

HARVEY COUNTY SPECIAL EDUCATION COOPERATIVE

Resource Manual

For

Students with Emotional Disturbance



Serving Children of Newton, Halstead and Hesston School Districts

2002

Revised January 2005

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Introduction

The work on this Resource Manual for staff working with students who have severe emotional disorders began as a revision of a previous set of manuals. Several staff members and administrators have devoted many hours to the revision and development of this product. This manual is intended to be used by school Student Intervention Teams, Staffing Teams, and IEP teams. We have thoughtfully discussed what to include and exclude in this manual. We hope that it proves to be a helpful document.

Members who served on this committee are:

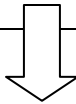
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Revised January 2005 by Juli Winter

The Assessment Process for Students Who May Be Emotionally Disturbed

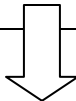
General Education Intervention Process

- Review Educational History
- Behavioral Observation(s): Building team needs to determine frequency of observation
- Behavior Interventions: Implemented and documented on Student Intervention Team forms
- Parent Consultations
- Rule out Medical/Sensory problems
- Functional Behavioral Assessment/Behavior Intervention Plan



Referral/Evaluation

- Behavior Observations
 - Teacher Behavior Rating (BASC, Achenbach, BES-2)
 - Intellectual/Achievement assessment
 - Social History: significant development, medical, family issues
 - Team defines target behaviors using data collected
 - Parent Rating (BASC, Achenbach, Social Emotional Early Childhood Scales-SEEC)
- (Optional)**
- Student Self Report (BASC, APS-SF)
 - Mental Health Evaluation
 - Medical Evaluation



Staffing – Eligibility Meeting

- Determine eligibility based on criteria and need – use Eligibility Analysis for additional assistance
- Behavior Intervention Plan Reviewed
- Develop the Individual Education Plan with PLEPs and goals/benchmarks based on GEI data
- Develop criterion for transitioning to more/less restrictive services.

Items of Differentiation

Characteristics	Seriously Emotionally Disturbed	Socially Maladjusted
1. Conscience development	Self-critical, unable to have fun	Shows little remorse; pleasure seeking
2. Reality orientation	Lives in fantasy world, naïve, gullible	Street-wise
3. Adaptive behavior	Consistently poor	More dependent on situation
4. Domain	Affective disorder	Character disorder
5. Aggression	Hurts self or other as an end	Hurts others as a means to an end
6. Ego strength	Easily hurt	Acts tough; survivor
7. Anxiety	Tense; fearful	Appears relaxed; “cool”
8. Peer relations	Ignored or rejected	Accepted by sociocultural group
9. Type of friends	Law-abiding; younger or no real friends	Bad companions; same age or older
10. School behavior	Seen as unable to comply; inconsistent achievement; good attendance; appreciates help	Seen as unwilling to comply; generally low achievement; excessive absences; does not want help
11. Locus of control	Blames self	Blames others
12. Cause	Psychological	Sociology
13. Distrust	Wants to trust; feels insecure	“Dumb” to trust others
14. Group participation	Withdrawn; unhappy	Outgoing
15. Management needs	Emotional support; likes structure; a need to decrease anxiety	Warmth; dislikes structure; a need to increase anxiety
16. Attitude toward authority	Overly compliant	Noncompliant; hostile
17. Self-insight	Aware a problem exists	Denies a problem
18. Developmental appropriateness	Inappropriate for age	Appropriate for age
19. Activity level	Hyperactive; hypoactive	Normal but acts out
20. Stability of affect	Variable labile (excessive reactivity and changes in moods or emotions)	Relatively stable; even moods

Eligibility Analysis Emotional Disturbance

Emotional Disturbance is a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance.

- ___ An inability to learn that cannot be explained by intellectual, sensory, or health factors;
- ___ an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- ___ inappropriate types of behavior or feelings under normal circumstances;
- ___ a general pervasive mood of unhappiness or depression; or
- ___ a tendency to develop physical symptoms or fears associated with personal or school problems.

Mark the appropriate response: Does the student exhibit one or more of the above characteristics? ___ Yes, continue. ___ No, stop.*

Please specify the behavior(s) that lead to Yes being checked.

