document • Level of risk</td>
</tr>
<tr>
<td>3. Contact Parents</td>
<td>Suicide Risk Assessment Form</td>
<td>Student Services staff member trained in SRA</td>
<td>• Contact CPS if contacting parent will exacerbate the situation • Share with parent/guardian the results of risk assessment • Advise parent to restrict lethal means.</td>
<td>• Notification of parent/guardian and recommendations. • Parent/guardian commitment to seeking immediate mental health assessment. • Consent for ROI from parent.</td>
</tr>
<tr>
<td>4. Refer to Community Mental Health Provider</td>
<td>Notification of Student Suicide Risk to Mental Health Provider Form, Decision-making Tree: Which professional are you going to contact?</td>
<td>Student Services staff member trained in SRA</td>
<td>• Arrange for mental health referral while parent/guardian are still at school</td>
<td>• Copy of forms and other documentation placed solely in Student Services staff member personal file; do not put in MMSD behavioral file.</td>
</tr>
<tr>
<td>5. Develop plan for follow-up and monitoring at school.</td>
<td>Involve administrator/designee</td>
<td>Student Services staff member trained in SRA</td>
<td>• Consider communication plan; shortened or altered schedule; plans for student observations or check-in’s; need for teacher collaboration to enhance their support of student. • Involve student in creation of plan if possible.</td>
<td>Document plan; including primary school contact person; how to contact community mental health providers; communication plan between home, school and community provider.</td>
</tr>
</tbody>
</table>
## Appendix 36

### Suicide Risk Assessment Form

Note: Risk assessment cannot be performed with complete accuracy, and does not predict with certainty the future behavior of this student. The findings and recommendations contained in this assessment represents the best professional judgement of the examiner/s based on information provided.

Describe what the student did or said to indicate risk of harm to self, include the words, actions or behaviors that initiated this process. Indicate date time and information source.

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific with intent</td>
<td>Specific no intent</td>
<td>Nonspecific</td>
<td>1. Have you ever thought about hurting yourself?</td>
</tr>
<tr>
<td>Method and access</td>
<td>Method</td>
<td>Nonspecific</td>
<td>2. Have you thought about how you would hurt yourself?</td>
</tr>
<tr>
<td>Hours, days</td>
<td>Few days/week</td>
<td>Nonspecific</td>
<td>3. What is your timeframe for this plan?</td>
</tr>
<tr>
<td>Multiple</td>
<td>Single</td>
<td>None</td>
<td>4. Have you ever tried to hurt or kill yourself?</td>
</tr>
<tr>
<td>Many</td>
<td>Few</td>
<td>None</td>
<td>5. Have you told or shown anyone what you are thinking about?</td>
</tr>
<tr>
<td>Hopeless</td>
<td>Ambivalent</td>
<td>Mild</td>
<td>6. Do you see hope for your future?</td>
</tr>
<tr>
<td>Frequently</td>
<td>Seldom</td>
<td>Never</td>
<td>7. Have you been using drugs or alcohol?</td>
</tr>
<tr>
<td>Major changes</td>
<td>Minor changes</td>
<td>None</td>
<td>8. Tell me about any big changes or losses you have experienced?</td>
</tr>
<tr>
<td>Severe</td>
<td>Moderate</td>
<td>Mild</td>
<td>9. Have you been irritable or depressed lately?</td>
</tr>
<tr>
<td>Many</td>
<td>Few</td>
<td>None</td>
<td>10. Consider all known Risk Factors</td>
</tr>
</tbody>
</table>

Behavior Education Plan Toolkit | 2014-15
Consider Known Chronic Risk Factors such as: prior history of hospitalization, history of abuse or neglect, trauma history, significant changes in environment, severe loss, LGBTQ youth, mental health diagnosis, etc.

Consider Known Warning Signs such as: notes, making final arrangements, giving away possessions, social isolation, increased risk taking, family history of suicide, friend has attempted suicide, etc.

Other important factors, if any, in the determination of risk include the following:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Analyze all available data and categorize the potential risk to the student. Each assessor should initial the box beside their perceived level of risk. **In the event two assessors do not agree, follow the protocol for the highest level of risk.**

High Level of Risk-
The student is in significant distress. There is clear suicidal thinking and warning signs are present. The student’s coping skills and social supports are limited or compromised. There may be a situation that is difficult to resolve. The student appears to be in imminent danger of inflicting self-harm or committing suicide. There is need for immediate intervention and possibly hospitalization.

[ ] [ ]
Moderate Level of Risk-
The student is in distress. There is suicidal thinking but the student does not seem intent on harming himself/herself. The problem situation can be resolved and the student appears able to use some coping skills. The student’s suicidal thinking is concerning but they are not expressing a clear intent to harm herself/himself. The student is open and responsive to support, or already has sufficient support. There is a need for parents involvement and a referral to outside sources.

Low Level of Risk-
The student appears to be at low risk for harming himself/herself based on information provided at this time. The student is in distress but has positive supports. The student’s concerns and needs may be readily addressed. The student does not appear serious about harming himself/herself nor have they thought seriously about a means to do so. Communication with parents and relevant staff is warranted.

Assessor Name/Title  Date/Time

Assessor Name/Title  Date/Time

Original in Student Services Staff file
Actions Taken: (Initial all that apply)

1. Continue monitoring risk factors
2. Notify family/family supervision*
3. Notify/consult with supervisor*
4. Recommend/refer to outpatient treatment*
5. Recommend/refer to psychiatric consult/med evaluation*
6. Recommend elimination of access to firearms/poisons
7. Notify legal authorities &/or CPS of risk to self/or others*
8. Recommend/refer to crisis unit/voluntary hospitalization*
9. Initiate involuntary hospitalization*
10. Communicate follow-up status to original referral source

*See Notification of Student Suicide Risk Assessment Concern to Mental Health Providers
Student Name:_________________________ Date of Birth:______________
School: ______________________________ Grade:________________

I have expressed thoughts about hurting myself. School staff members are concerned and want to support me. I understand that I have a part in keeping myself safe. If I think about hurting myself, I will help myself in the following ways:

☐ Get help from an adult immediately:
   At school I will talk to:
   1._________________________,or
   2._________________________,or
   3._________________________

   Outside of school, I will talk to:
   1._________________________,or
   2._________________________,or
   3._________________________

Call 911 or a Crisis Hotline that is open 24 hours per day:
Journey Crisis Intervention Line (24 hours) 280-2600
Briarpatch Crisis Line 251-1162
Catholic Charities 256-2358
National Suicide Prevention Lifeline (24 hours) 1(800) 273-8255

☐ If I cannot reach anyone, I will call 911 to get help for myself.

☐ Not take any alcohol or drugs

☐ I could also do this: ____________________________________________________

☐ I need help with: _______________________________________________________

Student Signature/Date  School Staff Signature/Date

Copy to student, parent, original with Student Service Staff.
Appendix 37

DECISION-MAKING TREE: WHICH PROFESSIONAL ARE YOU GOING TO CONTACT FOR A STUDENT SUICIDE CONCERN?

- Use Student Suicide Concern Form to sort on urgency.
- Use the left side of the above flow chart if there is NOT an urgent suicide concern.
- Use the right side of the flow chart if there IS an urgent suicide concern.
- If student has a current mental health provider, contact that provider.
- If student does NOT have a current provider, and there is an urgent suicide concern, contact the appropriate HMO. Use Journey Mental Health Center, if uninsured.
- Send Notification Form with parent or fax to Mental Health provider.

This form was developed to assist with obtaining mental health services in a timely manner for students with urgent mental health suicide concerns. Please use/send this form to providers only in urgent situations.

* If in need of immediate medical care, call 911 as you would with any medical emergency.
NOTIFICATION OF STUDENT SUICIDE CONCERN TO MENTAL HEALTH PROVIDER

Dear Mental Health Provider __________________________________________________________: Date/Time of Assessment: _____________

I am concerned about the safety of a student:

Student Name: ___________________________________________ School: _______________________________________
Address: ____________________________________________ Parent(s) Name(s): _________________________________
Telephone: ___________ / ___________ / ___________ DOB: ___________ ___________
Home# ___________ cell# ___________ Parent’s Work# ___________
Insurance: _________________________ Clinic/Primary Care Physician: __________________________
Current Therapist: __________________________________________________________________________

My impression is that the safety risk is:  □ Urgent/imminent  □ Potential Risk—Clinical risk assessment needed

My concerns are:

☐ Has current thoughts and/or intent of suicide or other self-harm
☐ Has past attempts
☐ Has done some planning
☐ Has specific plan
☐ Has lethal plan
☐ Has access to means
☐ Family member or peer has completed a suicide
☐ Vegetative symptoms of depression, unable to function
☐ Possible/probable AOD
☐ History of significant mental health problems in family

I have documented my concerns via:

☐ Student’s unsafe behaviors
☐ Student interview
☐ Interview of parent
☐ Suicide Risk Assessment Form
☐ Other

What does the student say about what keeps them from taking action today? ___________________________________________

I am operating with the following permissions from parent/guardian:

☐ Attached signed Authorization to Obtain or Release Patient Health Care Records (101370).
☐ Verbal permission for release of information in this urgent situation documented in our records.
☐ Unable to reach parent/guardian or emergency contact.
☐ Contacted primary care physician ______________________ who gave permission for us to contact a mental health provider.
☐ Parent has refused release of information and the police and/or Dane County Human Services have been contacted.
☐ Other

This information is being sent to you via: □ the parent  □ faxed to your office

Student Services Professional: _____________________________________________________________
(Print) __________________________________________________________________________ (Sign) __________________________________________________________________________________
Phone # ___________________ email address: ________________________________________________

Dean – 252-8226; Dean East – 260-6006; Dean West – 824-4777
UW Behavioral Health (non MA) – 233-3575
Unity & Physician’s Plus (MA/JA unassigned to HMO) Uninsured: Journey MHC: 280-2720
Journey MHC Crisis Intervention (24 hour line) 280-2600
Group Health Cooperative – 257-9700

Use for all referrals for Suicide Risk
Keep a copy for your professional records
June 2014
## Appendix 39

### Violence Risk Assessment Procedure

<table>
<thead>
<tr>
<th>Steps</th>
<th>Tools/Contacts</th>
<th>Who does this?</th>
<th>Comments</th>
<th>Documentation Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Notification of threat to safety coordinator, parent, and convenes team</td>
<td>Safety Coordinator: 663-1904</td>
<td>Principal/Designee</td>
<td>In order to interview the student in emergency situations involving potential harm, parent notification is good practice, but not required by law or professional ethics. If the parent refuses to grant permission for the school to conduct a student interview, or the student refuses to cooperate with the VRA process, this is noted and decisions are made based on existing data.</td>
</tr>
</tbody>
</table>
| 2     | Complete VRA checklist  
- Indicate what information is already available, and what information still needs to be gathered.  
- Determine what/how information will be collected (i.e., record review, student interview, parent/staff interviews, and interviews with community agencies.)  
- Assign tasks and responsibilities to appropriate members of the team. | VRA Checklist | Principal/Designee with Team  
Team is comprised of Administration, Student Services and Safety/Security | Training should be provided to Principals, Assistant Principals, Deans of Students, Safety Resources (e.g., ERO’s) and Student Services Staff on the use of the VRA Checklist to inform decisions  
Additional information is available in the VRA Procedures and Tools Narrative | The completed VRA checklist is a working document, and kept in Principal’s file |
| 3     | Behavioral Health Information  
- Interview guide, BHI checklist and Reference Tool | Interview guide, BHI checklist and Reference Tool | Student Services Staff team of 2 recommended | See note above (line 1) about parent notification  
Student Services staff require training in the tools and practices included in the Violence Risk Assessment, especially the mental health information component. | All behavioral and mental health information gathered are kept in the student services member’s files |
| 4     | VRA Team Decision Making  
- VRA Decision Agenda | VRA Decision Agenda | Principal/Designee with Team | This is a face-to-face meeting. Careful consideration is used to craft a plan that builds necessary support and intervention for the student as well as reducing risk to all. | Use Safety Plan Template |
| 5     | Summary Report and Dissemination  
- Summary Report template | Summary Report template | Principal/Designee and Team | Meet with parent and student | The summary report is kept in the behavioral file |
Appendix 40

Madison Metropolitan School District

VIOLENCE RISK ASSESSMENT

Procedures and Tools

Revised August, 2014

Department of Student Services
John Harper, Executive Director
Leia Esser, Director of Physical, Mental and Behavior Health

Office of Safety and Security
Luis Yudice, Safety Coordinator

Please direct questions about the tools and procedures included in the MMSD Violence Risk Assessment to
Jeannette Deloya, Coordinator of Mental Health Supports
jdeloya@madison.k12.wi.us
MADISON METROPOLITAN SCHOOL DISTRICT

VIOLENCE RISK ASSESSMENT (VRA) PROCEDURES
For responding to Violent Behavior or Serious Threats

I. INTRODUCTION

No one can completely predict the behavior of any other human being. The most accurate predictions of violence are based upon known “risk factors” for groups of individuals who have been violent. Clinical judgment that fails to focus on specific risk factors is not a particularly good predictor of violence. Madison Metropolitan School District (MMSD) has developed a set of procedures entitled Violence Risk Assessment (VRA) that is based upon known risk factors for violence.

The VRA consists of a violence risk checklist, the gathering of behavioral health information, and a summary report. The checklist is completed by the principal (or designee) and is focused on the events and the safety of the student in question and others. Behavioral health information is gathered and reviewed by members of the Student Services team. The tools used in the VRA process are not normative instruments. They are to be used to assist the VRA team in thoroughly assessing various risk factors.

Ideally, a VRA is conducted by a team of school and security staff that collectively assesses risks and makes recommendations based on their findings. Teams are comprised of:
1. Administrative staff
2. Law Enforcement and Security, and
3. Student Services

II. VRA DESCRIPTION

What is a Violence Risk Assessment?
A VRA is a set of tools and a procedure to use when the members of the school staff determine that a student may pose a risk to the safety of others that requires immediate action. The term ‘VRA’ refers both to the process of gathering the information and to the written documents that are produced as a result of an assessment.

When there is probable risk of harm to students, staff or school property, a VRA is recommended. Certain factors increase the level of risk. ‘Red Flags’ would include the specificity of the threat, e.g., time/date, access to weapons, target, location and/or an articulated plan. Impulsivity and lack of control, poor reality testing or lapses in judgment, a history of violence and/or anger, and antisocial behavior patterns are additional factors that increase the level of risk.
Examples of types of serious violence threats or behavior include:

- Acts of aggression toward others
- Threats of aggression or harm to others
- Intimidation of others
- Pattern of behaviors that raises the suspicion or risk for violence (violent poetry or stories, drawings, or internet communications).

The VRA Checklist, completed by the School Principal or designee, documents the behavior or threat and provides initial findings and recommendations. Completion of the checklist will require:

1. Personal knowledge of the student’s behavior and circumstance
2. Review of school records
3. Information from the student, parent, staff or school security.

Additionally, student services staff members gather behavioral health information to assess social, emotional and personal factors. This can include the following sources of information:

- Review of school records
- Student interview
- Parent interview(s)
- Staff Interviews
- Law enforcement information
- Community agencies, social services, mental health providers, with written permission

**What is the purpose of a Violence Risk Assessment?**
- To determine the risk of harm posed by the student: high, moderate, low
- To gather information critical to maintaining a safe school environment
- To develop a relationship with the student who is suspected of being at risk for school violence
To guide the development of appropriate interventions for the student

When is a Violence Risk Assessment initiated?
The school principal determines when it is necessary to implement the VRA, with input from school staff. The VRA procedures are initiated with any student who exhibits potential serious violence risk BEFORE the student is allowed to continue his/her usual school program. If a principal is not sure whether a VRA is necessary, consultation with the MMSD Safety Coordinator and members of the school’s Student Support and Intervention Team is recommended. This allows risk to be shared amongst the members of the VRA team.

The student who has engaged in violent behavior or threats is often suspended or removed from school. If possible, the VRA should be completed prior to the student’s departure. Efforts are made to obtain parental permission for the student interview, as well as consents to exchange information with non-MMSD providers. If unable to conduct the interview immediately, arrange for meeting at a neutral site, or have the student brought to school under supervision for an assessment appointment. In some cases, if the student is in police custody, interviewing may not be possible. In these cases, decisions are made based upon existing data.

How do we complete a Violence Risk Assessment?

STEPS
1. The principal notifies the MMSD Safety Coordinator’s Office of serious violent acts or threats that endanger school safety. The purpose of this notification is for the Safety Coordinator to track violence trends, assist in the deployment of security resources, and provide security consultation. Parents are notified.

2. The principal (or principal designee) completes the VRA checklist of risk factors. Indicate what information is already available, and what information still needs to be gathered. Determine whether this information will be collected through a record review, and/or through the use of a student interview, parent/staff interviews, and interviews with community agencies. Assign tasks and responsibilities to appropriate members of the team.

3. The assigned student services staff completes his or her assessment using the Behavioral Health checklist, interview(s) and record reviews. This is done by an individual or by a team of individuals.
In order to interview the student in emergency situations involving potential harm, parent notification is good practice, but not required by law or professional ethics. If the parent refuses to grant permission for the school to conduct a student interview, or the student refuses to cooperate with the VRA process, this is noted and decisions are made based on existing data.

Use records and collateral information as well. Other sources of information include:

- school records
- parents/guardians
- community providers
- staff
- law enforcement
- county social services, mental health providers

Parent permission is not required for the student services staff to review existing data or to interview other individuals at school. Consents to release information must be obtained in order to gather or exchange information with non-MMSD agencies and service providers.

4. VRA Team Decision-Making: The team meets to:
   a. Review findings from multiple professional perspectives;
   b. Formulate a safety plan; and
   c. Formulate intervention plan.

5. Summary Report and Dissemination of Information
   The team uses the template to write a summary report.
   A representative, or team of representatives, meets with the student and family.
   Outcomes are communicated to appropriate staff using “need to know” guidelines.
Who completes the Violence Risk Assessment?
The principal determines whether or not a VRA is necessary. This decision is made with input from Student Services and Safety and Security. The principal or designee completes the VRA checklist. The gathering of behavioral health information is completed by members of the student services staff who are trained in the VRA procedures. Once the information is collected, the VRA team meets to share information, analyze the data, assign risk level and make recommendations.

What are some possible outcomes of the Violence Risk Assessment?
In situations where the VRA is unable to rule out serious violence risk, the principal may be required to take steps to protect the safety of the student and of the school through the development of a safety plan, until the threat is resolved. The principal has a range of options including:
- arranging alternative transportation to and from school
- modifying school starting and ending times
- temporarily reducing the academic schedule and developing a reintegration plan
- delivering instruction in a separate room
- providing greater student supervision
- scheduling regular meetings with a member(s) of the student services staff
- conducting searches of student, locker or backpack
- seeking additional resources*
- off campus programming*
- referral to community based mental health providers

* The principal makes a request in writing to the appropriate Level Assistant Superintendent should these options be considered necessary. A summary report of the VRA findings and recommendations is included in the request.

Special Situations
What if a parent refuses to make his/her child available for the interview?
The information is collected from other sources and a decision is made without the interview information. It is documented that parents did not allow the interview.

What if the student has an Individual Educational Program and receives services in Special Education?
Having an IEP does not preclude completing a VRA. The student’s case manager(s) should be interviewed if possible. Results of the VRA may be included in the IEP document, or used in completing a Functional Behavior Assessment.

III. VRA DOCUMENTATION AND NOTIFICATION

How are VRAs documented?
The VRA team produces a written summary report that incorporates the information obtained and the recommendations of the team. This summary report is written with parents, teachers and other readers in mind and is attached to the VRA checklist. Both documents are stored in the Behavioral File. The Behavioral Health Information worksheet, interview notes, record review notes and other personal notes used in completing the
VRA are not part of the student record and are kept in the personal file of the individuals who used them for data collection and analysis.

It is not necessary to send the complete report to the Safety Coordinator. However, the Safety Coordinator Office is noticed as to the completion of the VRA and the outcome.

**Who has access to the written reports?**
Copies of the findings and recommendations are distributed to the following individuals:
- Parents
- School Principal
- Staff members that work closely with the student and have responsibility for implementing the recommendations.
- Parents must give written permission for the VRA report to be sent to agencies/persons outside the school.