Emotional disturbance is an emotional condition, including schizophrenia, with one or more of the above characteristics that are:

Interfering consistently with the student's educational performance
And
Exhibited at either a much higher or lower rate than is appropriate for one's age
And
Documented as occurring over an extended period of time (from 6 months to 2 ½ years as indicated in the DSM-IV when appropriate)
And
Not due to social maladjustment.

If the statements in the box above are all true for one or more of the characteristics in the top box the student would be considered to have met the definition of a child with emotional disturbance.

This form is an optional form that may be used to assist teams. The Eligibility Report Form must be completed by the team and signed by each team member to document the child's eligibility and need for special education services.

*If not eligible, the student should be considered under Section 504 of the Rehabilitation Act of 1973. Building level teams should then develop an intervention plan to address the behavioral problem(s) of the student.

Functional Behavioral Assessment: Part 1 (Description) Date: _____

Student Name: _____ ID: _____ DOB: _____ Case Manager: _____

Data Sources: Observation | Student Interview | Teacher Interview | Parent Interview | Rating Scales | Normative Testing

Description of Behavior (No. ____):

Setting(s) in which behavior occurs: (Where does the behavior occur and who is typically involved?)

Frequency: _____ times per _____. (Ex: three or four times an hour.)

Intensity (Consequences of problem behavior on student, peers, instructional environment):

Duration: (Check box that corresponds to the approximate length of action and circle the appropriate time measurement.)

- | | | |
|---|--|--|
| <input type="checkbox"/> 1-2 seconds/minutes | <input type="checkbox"/> 10-15 seconds/minutes | <input type="checkbox"/> 25-30 seconds/minutes |
| <input type="checkbox"/> 3-5 seconds/minutes | <input type="checkbox"/> 15-20 seconds/minutes | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> 5-10 seconds/minutes | <input type="checkbox"/> 20-25 seconds/minutes | |

Describe Previous Interventions:

Educational impact:

Name: _____

Functional Behavioral Assessment: Part 2 (Function)

Date: _____

Function of Behavior (No. ____): Specify hypothesized function for each area checked below.

Affective Regulation/Emotional Reactivity (Identify emotional factors; anxiety, depression, anger, poor self-concept; that play a role in organizing or directing problem behavior):

Cognitive Distortion (Identify distorted thoughts; inaccurate attributions, negative self-statements, erroneous interpretations of events; that play a role in organizing or directing problem behavior):

Reinforcement (Identify environmental triggers and payoffs that play a role in organizing and directing problem behavior):

Antecedents:

Consequences:

Modeling (Identify the degree to which the behavior is copied, who they are copying the behavior from, and why they are copying the behavior):

Family Issues (Identify family issues that play a part in organizing and directing problem behavior):

Physiological/Constitutional (Identify physiological and/or personality characteristics; developmental disabilities, temperament; that play a part in organizing and directing problem behavior):

Communicate need (Identify what the student is trying to say through the problem behavior):

Curriculum/Instruction (Identify how instruction, curriculum, or educational environment play a part in organizing and directing problem behavior):

Page ____ of ____

Behavior Intervention Plan

A Behavior Intervention Plan should contain the following information:
(Teams can format how they want to.)

Name: _____ Date Implemented: _____

Behavioral Assessment Summary (summarize the behaviors of concern from the Functional Assessment to include antecedent and consequences)

Replacement Behavior(s) (how will you measure and document the replacement behavior?)

Positive Reinforcement (list the specific reinforcers you will use and under what conditions they will be given)

Intervention(s) (based on antecedents and consequences – what can be changed in these areas to change the behavior? What can be done to support the implementation of replacement behaviors(s)?)

Reactive Strategies (what will be done immediately when the student does not respond to interventions, to maintain the appropriate classroom environment?)