**Where are the VRAs filed?**
In the Madison Metropolitan School District, The VRA Principal checklist and the summary report are filed in the student's Behavioral File.

**What happens to the documents after a student is no longer enrolled in MMSD?**
Copies of the VRA findings and recommendations are destroyed as per student record guidelines.

**How is the information in a VRA disseminated?**
The VRA team decides what information is disseminated and to whom the information should be given. Parents have access to the report. Findings and recommendations related to safety risk are included in the report. It is not necessary to include personal family information that is not related to the safety risk.

**How are decisions made about the notification of staff, students, victims, and families of victims? Who should be notified? What are procedures around this?**
Notification is required to those individuals that are at risk. The VRA team collectively decides who is considered to be at risk.

**IV. LIABILITY**

MMSD has Legal Counsel to assist and consult regarding specific situations. When school professionals know there may be a risk for violence, doing nothing can be a liability risk. Professional organizations and the courts have supported professionals who are following current best practice in carrying out violence risk assessments. Best practices include following agency procedures and guidelines, reviewing available records and information, interviewing the threatening person, and documenting the work and recommendations.

Student right to confidentiality is no longer applicable when there is a threat to safety and the threatened targets (and parents) need to be notified. When in doubt about the appropriate action, work with your principal, safety coordinator, professional support person, colleagues, and/or MMSD legal counsel.
V. DECISION MAKING

Decisions about actions to take once the VRA is completed are informed by a team of people, rather than an individual. Representatives from administration, police or security, and student services, are on the decision-making team and seek to make well-informed recommendations to address individual supports & intervention as well as safety plans. In the event of dissenting member recommendations, the building administrator has role authority regarding final decisions. Team members with dissenting viewpoints should express their concerns in writing to the level assistant superintendent.
I. BHI DESCRIPTION

What is the purpose of the Behavioral Health Information process (BHI)?
There are three major purposes for the BHI:

a. To collect information necessary so that the VRA team can make informed decisions about violence risk and safety planning

b. To develop a collaborative relationship with the student

c. To proved information for intervention planning and necessary supports for the student

What are the qualifications required to complete the Behavioral Health Information?
The BHI is completed by members of the MMSD Student Services staff. These professionals need to have knowledge about normal child and adolescent development and behavior, personality and emotional disorders, and violence risk. They must have clinical interview and rapport-building skills, observational skills, report writing skills and ability to develop/recommend interventions. They must also have understanding of how mental health issues, school climate, interpersonal relationships at school, family dynamics and prior experiences may influence behavior, in particular, violent behavior at school. In most instances, MMSD Student Services staff are qualified by their licensure, education and training to perform these assessments. Student Services staff in each school who are qualified to complete the BHI are identified at the beginning of each school year. Training specific to violence risk and the procedures and guidelines for completing the MMSD Violence Risk Assessment will be provided on a regular basis.

What are the steps in completing the Behavioral Health Information part of the VRA?

1. The VRA team meets to review information that is already available (the VRA checklist), and to determine what additional information needs to be collected and from where. Examples of sources of information include staff members, family, agency providers, and law enforcement.

2. One or two members of the team interview the student using the Behavioral Health Interview guide as a reference (two members are recommended, as it provides for a better assessment of verbal responses, affect and behavior).
3. The Student Services staff member(s) meets to review the items on the BHI worksheet and the corresponding Reference Guide for the BHI worksheet. These working tools are designed to allow the members of the team to review the information gathered through the perspective of risk, safety, and intervention planning.

4. The entire VRA team meets to discuss the information gathered, to make recommendations about safety planning & the development of an intervention plan on behalf of the student. At this meeting, the team also decides who has a need to be notified about the risk and makes a plan for the appropriate dissemination of information.

5. The team completes the VRA summary report and follows stated procedures for communication and the appropriate filing of records.

Is Parental Consent required to complete the BHI?

In order to interview the student in emergency situations involving potential harm, parent notification is good practice, but not required by law or professional ethics. Parent permission is not required for the student services staff to review existing data or to interview other individuals in the school. If the team determines that it is necessary to interview non-MMSD agencies and service providers, parental consent to gather or exchange information is required. If the parent refuses to grant permission or the student refuses to cooperate with the VRA process, this is noted and decisions are made based on existing data.

If parent permission for assessment is not granted, what should be done? When parents do not grant permission for assessment, or if a student refuses to cooperate with the BHI procedures, the principal makes decisions about what is needed to guarantee safety based on existing information. Student and parent refusals are documented in the summary report.

Where and when should the BHI assessment take place?

Students will typically accompany the Student Services staff member to his/her office for interviewing and testing. If the student has been suspended, a community location can be arranged. If there are concerns regarding safety, modifications such as a more public location, someone immediately accessible outside the office door, a parent waiting nearby, or a second adult sitting in during the assessment, may be made. If safety concerns are significant, the principal may suggest a community based assessment of violence risk. The VRA team documents concerns that led to the recommendation for a community-based assessment.

Assessments are completed as soon as possible after the initial threat. However, it is not useful to try to assess any student who is disoriented, angry, or agitated. If there is an imminent threat to safety, the principal should involve police/security.
What if the student has previously been assessed using the BHI?

For recent repeat offenders, obtain current parental consent, update any needed information which may require additional interviewing or testing, and document updated information either by noting the new date and information on the recently completed BHI or by writing an addendum report. Repeat offenses generally increase violence risk.

II. VRA SUMMARY REPORT

The VRA Summary Report is placed in the student’s Behavioral File. The BHI checklist remains in the personal file of the Student Services staff.

The content of the VRA Summary Report includes:

- Identifying information
- Reason for referral
- Techniques used (interviewing, testing, etc.)
- Statement of who reviewed the total student record including discipline
- Summary risk factors and of protective factors
- Estimate of risk level (low, medium or high)
- Recommendations for the safety of the student and others, and recommendations for future assessment or intervention

The principal’s summary to the central office includes:

1. Review of the investigation of the violent threat or actions
2. Review of school history including previous history of discipline,
3. Recommendations for the student.

Note: Students and their parents have access to their own written records. Do not refer to another student by name in the Summary Report. The personal notes taken on the VRA or BHI forms are considered personal records and may contain names of others as long as these forms are not shared with others. If these forms are to be shared, information that identifies other students should be written elsewhere.
Related Documents:

- VRA Procedures (Table)
- Principal's Violence Risk Assessment Checklist
- Behavioral Health Interview Guide
- Behavioral Health Worksheet
- Behavioral Health Reference Guide
- Violence Risk Assessment Decision-making Agenda
- VRA Summary Report Template
Appendix 41

MADISON METROPOLITAN SCHOOL DISTRICT

VIOLENCE RISK ASSESSMENT

VIOLENCE RISK FACTORS CHECKLIST

Completed by the School Principal/Designee

Student Name____________________________ b#_______________ Date_________________

Name(s) of staff completing checklist:  __________________________________________________________

VIOLENT BEHAVIOR (describe) ____________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________

THREAT

1. Specificity of Violence Threat................................. _____ Needs more info
   _____vague
   _____some specifics
   _____well thought out, knows when, how, and who

2. Viability of Violence Threat................................. _____ Needs more Info
   _____ not defined
   _____ plan unrealistic, unlikely to be implemented
   _____ some detail of plan are plausible
   _____ plan is realistic

3. Means (circle) firearms / explosives / other___________ _____ Needs more info
   _____unavailable, difficult to obtain
   _____available, will have to obtain
have on hand, easy access

4. **Lethality**
   - ____ Needs more info
   - ____ non lethal means
   - ____ lethal means

5. **Focus**
   - ____ Needs more info
   - ____ on specifically named individual(s)
   - ____ peer(s)
   - ____ staff
   - ____ generalized threat
   - ____ school property
   - ____ community individual or property

**LEAKAGE (2-3 factors below)**
   - ____ Needs more info

1. ____ Recent communications about violence/threat.
2. ____ Escalating frequency of concerning communication
3. ____ Broadening of communications (more locations, contexts).

The above constellation of factors, in BOLD, should be considered strongly indicative of need to conduct a VRA.

The following factors in isolation (without a significant behavioral incident, threat of violence and/or leakage, items on Page 1) **do not** suggest risk of violence. In conjunction with Page I risk factors, the following factors, in BOLD, suggest increased need to conduct a VRA.

**RESPONSE**

1. Police contacted
   - ____ no
   - ____ yes, as more information became available
CURRENT BEHAVIOR…………………………………………  _____ Needs more info

1. Violence/Aggression
   _____ no
   _____ other threats of violence
   _____ violent or aggressive behaviors
   _____ no information available

2. Discipline Problems
   _____ no
   _____ yes, but infrequent
   _____ yes, frequent but not aggressive
   _____ yes, frequent and aggressive (verbal or physical--circle)

3. Aggressive Behavior in the Community (based upon reports of others)
   _____ no apparent aggression
   _____ aggressive acts (specify_________________________)
   _____ physical assaults
   _____ gang affiliation
   _____ fire setting
   _____ cruelty to animals
   _____ police/court involvement
   _____ no information available
4. Attendance
   _____ no problems currently
   _____ poor attendance
   _____ habitual truancy

PERSONAL FACTORS

1. Learning
   _____ achieving/learning to ability
   _____ some academic problems
   _____ severe academic problems
   _____ special education

2. School Attachment
   _____ commitment to learning, social relationships and school activities
   _____ some commitment to learning, relationships and activities
   _____ some social relationships and connections within school
   _____ appears to lack positive social relationships and connections with school

3. Peers
   _____ peers are generally pro-social
   _____ peers have behavior problems
   _____ peers avoid/fear him/her
   _____ limited peer relationships
   _____ no close peer contacts

4. Drug or Alcohol Use
   _____ no suggestion of use
   _____ indications of use
5. Emotional Stability

- appears stable
- emotional factors may impact functioning
- major problems, interference with functioning

HOME/COMMUNITY

- Needs more info

1. Parental control

- parent appears to have good control and supervision
- parent has some control
- parent has little control/ignores problem behaviors
- parent supports anti-social activities

2. Mental Health Interventions

- no apparent need for intervention
- past therapy
- past medication
- currently in therapy
- currently on medication
- AODA program
- no mental health interventions despite apparent need

3. Structured Activities in community

- some involvement
- no involvement
4. Current or Previous Dane County Human Services (DCHS) supervision

_____no

_____yes, Name of Social Worker:________________________________________
Reason for Supervision___________________________________________________

HISTORY

1. _____Attendance Problems
   Comments:

2. _____Exposure to Violence
   Comments:

3. _____History of Abuse/Neglect/Trauma
   Comments:

4. _____Victim of Bullying or Harassment
   Comments:
Appendix 42

Behavioral Health Interview Guide

Goals of Interview

1. Gather information to address the student’s need for intervention and support.
2. Form foundation for a relationship. (you are not the disciplinarian)
3. Despite problem, keep focus on strengths, positives choices made.
4. Understand the student’s inner and outer world, motivation, goals.
5. From the information gathered, glean specific information about risk factors. Read the Behavioral Health Information Worksheet to check that you have knowledge about all areas.

Recommendations about interviewing style and language choice:

- Use open questions and non-dichotomous stems: What..., How..., In what ways, What contributed to..., Tell me more about...
- Try to avoid ‘Why did you’ as a sentence stem as it can elicit a defensive response.
- Use pausing, paraphrasing, and some intentional silences to encourage the student to go deeper into responding to the original questions given.
- Try to avoid a consecutive stream of questions in order to gather information.
- Use language that is not ‘loaded’.
  - Instead of ‘Behavioral discipline problems, use “Have you been in trouble...,” “trouble with the law,” “the principal,” etc
  - Instead of ‘Addiction/abuse,’ use, ‘Have you had trouble with alcohol, drugs?’
  - Instead of ‘Harassment/Bullying,’ consider using: ‘What can you tell me about people at school? Have people at school been picking on you?”...“Giving you problems?”
- For students who externalize blame, turn questions around. ‘Did alcohol ever get you in trouble?’ or, ‘Have your friends ever gotten you in trouble?’
- For students that may be antisocial, emphasize self-interest, i.e., what is the benefit to them.
- Use tentative and exploratory language. Couple this with plural forms:
  For example, “What might be some...? instead of “What is...?”

INTRODUCTION

- Reason--Orient Student to Incident
Purpose
- Understand things from your perspective
- Decide how serious this behavior (threat) is
- Assure the safety of others
- Decide what might be helpful for you

Introduce interviewer (s)

Informed Consent

Limits of Confidentiality

THE INCIDENT--EXPLORE FULLY.

Tell me what happened in your own words from start to finish.

Use a timeline approach with specifics, who said or did what.

Environment and contributing factors. What might have contributed to this happening now?

1. WEAPONS if involved
   - Access
   - Interest/knowledge

2. Explore the student’s thinking at the time—What were you thinking at the time?

3. Planning
   - What thoughts have you had about this before? Did you think about doing this before today?
   - What contributed to it happening when it did—not last week for example?
   - Tell me about prior experiences you might have had. Have you ever done anything, or thought about doing anything, like this before?

   - What part of the total responsibility for this incident is yours?
   - If you could go back and do it again what would be different?

5. Recent thoughts/feelings
   - What have you thought about the incident since it happened?

SCHOOL
- Review classes, teachers, performance, activities for strengths & problems
- Relationships at school—trusted friends and adults, harassment, longstanding conflicts, where student fits into school socially
- Prior history of getting in trouble, suspensions

COMMUNITY/SOCIAL
- Review time spent out of school—activities, friends, work, internet
- Trouble out of school?—AODA, contact with the law, county social worker, neighbor relations, confrontations?
- Tell me about your friends? Parents’ opinion. Friends in trouble?

FAMILY
- Diagram family constellation, including extended family & others in home
- Relationships with others in family. Closest. Conflicts. Hurt you? Seen others hurt?
- Place in the family—responsibilities, worry about others in your family?

PERSONAL
- Timeline of life—where born, lived, critical experiences and people
- Personal assessment of self, personality, strengths and weaknesses
- Feeling bridges
- Mental and physical health and diagnostic questions
- Goals and aspirations

What else? What questions might you have for me?
Appendix 43

Behavioral Health Information Worksheet

Use accompanying Reference Guide to inform risk level and planning

Student Name: ___________________________ Date: __________________

Interviewer(s): ____________________________________________________

1. Awareness/Orientation
   ____ alert, responding
   ____ appears confused
   ____ incoherent, very confused thinking

2. Agitation
   ____ reasonably calm for circumstances or somewhat upset
   ____ too calm for circumstances
   ____ highly agitated

3. Thought disruptions
   ____ not evident
   ____ hallucinations – auditory or visual
   ____ command hallucinations
   ____ delusions, illogical thoughts, ideas of reference

4. Affect during description of threat
   ____ concerned, upset
   ____ very concerned
   ____ blaming others/denial/lacks remorse
little affect/empathy/concern

5. Precipitating event prior to threat
   no report of precipitating event
   yes, rejection/loss
   yes, other

6. Depression
   no or few symptoms
   moderate concern
   severe concern

7. Suicide risk
   no ideation or ideation without any plan
   some planning
   specific plan
   access to means

8. Anxiety
   no apparent anxiety symptoms or very mild anxiety
   moderate symptoms
   severe symptoms, panic or near panic

9. Victim or Witness of abuse/violence (Verbal, Sexual, or Physical)
   no report of abuse/violence
   report of abuse/violence
   documentation of abuse/violence in record

10. Exposure to trauma
11. Discrimination or bullying/harassment

_____no report of discrimination or harassment by others
_____reports being discriminated against or harassed
_____documentation of harassment or discrimination

12. Preoccupation with weapons, death, or violence

_____no unusual history
_____enjoys violence on television or in movies, interest in weapons, violence
_____preoccupation with violence and death in writings, fantasy, drawings, or conversation

13. Impulsivity/Hyperactivity/Mania

_____not apparent, mild, or medication taken effectively
_____probably some daily interference
_____severe factor

14. Suspiciousness/Paranoia

_____average trust in others
_____views others with mistrust
_____sees others as out to get him/her
15. Anger
   ____ no apparent anger or angry, but expresses appropriately
   ____ angry, but under some control
   ____ verbally or physically threatening
   ____ aggressive expressions of anger

16. Cognitive/Learning
   ____ no or few problems
   ____ moderately impaired or underachieving
   ____ significantly impaired or not engaged in learning

17. Values
   ____ pro-social
   ____ somewhat antisocial
   ____ appears to have an antisocial value system

18. Attitudes/Learning from prior school intervention
   ____ no previous interventions
   ____ some interventions, appeared helpful
   ____ some interventions, little or no resulting change
   ____ intensive or frequent previous interventions, appeared helpful
   ____ intensive or frequent previous interventions, little or no resulting change

19. Attitudes/Learning from prior or current behavioral and/or mental health interventions
   ____ no community interventions
   ____ has been in therapy, helpful
____has been in therapy, not helpful
____on medication, past or present, helpful
____on medication, past or present, not helpful

20. Supportive peers or adults in school or community (that student identifies as knowing best or would seek out for help)

__________________________
__________________________
__________________________

21. Does the student have friends?

____yes
____no
Appendix 44

Reference Guide for the BHI Worksheet

Item 1 **Awareness/Orientation.** Check to see if the student knows their name, the day/date, their location and the purpose of their visit with you. Students who are disoriented may need an immediate community based (e.g. Mental Health Center or emergency room) evaluation and a secure setting until an evaluation can be arranged. The possibility of alcohol/drug abuse needs to be considered. Ask directly. Involve your school nurse if you suspect drug/alcohol use.

Item 2 **Agitation.** Students who are highly agitated may need immediate mental health attention. If a student seems overly calm/unconcerned this may suggest emerging antisocial personality, a high level of denial, shock or "closed down emotion."

Item 3 **Thought disruptions.** Auditory command hallucinations (regardless of etiology) to commit violent acts a serious risk factor. A community based evaluation for the safety of the threatening individual and others should be conducted. Confused thought of any kind is concerning in terms of violence risk because the threatening individual may not rationally processing the situation, and may have impaired judgment.

Item 4 **Affect during description of threat.** Concern over the making of a threat is a positive sign. Blaming others, denial, and lack of remorse are associated with increased risk. Lack of affect or concern may suggest emerging psychopathy which is associated with increased risk.

Item 5 **Precipitating event prior to threat.** If there is an identifiable precipitating event, this may be useful in planning intervention. Losses, including loss of a relationship, and being victimized/bullied are associated with increased risk. If harassment or bullying have occurred it is important to assess the school-wide climate and staff response to this type of behavior.

Item 6 **Depression.** Depression is a risk factor for violence. Individuals who carry out violent acts often subsequently kill themselves, or behave in such a manner that increases risk of being killed. If antidepressant medication has recently been started, a depressed student may be energized to action prior to reduction of the depression. If depression is present refer for treatment and collaborate with the community provider. Successfully addressing depression may reduce future violence risk.

Item 7 **Suicide risk/Homicide risk.** When asking about thoughts of harming self, also ask about thoughts of harming others, particularly when angry/frustrated. School shooters often envision both in their planning. Investigate thoughts, urges, fantasies, wishes to kill or be killed or to hurt others. Ask others and look for communications (writing, drawing, internet messages) on this topic. If there is suicide risk, the Self-Harm protocol should be followed.

Item 8 **Anxiety.** Some anxiety is "normal" for an individual who has made a threat. Lack of anxiety may indicate denial or emerging psychopathy. Severe anxiety or acute obsessive thoughts will need to be addressed immediately, probably by community professionals.
Item 9 Victim/Witness of abuse/violence. Individuals who have experienced or witnessed violence are more likely to act in a violent manner. Sometimes violence is considered revenge for victimization. Individuals who are both violent and victims of violence need interventions addressing both issues.

Item 10 Exposure to trauma. Trauma exposure in itself does not increase the risk of violence. However, if the trauma resulted in Post-Traumatic Stress Disorder (PTSD) with symptoms such as hyper vigilance, hyper arousal, flashbacks, numbing, intrusive thoughts, avoidance of reminders of the event, triggered responses, then the risk of unexpected violence increases.

Item 11 Discrimination or bullying/harassment. In many cases of school violence, the threatening individual has a history of being bullied or abused. Victimization increases violence risk. If this evident, a school-wide assessment should be completed. A preventative program of intervention and education can be initiated. Violent students may exaggerate the extent to which they have been victimized, may “collect injustices.” Try to sort this out through collateral sources. If this pattern appears to be the case, community based mental health is appropriate.