Evaluation (who will evaluate, when they will do it, how often it will be done and how it will be reported to parents and others involved with this student)

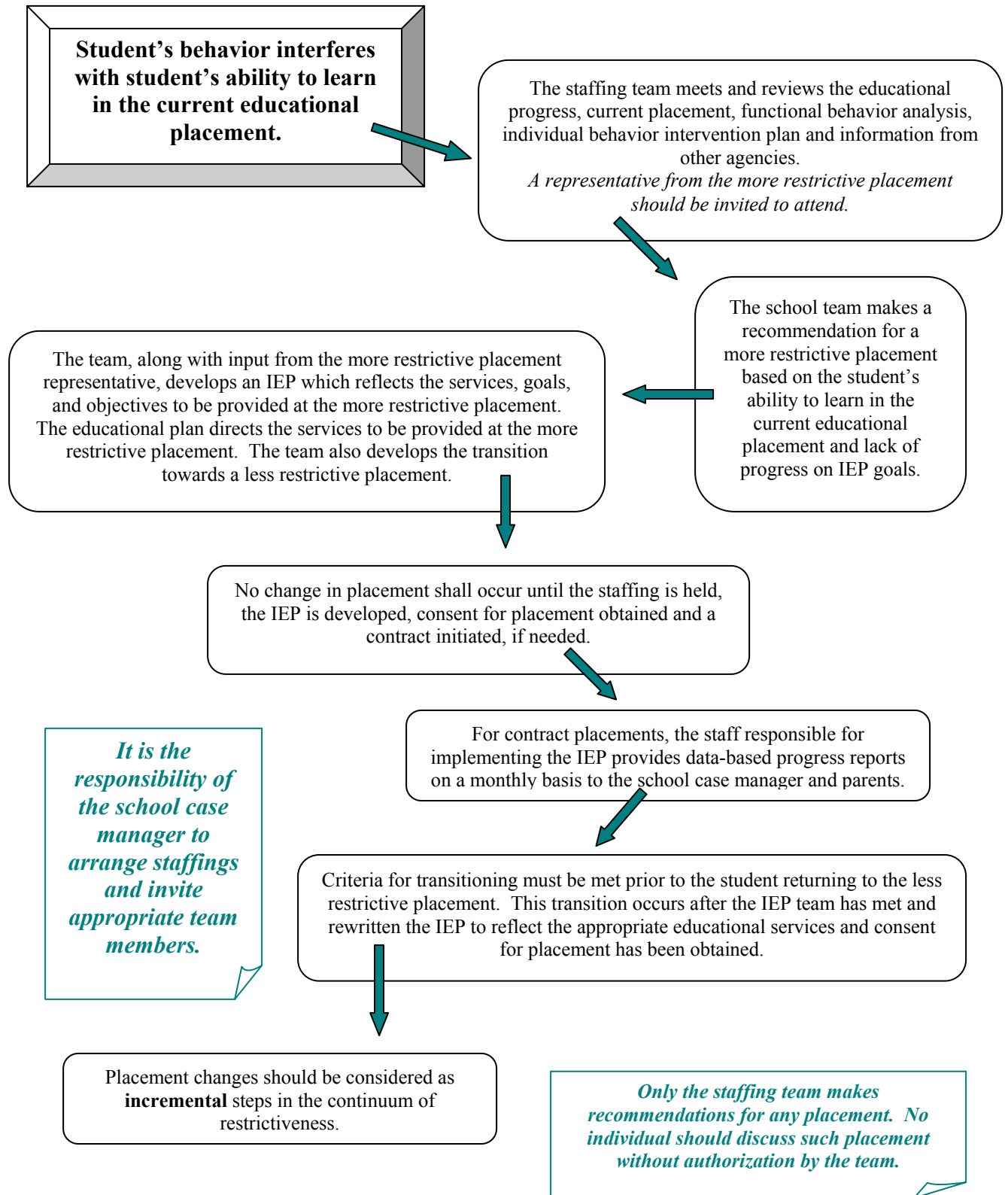
Individual responsible for implementing the plan.