Item 12 Preoccupation with weapons, death, or violence. This has been associated with school shooters and increases risk level. Look for communications related to weapons, death, violence. Procuring weapons, preferring violent video games, and believing that violence solves problems add to risk. The more specific the threatening content, the greater the risk. In 80% of school shootings, the perpetrators told someone before committing the act. Prevention involves education of students and forming of trusting relationships between students and staff.

Item 13 Impulsivity/Hyperactivity/Mania. Even in the absence of long-standing patterns, highly impulsive, manic or labile individuals may carry out acts without forethought. School shooters tend to be planned, while “lesser” acts are more likely to result from impulse. This risk factor paired with a history of aggression is a significant concern.

Item 14 Suspiciousness/Paranoia. Suspicious/paranoid individuals may be experiencing thought disruptions, exhibit faulty judgment, or act based upon fears of being victimized by others. They may also be more apt to carry out revenge violence. Community based treatment is needed, but often difficult to arrange, due to the lack of cooperation with treatment. Some types of paranoia are amenable to treatment with medication.

Item 15 Anger. Previous aggression is the single strongest predictor of future aggression in group studies. Investigate whether anger has been acted out in physical aggression.

Item 16 Cognitive/Learning. This is not a strong single predictor of violence. Cognitive limitations may result in individuals not fully understanding the seriousness of their threats or to understand cause and effect in regard to their actions. Intervention to address learning issues is appropriate, or to problem-solve frustrations of the student in a proactive manner.

Item 17 Values. Antisocial values are a violence risk factor. An attitude that violence/aggression is the way to solve problems is associated with risk.

Item 18 Attitudes/Learning from past school interventions. If school interventions have been tried without success, the violence risk tends to increase. It may indicate a “non-customer” attitude on the part of the student, lack of engagement in school, inappropriate intervention or other factors.

*Document and assess responses to the previous interventions.*
Item 19 Attitude/Learning from prior or current behavior and/or mental health interventions. If inter-
ventions have been tried without success, the violence risk tends to increase. It may indicate
a "non-customer" attitude on the part of the student, lack of support for intervention in the
family or a number of other influencing factors. Try to determine the reason for lack of success
with past interventions.

* Document and assess the response to prior interventions.

Item 20 Supportive peers or adults in school or community that student identifies as knowing best or
would seek out for help. This is both a measure of degree of student attachment within school
and community and a source of information about individuals who may have insight into the
student.

Item 21 Does the student have friends. It is important to look for students who may be experiencing
isolation, so that might be addressed in the subsequent planning for support.

Note to Interviewers: Obtain written parent/guardian permission for any Student Services staff testing,
including the date of procedure and when permission was granted.

Note on developing recommendations:

Synthesizing any assessment data and formulating recommendations is always the most difficult part
of the assessment process. There is no "cookbook" approach to carrying out violence risk assess-
ments since base rates on various risk factors in the school setting have not been established at this
time. The recommendations based upon the BHI worksheet are not primarily disciplinary. Issues that
need to be addressed include:

1. Decreasing risk for injury or harm to others
2. Supervision
3. Behavioral, mental health and/or school interventions might support the student
Student Name: ______________________ b# __________ Date: ____________________

I. Discuss Findings and Assign level of risk: Low: _____ Moderate: _____ High: _____

II. For each recommendation checked in the table below, include a description of the recommended action in the VRA Summary Report.

<table>
<thead>
<tr>
<th>Safety Planning</th>
<th>YES</th>
<th>Student Intervention and Supports</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Response:</td>
<td></td>
<td>Immediate Secure Treatment Setting</td>
<td></td>
</tr>
<tr>
<td>Immediate Secure Setting necessary (e.g., hospitalization or police custody)</td>
<td>YES</td>
<td>Building-based Evaluation</td>
<td></td>
</tr>
<tr>
<td>School-based Supports:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modify school start and end times</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive supervision in school setting</td>
<td></td>
<td>IEP Evaluation</td>
<td></td>
</tr>
<tr>
<td>Alternative transportation</td>
<td></td>
<td>Scheduled meetings with Student Services staff</td>
<td></td>
</tr>
<tr>
<td>Reduce or change academic schedule</td>
<td></td>
<td>Referral to MMSD Positive Behavior Support Team</td>
<td></td>
</tr>
<tr>
<td>Deliver instruction in another location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student, backpack and/or locker searches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of wands (portable metal detector)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instruction delivered in another location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community – based Supports:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Off-campus programming</td>
<td></td>
<td>Referral to Community-based services</td>
<td></td>
</tr>
<tr>
<td>Referral to Police for safety</td>
<td></td>
<td>Referral to Dane County Dept of Human Services</td>
<td></td>
</tr>
<tr>
<td>Other Considerations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of school placement needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consideration by principal of recommendation for expulsion</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. Plan for Notification and Information dissemination:
1. Recommendations for staff members responsible for implementing intervention plan.
2. Who needs to be notified about the findings and recommendations of the VRA team?
   _____ Parents
   _____ Student
   _____ Target(s) of threat
   _____ Others:
   _____ Staff members: Specify
Appendix 46
Violence Risk Assessment Summary Report

Name: __________
Date of Birth: __________
School: __________
Grade: __________

1. Reason for referral

__________ was referred for a Violence Risk assessment due to (general statement). According to the (Then describe the incident including relevant facts).

The purpose of this assessment is 1) to assess risk to determine what safety measures, if any, should be put into place, and 2) to aid in developing interventions and supports for _______ (student).

2. Methods Used

To understand ________’s (student) school history and past behaviors, a review of behavioral and cumulative files as well as review of Infinite Campus data was completed by _________ (indicate person). In addition _______ was interviewed using the VRA structured interview to assess personal, educational, social, familial, mental health and other risk factors related to the incident. To provide collateral information, the following individuals were also interviewed: (List all individuals that contributed to the information gathered for this assessment).

3. Summary of Risk Factors

A number of factors contribute to ________’s risk for actions that might harm others.

Discuss:

- Incident—specificity of threat or behavior in terms of target (do not list names), time, weapon, plan. Also access to weapons, lethality of weapons.

- Student factors—capacity to carry out plan, lack of empathy, antisocial values, impulsivity/risk taking, victim of bullying/harassment, alienated, angry, poor cause/effect thinking, poor judgment, authority problems, interest in violent videos/games, or violent products (writing, art, internet), past history of violent acts/threats.

- Mental health factors—paranoia, poor reality testing, delusions, command hallucinations regarding violence, compulsive/obsessive focus on violence/retribution/death/weapons, AODA use problems, anger management problems.
☐ Social factors—antisocial, delinquent or violent peer group, rejected or isolated, few or negative peer relationships.

☐ Educational factors—struggling academically, poor attendance, truancy, history of discipline problems, negative attitude toward school, disengaged.

☐ Family factors—criminal activity in family, low parental involvement, low parental control, exposure to violence or abuse, AODA or mental illness in home, family dynamics that contribute to anger, weapons access in home, aggressive acts at home (cruelty to animals, fire setting, threats/acts directed at family members).

☐ Community factors—legal or DCDHS involvement related to aggression or antisocial acts, aggressive acts in community (gang affiliation, assaults, threats).

4. Summary of Protective Factors

Some factors reduce _____’s risk of harming others. These should be encouraged and supported.

Describe Protective factors including: close relationships with others, empathy, remorse, no past history, pro-social involvement, positive family or peer support, positive attitudes toward school/authority/getting help, achievement, at least one trusted adult at school.

5. Recommendations

(Use recommendations at the end of the Part I and Part II checklists, the Team Decision Making Agenda, or add your own team’s suggestions. Please document person/s responsible for implementing.)

Based upon the above risk factor constellation, the following recommendations are made for insuring safety of other students and staff:

1. ...
2. ...
3. ...
4. ...

In addition the following interventions and supports are recommended to address student needs:

1. ...
2. ...
3. ...
(Your signature/s) ___________________________ (date) .

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Type names and dates
Appendix 47

BEP Toolkit - Behavior Consultation Team

Description of Behavior Consultation Team (formerly PBST)

The Behavior Consultation Team is a district-wide program designed to support students demonstrating significant aggression and behavioral challenges (as well as the staff members who serve them).

Our programming measures student success by focusing on:

- safety
- skill development
- behavioral change

Interventions are determined by the needs of the student as defined by:

- students and their families
- school staff members
- community providers
- Behavior Consultation Team members

We focus on long-term behavioral and academic success rather than short term crisis response.

Our team is comprised of special education teachers and student services staff members (school psychologist or social worker). We are grounded in trauma-informed care.

Types of Support

Consultation is offered to assist school staff to address behaviors of concern through a process of problem identification and analysis, followed by intervention development, implementation, and evaluation.

Collaboration allows the Behavior Consultation Team and school staff to work together to 1) conduct a functional behavior assessment from a “strengths-based” perspective; and 2) design, demonstrate, and implement positive behavior interventions. When necessary, Behavior Consultation Team staff work side-by-side with school staff in the appropriate environments to provide the opportunity to discover the most effective educational interventions for the child or adolescent, as well as facilitate ongoing problem solving.

Staff Development is available for whole or partial staffs including topics such as trauma, regulation, brain development and functioning, Love & Logic, and behavior support planning including Functional Behavior Assessments (FBA) and Behavior Intervention Plans (BIP).

Referral Criteria

Who is eligible?

Student who are...

- pre-Kindergarten through high school in the Madison Metropolitan School District
- receiving general or special education programming
• identified as exhibiting chronic aggressive behaviors at school
• not experiencing academic, social emotional, and behavioral success
• receiving substantive interventions by school staff that are unsuccessful

Making a Referral

Our referral form can be downloaded from: mmsd.org/behavior-referral

What is the referral process?

Students who meet eligibility criteria are usually referred by school staff members (parents must be informed, but their consent for referral is not required.) Other community professionals may also refer in consultation with parents and schools. Initiation of services is dependent upon parent and school staff agreement to participate. On occasion, we receive more referrals than capacity allows; wait lists may apply.