Models of Service

Emotional Disturbance

	<i>Teacher</i>	<i>Student</i>
I N C L A S S S U P P O R T	<ul style="list-style-type: none"> • May co-teach with the regular ed. teacher in subject areas where support is given to IEPed students. • Will act as resource or consultant for regular ed. teachers. • Will encourage the IEPed student to self-regulate behavior on an as-needed basis. • Will provide minimal services directly to the student. 	<ul style="list-style-type: none"> • Will respond to “typical” classroom discipline the majority of the time. • Will not threaten the safety of others. • Will participate in regular classroom instruction requiring minimal help from teacher.
R E S O U R C E	<ul style="list-style-type: none"> • Will adapt and adjust academic and social skills for no more than 50% of the day. • Will provide structured behavior management program to be used in the resource and regular classroom. • Will teach basic skills in areas of organization and social behavior. 	<ul style="list-style-type: none"> • Will not threaten others although there may be an occasional outburst. • Will cooperate and work in small group settings. • Will follow regular classroom <i>and individual</i> behavior plan. • Will create minimal classroom disruptions.
S E L F C O N T A I N E D	<ul style="list-style-type: none"> • Will provide over 50% of academic and social skills curriculum. • Will provide a behavior program to be used at all times of the day in all settings of the school. 	<ul style="list-style-type: none"> • Will need adult assistance in regaining control of behavior. • Will require individual instruction and private work areas. • Will follow an individual management plan for behavior. • Will be able to gain control of behavior in a reasonable amount of time.
S P E C I A L P U R P O S E	<ul style="list-style-type: none"> • Will attend staffing to review current placement. • Will help develop new IEP and transition goals. • Will provide monthly updates to SED teacher, school psych, and/or social worker. • Will provide 100% of academics and social skills training. 	<ul style="list-style-type: none"> • Will require 1-1 instruction time. • Will require an isolated setting to regain control of behavior. • Will attend and cooperate in group therapy on daily basis. • Will carry through with school and individual behavior plan.

Process for Placing Students in More Restrictive Placement



Guidelines for Using Time Out In Schools

Albert Learning, December 2001 Special Program Branch

There are many ways to promote safe and caring schools and encourage responsible and respectful behaviors in students. All behavioral interventions assume a regard for the well-being and dignity of students and staff. The use of timeout procedures is well documented in the professional literature and, when implemented correctly, has proven to be an effective method of reducing a wide variety of disruptive behaviors in children.

Timeout may not be effective for all children. Each child is unique and may require alternative strategies to deal with inappropriate behaviors. The use of timeout requires well-defined procedures, routines and interventions to prevent and modify problem behavior before timeout is ever considered.

Timeout lies within a continuum of behavioral interventions and should only be used when less restrictive interventions have not been successful. The exception to this would be when a student presents with acting out behaviors that school personnel did not anticipate and the safety of staff and students is in jeopardy. Subsequent to this single, unpredictable incident, a behavior plan must be developed.

- Educators, parents and other members of the school communities should work together to promote positive behavior, teach and reinforce appropriate social skills and encourage the development of respect and responsibility in students.
- Early intervention is the first strategy to be used to prevent acting-out behavior and promote academic and behavioral student success.

If timeout is used, strategies must be systematically planned, delivered, supervised and evaluated to determine their effectiveness with individual students.

- Parental permission *must* be obtained in order to utilize timeout as a strategy in the behavior management of their children. Parents may not support the use of timeout. If that is the case, they must be involved in determining alternative strategies for dealing with inappropriate behaviors of their children.
- Administration *must* play a leadership role in the development, implementation and monitoring of the timeout procedures and processes. Administration must also provide opportunities for regular consultation and feedback with students, parents and staff about school behavior requirements and expectations and timeout.

Timeout Definitions

1. **Contingent Observation or Non-exclusion Timeout** – The student is removed from the reinforcing activity, but is still allowed to observe the activity. For example, a grade 4 student continues to disrupt the class by poking a neighbor and talking during a class project, despite attempts from the teacher to encourage the student to stop and focus on the task at hand. The teacher directs the student to a timeout area in the classroom where the student is able to listen to the discussion, but not allowed to participate for a period of time.

2. **Exclusion Timeout** – The student is excluded from the reinforcing activity and is not allowed to participate or observe the activity. For example, the student continues to talk while in contingent observation timeout. The student yells, throws a pencil and disrupts the class activity. The teacher asks the student to leave the timeout area and go to another supervised area until the student demonstrates appropriate behavior and is ready to return to class.
3. **Seclusion Timeout** – The student is removed from the reinforcing activity area, placed in a separate room and is supervised during the entire seclusion timeout. For example, the student grabs a pair of scissors off the teacher’s desk and runs around the room and then out of the class. The student threatens other students and is in danger of hurting self and/or others. The student is moved to a timeout room that is safe, where he or she is constantly supervised.
4. **Suspension and Expulsion** – These interventions are recognized as forms of timeout. School authorities are advised to abide by Kansas Law and IDEA when considering suspension or expulsion procedures.

Effective Timeout Strategies

The effective use of timeout is contingent upon a number of factors. The strategies listed below are designed to provide guidance to schools and school communities as they refine, develop and implement timeout procedures.

- When implementing timeout consider the following questions:
 - Does the student understand the reason for the timeout?
 - Does the student have an opportunity to stop the misbehavior and demonstrate appropriate behavior?
 - Does the student have an opportunity to demonstrate responsibility for his or her own behavior and have opportunities to practice self-control?
 - Does the student understand what the expectations are for a successful return to classroom activities?
 - Is the length of time in timeout reasonable and appropriate for the student’s age and/or ability?
 - Is the timeout space reasonable, safe and respectful of the needs of all students?
 - Is data routinely collected and reviewed to evaluate the effectiveness of timeout?
- There must be a documented attempt to establish the cause of the behavior leading to timeout. This documentation will also guide future education and behavior programming decisions. Through the analysis of documentation and data collected, more effective prevention programs may be established.
- Research indicates that the degree of timeout effectiveness is tied to an understanding of why the student is misbehaving. A functional behavior and/or communicative assessment should

be conducted for students who display chronic, inappropriate behaviors. This may include, but are not limited to, an assessment of:

- the student's ability, areas of strengths and needs
 - the situation(s) that occur prior to the student's behavior
 - the frequency, intensity, duration and intent of the behavior
 - previous attempts to deal with the behavior and the result of those attempts
 - the environmental factors that may be contributing to the behavior.
- The classroom environment must provide a nurturing, safe, and caring environment where the student benefits from a wide variety of positive reinforcements and instructional strategies.
 - Clear, concise expectations for behavior, including pre-correction, must be communicated to the student, in a manner the student is best able to understand, prior to the use of timeout.
 - Positive reinforcement for appropriate behavior, as well as negative consequences for inappropriate behavior, must be stated clearly and in a manner appropriate for the student's age and/or ability.
 - There must be a clear distinction between the amount of positive reinforcement the student receives when engaged in appropriate behaviors and when involved in a timeout from the activity.
 - Positive behavior strategies may include, but are not limited to, praise and encouragement, positive behavior contracts, positive phone calls and notes home. The praise and encouragement provided should be delivered frequently and provide the student with clear descriptions of expected behaviors. Strategies to deal with misbehavior may include, but are not limited to, ignoring minor misbehavior, redirecting students to another task, loss of privileges and timeout.
 - If timeout is to be at all effective, the student must perceive the environment he or she is removed from as being considerably more reinforcing than the timeout environment.
 - Timeout procedures for specific behaviors *must* be included as part of the student's behavior plan and clearly stated and communicated to the student, parent(s), staff and the administration.
 - The behaviors that result in timeout *must* be stated prior to the use of timeout. Staff should be able to identify the specific behavior that has resulted in the timeout and the reinforcing situations that are allowing the student's inappropriate behavior to continue.
 - Should a student present with behaviors that compromise the safety of others, and the student has never presented such behaviors before, the use of timeout, for safety reasons, may occur regardless of the contents of the BIP. This incident must be documented and reported to the parents. Revisions to the BIP are advised immediately after the incident.