For more information or to download our most recent brochure, please visit our staff only page: mmsd.org/behaviorconsultationteam
GUIDE FOR ASSISTING FAMILIES/CAREGIVERS: REFERRAL FOR MENTAL/BEHAVIORAL HEALTH SERVICES

ACCESS TO HMOs MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES

UW Behavioral Health: 233-3575, 8 – 4:30, M-F Serves:

1) **Unity** commercial insurance with a Dane County Primary Care Provider (PCP) and Unity Badgercare with Primary Care Provider OUTSIDE of Dane County
2) **Physician’s Plus** commercial insurance
3) Unity and P-Plus BadgerCare are seen at Journey MHC (with the exception noted in #1)

Phone is routinely answered by a referral specialist or consultation specialist who are trained to conduct an intake over the phone. No PCP referral is necessary. Appointments are made for therapy or psychiatric evaluation as deemed appropriate. Families/caregivers may request appointments with specific providers.


Serves: Deancare commercial and BadgerCare assigned to Dean.

No PCP referral is necessary, and Behavioral Health Consultants are available at each Dean psychiatry department to assist with well-matched appointments. Intake forms and “new patient packets” are available on-line to streamline the first appointment:

- **Dean Clinic – East** (608) 260-6006
- **Dean Clinic - Fish Hatchery** (608) 252-8226
- **Dean Clinic - Hematology & Oncology** (608) 410-2700
- **Dean Clinic - Janesville East** (608) 371-8625
- **Dean Clinic - Sun Prairie** (608) 825-3777
- **Dean Clinic - West** (608) 824-4777

*Case Management services* can be requested if diagnosed with a chronic health condition or a complex health care need. To enroll contact the Dean Health Plan Customer Care Center at (800) 279-1301


Serves: GHC commercial and BadgerCare assigned to GHC

Members can access GHC-SCW mental health directly, without PCP referral, by contacting any clinic. *For immediate help with an urgent mental health crisis, 24-hour crisis intervention services are available at (608) 257-9700.* A nurse or an on-call crisis counselor who will address the concerns, including safety, need for follow-up services.
**Intake:** New clients should contact **Central Intake at (608) 280-2720** to access services at JMHC. Information is provided on this line (including the Open Access process), but it is not answered directly. There is an option for families to leave messages requesting a scheduled appointment, or for questions.

JMHC accepts the following insurance types: Physicians Plus BadgerCare, Unity BadgerCare, Medical Assistance without an assigned HMO (“Straight MA”), Medicare, and children without insurance. JMHC is able to see some GHC BadgerCare members, if they have a prior authorization from GHC. JMHC also accepts most employer-sponsored and private insurance plans (including WPS, GHC, Unity, etc.) with a prior authorization. Insurance plans vary widely, so it is suggested families call the number on the back of their insurance card to understand the details of their specific plan.

- The recording at 280-2720 will inform families that the fastest way to access services is to utilize Open Access. Families arrive at Journey at 8 a.m. any Tuesday through Friday to complete a same-day Intake interview, which will be scheduled in the morning or early afternoon. It is important that individuals arrive promptly at 8:00 a.m., because appointments fill very quickly.
- Families also have the option to schedule an Intake appointment in advance. Appointments are scheduled on Mondays, and after-school times are available. These appointments generally schedule out approximately four to six weeks.
- The legal guardian and child must be present for the Intake appointment. Exceptions are made for very young children, and for children unable to participate in the hour-long interview.
- The Intake appointment consists of paperwork (Informed Consent, HIPPA, etc.), verification of insurance and fee-setting, plus an hour-long psychosocial Intake interview.
- Parents/caregivers are required to attend a two-session Parent/Caregiver Orientation Group. Each session is two hours long. Parents/caregivers can start group as soon as a few days after the Intake appointment, and day and early evening hours are available. These groups provide general information regarding services at JMHC, teach coping skills, and provide education regarding the ways families and JMHC work together to support the child(ren). Parents/caregivers need to attend this group in order for the child(ren) to be assigned an individual clinician, as parental engagement is key to family-based services.
- There is a waiting list for assignment to individual clinicians. The length of the wait varies depending on the acuity of the situation, as well as specific needs of the child(ren). Some children need to work with clinicians with specialized skills.
- Starting in November, a four-week FaCT (Families Coping Together) Group will be available for all families waiting to be paired with an individual therapist, and for those already receiving individual therapy. Groups are held simultaneously for parents/legal guardians and youth (both younger and older youth).
- Psychiatric consults may result by referral of the therapist. Intake can also initiate the process of a one-time psychiatric consultation, in which the child’s primary care provider prescribes the medication after receiving recommendations and guidance from one of Journey's psychiatric prescribers.

**Crisis Intervention Services:** In the event of a mental health emergency, please call Journey’s **24-Hour Crisis Unit at (608) 280-2600.** This number is always answered; it does not take messages. Callers during
shift change (8:00 – 8:30 a.m. and 4:00 – 4:30 p.m.) will reach a recording asking them to call back or to push a button to interrupt shift change.

The Crisis Unit provides services for individuals with the following insurance types: Physicians Plus BadgerCare, Unity BadgerCare, Medical Assistance with no assigned HMO (“Straight MA”), Medicare, and for individuals without insurance.

Crisis Intervention is a 24-hour/365 day service for Dane County residents, including children and youth, who are experiencing a mental health crisis. CIS staff provide short-term counseling and/or link the individual to on-going services. Potential responses when calling include:

- Consultation with families and/or school staff regarding imminent need, which may include police response and/or emergency room services. It is possible for services to be mobilized to the community setting.
- Consultation and support in linking to youth’s current mental health providers (clinician and/or psychiatric prescriber).
- Scheduling same and next day appointments for youth not currently linked to services.
- Assistance with involuntary hospitalizations for all youth, regardless of insurance.
Appendix 49
MENTAL HEALTH & AOD RESOURCE LISTS

UWHC AADAIP -
University of Wisconsin Hospital and Clinics’ Adolescent Alcohol/Drug Assessment Intervention Program in Madison is a comprehensive alcohol and drug evaluation program providing screening, assessments, intervention and referral services for youth and their families. Assessments take place over four meetings, about once a week for an hour. Parents attend the first and final sessions with their teen. The purpose of the assessment is to identify strengths/risks, determine the level of current or past alcohol or drug involvement, and identify related problems. Assessments are provided for Dane County adolescents up to age 18, and youth who are still in high school or an HSED/GED program up to age 21.


Connections Counseling -
This clinic provides a resource list including residential treatment options for AOD treatment (youth & adult), online screening tools, and support group listings. (Look under resources section) www.connectionscounseling.com

Dane County Human Services -
Dane County Human Services provides information regarding comprehensive services provided through the county system. www.danecountyhumanservices.org

Horizon High School -
The mission of Horizon High School is to provide a school that fosters emotional, social and academic growth for students who want to learn in an alcohol-free, drug-free environment. Students actively assume responsibility in creating their own safe and nourishing community. To inquire about Horizon High School contact School Director Traci Goll 608.335.0387 ttgoll@tds.net

http://www.horizonhs.org/index.html

NAMI resources -
Our local NAMI chapter provides an extensive list of Dane County/Madison Area mental health resources. Look under the Resources Guide section. http://www.namidanecounty.org/resource-guide/

Safer Communities -
The Educator Prevention Network is an interactive site that allows for viewers to contribute additional educational resources, interventions, programs that have potential or proven effectiveness. This in-
Appendix 50

RESOURCES FOR GLBTQ YOUTH & FAMILIES, MADISON AREA

YOUTH RESOURCES

Alianza Latina
Gay and Lesbian social and educational group for LGBTQ Latino/a youth ages 15-18 years as well as their adult allies. Meet at Outreach, 600 Williamson St., 608. 255.8582 Second Thurs. of month, from 7-9 pm. Also provides English-Spanish translation services at Outreach. Phone: Baltazar at 608.246.8372 or email at: alianzalatina1@gmail.com  www.facebook.com/alianzalatinamadison

Freedom, Inc & People Like Us (PLUS)
PLUS is a queer youth of color group that engages in grassroots organizing for communities of color around issues of sexuality and gender identity & expression. Freedom Inc. includes a specific Hmong, Southeast Asian, & Black group. adams4730@gmail.com  M Adams 1.414.430.1321 608.661.4088 office

Gay Straight Alliance for Safe Schools
(GSAFE): increases the capacity of LGBTQ youth and students, educational staff and families to create school environments where LGBTQ youth thrive. Offers opportunities forstrength building programs of support including GEST a group for trans*/gender nonconforming youth which meets 2nd & 4th Mondays from 6-8 pm. One session provides care for younger children at Trans*Parent group. Call for more info. Lane at 608. 661.4141 info@gsafewi.org

MMSD – GLBTQ Resource Person
Support for GLBTQ students, staff and families to increase safety and achievement for all. Sherie Hohs  608.663.8449  shohs@madison.k12.wi.us

Proud Theater
An award-winning youth run, youth organized queer theater group that performs in the Madison area. (for GLBTQ youth, children of LGBTQ parents or allies of LGBTQ community) Brian Wild, 608.222.9086 brian@proudtheater.org  www.proudtheater.org  www.facebook.com/proudtheater

Teens Like Us (TLU) Youth Services of Wisconsin & 24-hour Helpline
Madison based, drop in social and educational support group for LGBT ages 13-19. Tuesdays from 5-7pm at YSOSW, Briar patch, TeensLikeUs@youthsos.org  (608) 251-1126  2720 Rimrock Road, Madison, 53704

PARENT RESOURCES

PFLAG  Parents, Families and Friends of Lesbians and Gays, promotes health and well being of lesbian, gay, bisexual and transgender persons, their families and friends through support and advocacy.  www.pflag-madison.org  www.facebook.com/pages/Pflag-Madison/108173265977829 Phone:  608.848.2333

Trans*Parent
Support and information for parents of gender expansive/gender nonconforming/transgender students. Meets 2nd Monday of Month 6-8pm, school year. (GEST – youth group meets at same time to be with younger kids) Can access through GLBTQ resource person, (608) 663-8449

RESOURCES FOR 18 YEARS AND OLDER

http://www.brianj@gsaforsafeschools.com OutThere
LGBTQ 18-24 year old social group meets at Out Reach Community Center. Includes activities such as movie nights, trips, social gatherings.  (608) 255-8582 or  www.outheremadison.org  outheremadison@hotmail.com
www.lgbtoutreach.org

FTM/ Genderqueer Support Group
Meets 4th Monday of month from 6-8pm. Peer-led non-professional support/social group for FTMs, genderqueers, and anyone else assigned female at birth who identifies as masculine. Allies, friends, family also invited to attend. At Outreach 608.255.8582
Appendix 51

Student Support and Intervention Team Guidelines

**Purpose**

Student Support and Intervention Team (SSIT) is an interdisciplinary team that uses the Collaborative Problem-Solving Process to address the needs of individual students who are not making expected progress.