- Milder forms of timeout must be tried prior to resorting to the use of seclusion timeout. Documentation that milder forms of timeout have not been effective with a student should be provided before using seclusion timeout.
- If exclusion and/or seclusion timeout is to be utilized as a strategy in the behavioral interventions continuum, the specific behavior(s) resulting in timeout *must* be clearly communicated to the student, parent(s) and the administration prior to the use of exclusion and/or seclusion timeout. The plan should be documented on the student's Behavior Intervention Plan(BIP) and should include specific strategies to deal with the disruptive behavior(s).
- When using seclusion timeout, the following procedures should be utilized:
 - The use of seclusion timeout should be documented in the student's behavior plan and/or on the student's IEP and signed by the student's parent and IEP team that includes the student, parent(s), teacher(s), administration and other appropriate personnel.
 - Administration *must* be informed of the student's need for seclusion timeout and involved in providing support and assistance, if necessary.
 - A staff member who is familiar with the student's behavior plan must continuously supervise the student.
 - The staff member should document, in a central log available to all members of the team, the student's name, the behavior resulting in seclusion timeout, the time of day that the student entered timeout, the time the student was released from timeout, the total time in timeout and the student's behavior in timeout.
 - The effectiveness of the use of seclusion timeout should be evaluated on an ongoing basis.
- Timeout rooms *must* provide for the safety and security of the student and be shown to be effective in the reduction of dangerous behaviors and the promotion of appropriate behavior. For example, timeout rooms must:
 - not be locked from either the outside or inside
 - meet Fire Marshal standards
 - be supervised at all times
 - not contain items or fixtures that may be harmful to students
 - be well ventilated
 - allow students to exit should there be an emergency
 - provide the means where adults can visually monitor the student at all times.

PHYSICAL RESTRAINT & AVERSIVE THERAPY POLICY

BACKGROUND AND PURPOSE

The purpose of this policy is to ensure that every student participating in a Harvey County Special Education Cooperative program is free from the unreasonable use of physical restraint or aversive therapy and that such an intervention is used only in emergency situations after other less intensive alternatives have failed or have been deemed inappropriate. Physical restraint should be administered only when needed to protect a student or other students and staff from imminent, serious physical harm. Physical restraint should be administered in the least intrusive manner possible and should be used to prevent or minimize harm to the student.

At the beginning of each school year, Principals and/or the Director of Special Education will identify program staff to participate in training in the use of physical restraint and appropriate de-escalation methods.

School officials shall not use aversive therapy or restraint on a student to modify or change that student's behavior without parent consent according to a written behavior intervention plan.

DEFINITIONS

The following terms shall have the following meanings:

Aversive Therapy: Aversive therapy is the application of unusual, noxious or potentially hazardous substances, stimuli or procedures to a student. The types of aversive procedures prohibited include, but are not limited to: Electric shock, White noise at 95 decibels, Shaving cream in the mouth, Lemon juice, vinegar, or jalapeno pepper in the mouth, Water spray to the face, Placement in cold water, Slapping or pinching, Pulling the hair, Ammonia capsule to the nose, Blindfolding, Placement in a dark, isolated box, Ice to the cheeks or chin, Teeth brushed or face washed with antiseptic solutions, Prolonged physical restraint or isolation, & Withholding of meals

Physical escort: Touching or holding a student without the use of force for the purpose of directing the student.

Physical restraint: The use of bodily force to limit a student's freedom of movement.

Extended restraint: A physical restraint the duration of which is more than twenty (20) minutes. Extended restraints increase the risk of injury and therefore, require additional written documentation.

School working day: Any day or partial day that students are in attendance at the public education program for instructional purposes.

DETERMINING WHEN PHYSICAL RESTRAINT MAY BE USED

1. **Physical restraint may be used only when:**
 - (a) Non-physical interventions would be ineffective.
 - (b) The student's behavior poses a threat of imminent, serious, physical harm to self and/or others, or;
 - (c) Restraint is administered to a student with a disability as part of an Individualized Education Plan (IEP) behavior intervention plan developed in accordance with state and federal law to which the school system and the parent/ guardian have agreed.
2. **Limitations of restraint:**

Physical restraint will be limited to the use of reasonable force as is necessary to protect a student or other students and staff members from assault or imminent serious physical harm.
3. **Instances when restraint is not to be used:**
 - (a) Physical restraint is not to be used as a means of punishment.
 - (b) Physical restraint is not to be used as a response to destruction of property, school disruption, refusal of the student to comply with school rules or staff directive, or verbal threats that do not constitute a threat of imminent serious physical harm.
 - (c) Physical restraint should not be used as an intervention, if the student has known health or physical problems that would knowingly exacerbate their condition.
4. **Nothing in this document prohibits:**
 - (a) The right of an individual to report to appropriate authorities a crime committed by a student or another individual.
 - (b) Law enforcement, judicial authorities or school personnel from exercising their responsibilities, including the physical detainment of a student or other persons alleged to have committed a crime or posing a security risk.
 - (c) The exercise of an individual's responsibilities as a mandated reporter of child abuse/neglect to the appropriate state agency.
 - (d) The protection afforded publicly funded students under other state or federal laws, including those laws that provide for the rights of students who have been found eligible to receive special education services.
 - (e) Any teacher, employee or agent of a public education program from using reasonable force to protect students, other persons or themselves from assault or imminent, serious physical harm.

PROPER ADMINISTRATION OF PHYSICAL RESTRAINT

1. **Trained personnel:**

Only staff that has received proper training in physical restraint procedures shall administer it to students. To the greatest degree possible, another adult who does not participate in the restraint should witness administration of a restraint. However, nothing in this policy shall preclude a teacher, employee or agent of the school system from using reasonable force to protect students, other persons, or themselves from assault or imminent, serious physical harm.
2. **Use of force:**

Any individual(s) administering physical restraint shall use only the amount of force necessary to protect the student or others from physical injury or harm.
3. **Safety requirements:**
 - (a) Restraint will be administered in a manner so as to prevent or minimize physical harm to the student.
 - (b) A restraint will not be administered in a manner that prevents the student from speaking or breathing.
 - (c) During a restraint, a staff member shall continuously monitor the physical status of the student including skin color and respiration.
 - (d) If at any time during the restraint the student displays significant physical distress, the restraint will immediately terminate and medical assistance will be sought.
 - (e) Staff will review and take into consideration any known medical or psychological limitations and/or behavioral intervention plans regarding physical restraint on an individual student.
 - (f) During a restraint, staff will try to de-escalate behavior and to end the restraint as soon as possible.
 - (g) Staff administering physical restraint will use the safest method available that is appropriate to the situation.
 - (h) Floor or prone restraints are prohibited unless the staff administering such restraint has been trained and in the judgment of that staff, such restraint is necessary in order to provide for the safety of the student as well as others present. In such a situation, the primary staff member administering the restraint will communicate with the student for safety purposes in an attempt to de-escalate and end the restraint as soon as possible.

- (i) Restraint will immediately terminate when the staff member determines that the student is no longer at risk of causing imminent physical harm to himself or others.
- (j) After release of a student from restraint, the incident, when applicable, will be reviewed with the student and the behavior that led up to the restraint will be addressed.
- (k) The administrator in charge will review the incident with the staff member who administered the restraint to ensure that proper procedures were followed and to consider if any follow-up is appropriate for students who may have been present during the restraint.

REPORTING REQUIREMENTS

1. Any staff member, who administers a restraint which lasts longer than twenty (20) minutes or results in any injury to a student or staff member, shall verbally inform the Principal as soon as possible and by written report no later than the next school working day. This must be kept on file by the school, however, if the Principal has administered the restraint, then he/she shall submit the report to the Superintendent or designee.
2. The Principal or his/her designee shall inform the student's parents or guardians of the restraint as soon as possible following the use of restraint.
3. Report extended restraint or serious injury to a student or staff member as a result of restraint to the Superintendent or Director. In the event a restraint results in: (a) serious injury to a student or staff member or (b) an extended restraint, that is, one that lasts longer than twenty (20) minutes, a report must be filed by the person who restrained and the witness. The parent must be notified immediately.

Attachment A: Physical Restraint Report

2002-2003

Physical Restraint Report

NOTE: This report is required to be submitted to the Director of Special Education after any physical restraint of a student lasting longer than twenty (20) minutes and/or after administration of a physical restraint that results in serious injury (requiring emergency medical intervention) to a student or staff member. This report must be sent to the Director or Superintendent within (3) school working days of the administration of the restraint.