**Parameters**

We accomplish our purpose through:

- Alignment, integration and interaction with the work of other teams (at all tiers)
- Regular meetings, agendas and note-taking
- The Collaborative Problem-Solving Process which includes:
  - Problem Identification
  - Problem Analysis
  - Plan Implementation & Monitoring
  - Plan Evaluation
- Culturally and linguistically responsive practices
- Collaborative meeting practices, including clear roles and responsibilities
- Membership that includes established leadership, standing members & representatives specific to the desired meeting outcomes
- The use of approved referral, documentation and feedback tools
- Consistent follow-through and communication

**Presuppositions**

- Leadership Team regularly utilizes the Collaborative Problem-Solving Process to improve larger, school wide ‘systems’ (e.g., PBS, Literacy) that impact all students (Tier 1)
- Other teams (student services, grade level, department, instructional teams) are in place, and respective team members regularly use the Collaborative Problem-Solving Process to:
  - Improve systems and practices within the classroom
  - Identify and provide groups of students with (tier 2) interventions
  - Analyze data to support, develop, select, and evaluate tier 2 and 3 interventions
  - As needed, refer students to SSIT for individual problem-solving
● Principals play a vital role in supervising the team to ensure high quality SSIT as part of a larger school team structure

● Through district support structures and aligned with their schools SIP and professional learning plan, SSITs will access the necessary tools and professional development needed to fulfill defined purpose

● MMSD will provide adequate technology resources to complete and document practices as described by these guidelines, expectations and recommendations

Guidelines for team membership

The following should be considered for membership on the SSIT at both elementary and secondary levels

● Administrator:

   Supervises team to ensure high quality SSIT as part of a larger school team structure, provides role authority necessary for instructional decision-making, and serves as the primary conduit to Leadership Team

● Parent:

   Good faith effort to include the student’s parent/guardian at the individual student problem-solving meeting is an expectation. In the event that the parent is unable to attend, plans should include methods for including parent input prior to the meeting, and communication of meeting outcomes following the meeting

● Academic representative(s):

   Learning Coordinator (LC), Instructional Resource Teacher (IRT), Literacy Coach, etc.

● Behavior representative(s):

   Positive Behavior Support (PBS) coach, cross categorical teacher (CC), etc.

● Classroom representative(s):

   Classroom teacher, CC, English Language Learner (ELL) teacher, etc.

● Student services representative(s):

   Counselor, nurse, psychologist, social worker

● School-based program support teachers when available and/or applicable

● Speech/Language clinician

● Representatives from additional areas as determined by individual concern and systems level work:

   Interventionists, Occupational and/or Physical Therapist (OT/PT), Talented and Gifted resource
teacher (TAG), IRT, ELL, Lesbian, Gay, Bisexual, Transgender and Questioning resource teacher (LGBTQ), parent liaisons, engagement coordinators, specials teachers, prior teachers, etc.

Guidelines for team member roles
SSIT clearly identifies and defines team member roles which include coordinator, facilitator, time keeper, note taker and engaged participant

Coordinator:

Supports systems purpose in following ways:

- Schedules completion of SSIT Self-Assessment Survey annually
- Gathers data on the work of the SSIT for school leadership team review
- Data point person who gathers and brings data sets to the SSIT

Supports individual problem-solving purpose in following ways:

- Collects SSIT referrals and ensures appropriate membership and roles for the SSIT meetings
- Manages calendar and list of invitees for new referrals
- Ensures that representation for SSIT work is adequate to develop an informed intervention plan
- Monitors calendar to ensure that team follows up on referrals and is prepared for re-visits

*It is the administrator’s responsibility to determine who will serve as the SSIT coordinator. Desired skills include the ability to use/interpret data, attend to organizational detail, maintain adequate records and manage time.

Facilitator:

Facilitates the SSIT meeting:

- Prepares agenda and states the desired outcomes
- Adheres to the SSIT agendas, maintaining one topic and one process at a time
- Uses the Collaborative Problem-Solving process
- Ensures that participation is balanced, and that conflict is managed effectively

Time Keeper:

- Keeps track of time and makes sure the group finishes tasks on time
- Ensures that there is ample time to document the intervention plan

Note Taker:
● Records information regarding the work of the SSIT

Engaged participants:

● Come prepared to contribute fully to the Collaborative Problem-Solving Process

**Meeting Frequency and Time:** Weekly, 60-90 minutes
Appendix 52

SSIT Individual Student Problem-Solving Process

**Individual Student Problem-Solving Agenda**

*(1 min.)*

**Introductions and Define the Purpose**

- Names & roles of participants
- “We agree to stay on topic and end on time”

*(5-10 min.)* **Problem Identification**


*Summarize the key points, and specify the concern which will be the focus of the consultation*

- Student strengths
- Record Review: Referring teacher and SSIT member provide team with a summary of automated data pull and pre-meeting data review to describe current level of performance
- Expected level of performance (what do you want the student to be able to do?)
- What instructional strategies are and are not effective with this student?
- What additional interventions have been tried?
- Specify not more than 2 academic/behavior concerns total for consultation (last component of the Problem Specification worksheet)

*(10-15 min.)* **Problem Analysis**

*Document essential outcomes of conversation in SIMS*

- Academic & Behavior Considerations
  - Effect of *Instructional* variables
  - Impact of *Curriculum*
  - Key *Environmental* factors
- **Learner** variables (rate of learning, response to prior intervention, culture, developmental level)

- Resources: RIOT/ICEL; Brief FBA

- Develop hypotheses & prediction statements (If...then...)

**(15-20 min.) Implementation Plan**

*Document essential outcomes of plan in SIMS*

- Intervention Selection: What needs to be happening?
- Implementation Plan: Who will do what?
- How will you monitor the student’s progress?
- How will you know when your plan is working?

**(1 min.) Closing**

*(max: Document review date in SIMS, and add to SSIT calendar)*

**47 min. total** Set up follow-up meeting for **Planned Evaluation** of student outcomes
Appendix 53

Definition of In-School Suspension and Permissible Use

According to the Behavior Education Plan (BEP), in-school suspension (ISS) is when, “A student is removed from the classroom environment and assigned to work within an alternate school environment for up to one day.” The permissible use of ISS, by response level, is as follows:

<table>
<thead>
<tr>
<th>Response Level</th>
<th>K-3</th>
<th>4-5</th>
<th>6</th>
<th>7-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Level 1</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Response Level 2</td>
<td>---</td>
<td>Up to 1 day</td>
<td>Up to 1 day</td>
<td>Up to 1 day</td>
</tr>
<tr>
<td>Response Level 3</td>
<td>Up to 1 day</td>
<td>Up to 1 day</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Response Level 4</td>
<td>Up to 1 day</td>
<td>Up to 1 day</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Response Level 5</td>
<td>---</td>
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</tr>
</tbody>
</table>

Purpose of In-School Suspension

The purpose of in-school suspension in the Madison Metropolitan School District is to provide a short-term, disciplinary placement for a student while ensuring: (1) the student engages in a targeted intervention focused on decreasing the likelihood of future disciplinary events; (2) the student completes work for the classes he or she has missed or will miss.

Essential Components for In-School Suspension

- A clear set of positively stated, explicitly taught expectations
- A procedure for ensuring access to and understanding of class work
- Access to behavior intervention(s)
- Active attempts to involve the parent/guardian in planning for re-integration into the classroom environment
- A plan for monitoring student behavior while in ISS
- An opportunity for the student to meet with the referring adult or impacted peer(s) to positively repair harm
- A plan for monitoring student progress upon return to the classroom

**Critical Considerations for Assigning In-School Suspension**

- Is the use of ISS critical in decreasing the likelihood of future disciplinary events?
- Will the time spent in ISS result in higher response level behavior?
- Does ISS provide student(s) with the support necessary to shape future behavior?
- Will the use of ISS serve as a means of encouraging parent involvement?
- Does ISS provide temporary respite for student(s) while planning for intervention?

**Potential Interventions for Use During In-School Suspension**

The following are tools that may be used while a student is in ISS for the express purpose of problem-solving with the student, intervention, repairing the harm, and/or reintegrating back into the classroom:

- Fix-It Plans
- Student Reflection Form
- Classroom Re-Entry Protocol
- Restorative Circle Scripts
- Collaborative Problem-Solving
- Restorative Dialogue
- Replacement Behavior Lessons
- Brief Functional Behavior Assessment with the student (secondary)
- Meditation or mindfulness practices
STAFF GUIDANCE FOR CONDUCTING A DISCIPLINARY INVESTIGATION

OVERVIEW

There are three threshold issues that must be addressed in every situation when a student has allegedly engaged in behavior that may be a violation of the Behavior Education Plan (BEP): (1) the first issue is to determine exactly what behavior the student engaged in; (2) whether the pupil’s behavior is identified as misbehavior in the BEP, and (3) if the behavior is defined as misbehavior in the BEP, did the misbehavior occur under circumstances that provide the school district with the legal authority to impose a disciplinary consequence because of the misbehavior (known legally as jurisdiction).

THE LEGAL PREREQUISITES FOR IMPOSING BEP DISCIPLINE

The district can only impose discipline when the evidence confirms that the student engaged in misbehavior that violated the BEP, and that the misbehavior occurred under a circumstance that affords the Investigator with the legal authority to impose discipline for the misbehavior.

HOW TO CONDUCT A DISCIPLINARY INVESTIGATION AND TAKE APPROPRIATE ACTION WHEN WARRANTED

1: Identify all individuals who need to be interviewed. There are potentially three categories of individuals to interview: (a) those who were involved in the misbehavior, (b) those that witnessed the misbehavior, but were not involved in it, and (c) those that were neither involved nor witnessed the misbehavior, but were told about it by a participant in the misbehavior.

2: Interview each person separately. There is no rule as to who you must interview first. The facts of the situation being investigated often dictate who you will interview with first. Whenever possible, interview individuals in person so that you can observe their demeanor while answering your questions. It is important that you create written notes reflecting answers received by you to the questions that you ask. Be sure to include the name of the person being interviewed, and the date of the interview. Your notes don’t have to be a transcript of everything said, but rather a summary of key information that you receive about the behavior being investigated. With regard to the alleged perpetrator of misbehavior, it is not uncommon to interview him/her more than once. In the initial interview of the alleged perpetrator you should inform him/her of the specific section of the Behavior Education Plan that you believe
that he/she engaged in. Ask the potential perpetrator for his/her statement regarding the alleged violation. The alleged perpetrator should be interviewed a final time, after all other interviews have been concluded, and the Interviewer has arrived at a conclusion regarding what BEP section(s) have been violated. During the final interview of the alleged violator, the Interviewer will inform the alleged violator of the specific section(s) of the BEP that he/she believes was/were violated, and give the alleged violator a final opportunity to provide his/her view regarding the matter. [This is the student’s due process opportunity that is required by Board Policy 4043 and applicable law.]

3. **Investigation Questions To Ask.** When conducting investigatory interviews, at a minimum, the Interviewer should ask the “who, what, when, where, why, and how” questions for the purpose of ascertaining the facts regarding the potential misconduct. Examples are, who did what, who witnessed the incident, what did you do, and what was done by others, where did it happen at, when did it happen, why did it happen, and how did it happen? At a minimum, ask the following questions:

   a. **WHO** – who did what in the incident, who witnessed the incident?
   
   b. **WHAT** – what happened that led up to the incident, what did all participants do in the incident, what did the witnesses who observed the incident see, what did participants tell others about the incident, what caused the incident to end, what injuries were sustained?
   
   c. **WHEN** – when did the incident occur (time and day of the week, month, and year when the incident occurred)?
   
   d. **WHERE** – specifically where did the incident occur?
   
   e. **WHY** – why did the incident occur?
   
   f. **HOW** – how did the incident occur?

4. During and after each interview, evaluate the credibility (believability) of the answers that you received during the interviews. Determine the facts of what actually transpired after you have concluded your interviews, based upon credible evidence produced by your investigation.

5. If you conclude that a violation of the BEP has occurred, then (a) select the appropriate Response Intervention Level for that misbehavior, (b) consult with appropriate Student Services staff and select the Response Intervention(s) option(s) from the level that are deemed appropriate, and (c) if applicable, select the Disciplinary consequence that you decide is appropriate, given due regard to district identified disciplinary decision criteria.

6. Document relevant information about a student’s misbehavior (i.e., date of incident, section of BEP violated, Response Interventions selected for implementation, a description of the Discipline imposed, if any) into whatever system the district has operational for recording the relevant information about the student’s misbehavior.
CIRCUMSTANCES WHEN SCHOOL ADMINISTRATORS HAVE LEGAL AUTHORITY TO DISCIPLINE

The legislature has granted schools jurisdiction (meaning the authority to discipline students in the following situations) when a violation of the BEP has occurred, and one or more of the following applies to the student’s misbehavior:

1. **The student is non-compliant with school rules;**

2. **The student knowingly conveyed any threat or false information concerning an attempt or alleged attempt being made or to be made to destroy school property by means of explosives;**

3. **The student engaged in conduct while at school or while under the supervision of a school authority that endangered the property, health, or safety of others;**

4. **The student engaged in conduct while not at school or while not under the supervision of a school authority that endangered the property, health, or safety of others at school or under the supervision of a school authority; or endangers the property, health or safety of any employee or school board member of the school district in which the pupil is enrolled.**

RESPONSE INTERVENTION & DISCIPLINE - DECISION CRITERIA

Consideration should be given to the following factors when deciding what Response Intervention and Discipline, if any, should be imposed relative to the student’s most recent misconduct: (a) the student’s entire Disciplinary history and Response Intervention history for the current school year, and the preceding school year; (b) was the current act of misconduct the student’s first incident of that type, or had he/she committed the same form of misconduct previously, if so, how many times; (c) what Response Interventions and Discipline were initiated to address the students same or similar misconduct in the past, and when were the Response Interventions and Discipline initiated previously; (d) did the student’s most recent misconduct result in a disruption in the educational process for other students, if so, for how long, and (d) did anyone sustain significant physical or psychological harm as a result of the student’s misconduct?

JDH/7/17/14
RECOMMENDED BEST PRACTICES AND PROCEDURES FOR CALLING THE POLICE

There is growing concern regarding the unnecessary use of police in American schools to address ordinary student disciplinary issues and to enforce school rules. The referral of students into the juvenile justice system is associated with negative outcomes that impact students’ academic achievement and increased drop out rates. While the majority of student arrests and citations are for misdemeanor offenses such as disorderly conduct, trespassing or fighting, they often have a detrimental effect and contribute to further contact with the juvenile system that expose the students to possible institutionalization. New research indicates that the best indicator of adult criminality may be the youth’s prior incarceration in a juvenile facility.

MMSD’s goal is to minimize police involvement for minor student infractions that should be managed with the Behavior Education Plan. The District is committed to a non-criminal enforcement model that supports restorative justice concepts, early intervention and problem solving rather than reliance on law enforcement. However, it certainly doesn’t mean that police will never be needed in our schools. The following are circumstances where involvement of the police may be necessary

In a Situation that Poses an Imminent Threat to the Safety of Staff or Students

An Imminent Threat is defined as a situation, threats or actions of a individual(s) which present an immediate threat of harm which could reasonably be expected to cause death or serious bodily injury to staff or students. An example is a person on a school campus with a firearm, or a person armed with a weapon such as a knife. In these situations schools should activate emergency procedures and call the 911 Center to request immediate police assistance.

To Report an Incident on Behalf of a Student

These situations may be the result of child abuse/neglect concerns or to report a crime where the student was victimized off school grounds. Many students and parents don’t feel comfortable with or don’t know how to report incidents to the police and may need our assistance to do so. These types of incidents may include threats to the student on the way to or from school, cyberbullying, enticements or other situations that impact our students’ safety. With the exception of incidents of suspected child abuse or neglect (Bd. Policy 4400), administrators should contact parents first, before calling the police. However, if the administrator has reason to believe that delaying the report would jeopardize the student’s safety, and the parents can’t be reached, the police should be notified as soon as possible.
When any Person Engages in Violent, Disorderly and Threatening Behavior in School
and when it exceeds the School’s Ability to Safely Manage the Behavior

Calling the police is appropriate when an individual (adult or student) is involved in disorderly, violent or threatening conduct to the extent that it significantly disrupts school and when the behavior is such that it exceeds the school’s ability to safely manage it and when such behavior has the potential to escalate and jeopardize the safety of our staff or students. These situations include behavior that pose a danger of self-harm, as well as potential harm to others.

To Report Certain Crimes that Occur in School

There are other situations that require police involvement. These are related certain incidents or crimes that occur in schools, which are of such serious nature that they are beyond the scope of schools to manage within the BEP, alone. Examples of these include the following:

Sexual assaults
Possession of firearms
Actual, attempted or threatened use of a weapon toward another person or to cause disruption.
Bomb threats
Possession of explosives
Attempted or actual use of fireworks, smoke bombs, pepper spray/gas, MACE, or tear gas
Setting or attempting to set a fire
Possession of drugs with intent to distribute
Physical attacks against students or staff that result in significant injuries
Armed robberies
Robberies with use of force
Possession of child pornography

Factors to Consider

Decisions about calling the police are best made after consultation with the legal department or with the safety coordinator. Situations involving imminent danger require immediate action, but others require a closer examination of facts and consideration of all the factors involved, such as:
Age and grade level of the student
Cognitive/developmental issues
The existence of a BIP
The extent of the harm or intended harm to students or staff
The student’s ability to de-escalate and self-regulate
The school’s ability to safely manage the incident
The victim requests a report to the police

Contact with the Police and Resolution

A request for police assistance doesn’t necessarily need to result in an arrest. In fact, in many situations the best resolution will be reached when the police and the school administrator are able to discuss the reason for involving the police, review all the factors involved and jointly determine the best option to ensure the safety of the students.

All options should be explored. Can the incident be resolved by the simple presence of the police? Will a warning or counseling from the officer suffice? Is the officer able to withhold enforcement action pending a peaceful resolution of the incident? What other tools, short of arrest are available to the officer?

Law enforcement officers possess broad authority to arrest, but under most circumstances, they also have discretionary options that should be discussed. Principals will need to clearly articulate the desired outcomes and work with the officer to achieve them.

Any time the police interact with a student, the school administrator must implement Board Policy 4400, and ensure the needs of the school are clearly expressed.

The Madison Police Department, as well as MMSD, is committed to the reduction of existing disparities in academic achievement, as well as in arrest and incarceration rates, particularly of youth of color. To this end, it’s extremely important that schools utilize existing educational systems and resources to manage student behavior and rely less on police intervention, unless the behavior poses an immediate threat to the school or falls under the categories outlined above.

Use Of Educational Resource Officers (ERO’s)

Educational Resource Officers (ERO’s) are assigned to each high school to provide an extra layer of safety to our schools. They work alongside their school’s administrative team to address issues that may jeopardize staff or student safety. As defined in the contract between the District and the police department, the ERO’s have a dual and balanced role, as educators and law enforcement officers.
Their role is to support the school to maintain a safe environment but not to engage in the enforcement of minor school rules that should be addressed by the school utilizing appropriate interventions and the Behavior Education Plan.

The relationship between schools is most effective when there is a mutual understanding of the specific roles of the school and that of the ERO’s. It is an MMSD expectation that administrators will work closely with ERO’s and their command staff to discuss roles and situations in which the ERO may intervene directly or provide support to the school. All school administrators should be trained and included in these discussions to ensure a consistent interpretation of the critical role the ERO’s have in our schools.

**Disposal of confiscated items from Students**

All illegal and dangerous items need to be turned over to the police so they can be safely disposed of. These items include, but are not limited to: illegal drugs, firearms, explosives, live ammunition, brass knuckles, switchblade knives, and MACE/pepper spray.