IDENTIFYING INFORMATION:

Name of School: _____

Name of Student: _____ **Date of Restraint:** _____

Special education services student currently receives: _____

Date of this report: _____ **Site of restraint:** _____

This report prepared by: _____ **Position:** _____

Address: _____ **Telephone:** () _____

Staff administering restraint:

Name: _____ **Title:** _____ **Received prior restraint training:** Yes No

Name: _____ **Title:** _____ **Received prior restraint training:** Yes No

Observers (if any):

Name: _____ **Title:** _____

Name: _____ **Title:** _____

Administrator who was verbally informed following the restraint:

Name: _____ **Title:** _____

Reported by: _____ **Title:** _____

Parent who was informed of this restraint:

Name: _____ **Telephone:** () _____

Called by: _____ **Title:** _____ **Time:** _____

PRECIPITATING ACTIVITY:

Description of activity in which the restrained or other students were engaged immediately preceding use of physical restraint:

Behavior that prompted restraint:

Efforts made to deescalate and alternatives to restraint that were attempted:

DESCRIPTION OF PHYSICAL RESTRAINT:

Justification for initiating physical restraint (*check all that apply*):

- Non-physical interventions were not effective (*describe non-physical interventions tried*)**

- To protect student from imminent, serious, physical harm (*describe behavior*)**

- To protect other student/staff from imminent, serious, physical harm (*describe behavior*)**

- To implement necessary restraint in accordance with the student's IEP (*describe pertinent provisions of the IEP BIP plan*):**

Describe holds used and why such holds were necessary:

Student's behavior and reaction during restraint:

Time restraint began: _____

Time restraint ended: _____

CESSATION OF RESTRAINT:

How restraint ended (*check all that apply*):

- Determination by staff member that student was no longer a risk to himself or others**
- Intervention by administrator(s) to facilitate de-escalation**
- Law enforcement personnel arrived**
- Staff sought medical assistance**
- Other (*describe*):**

Description of any injury to student and/or staff and any medical or first aid care provided:

Incident report was filed with the following school district official: _____.

FOR EXTENDED RESTRAINTS (beyond twenty (20) minutes):

Alternatives to extended restraint that were attempted:

Outcome of those efforts:

Justification for administering extended restraint:

FURTHER ACTION TO BE TAKEN:

The school will take the following action and/or disciplinary sanctions (*check as many as apply*):

- Review incident with student to address behavior that precipitated the restraint.**
- Review incident with staff to discuss whether proper restraint procedures were followed.**
- Consider whether follow-up is necessary for students who witnessed the incident.**
- Conduct a local investigation of any complaint regarding this restraint (*describe investigation procedures*):**
- Disciplinary action/sanctions taken by the program (*describe*):**

PARENT/GUARDIAN NOTIFICATION (*required for all reported restraints*):

Verbally informed of physical restraint on _____ by teacher/administrator/other or documented attempts to contact verbally (*describe*):

Written report sent within 3 school working days of administration of restraint to parent/guardian on _____ by _____ (*teacher/administrator/other*) at the following address:

Sent in native language of the parent/guardian (*language*): _____

Parent/guardian was offered opportunity to discuss the administration of physical restraint and/or disciplinary sanctions with teacher/administrator. Results of discussion (*Attach separate page if necessary*):

**Copies to: Superintendent/Director
Building**

General Behavior Intervention

This section highlights low level, recurring behaviors typical to most classrooms. The strategies are meant to be simple and easy to implement:

Not Following Directions

- Ask child to repeat directions once teacher has stated them
- Stand near the student when giving directions, possibly with eye gaze toward child
- Write the directions on the board
- Repeat the directions paraphrasing what was said previously
- Model
- Use cues to highlight the steps of a skill such as numbering, color coding, etc.
- Have the child highlight key words
- Monitor for progress frequently
- Praise when directions are followed

Refuses to Work

- Apply natural consequences such as not going to recess, shorten passing periods, lunch detention
- Provide “get out of assignment free” cards for task completion
- Use a class store linked to earned money for work completed i.e. 100%-\$1.00
- Ignore, many times once we walk away they return to work
- Allow the child to complete work at developmental level to feel success and then reintroduce more challenging work
- Provide peer assistance
- Contract for specific tasks
- Allow the child to peer tutor children lower functioning than self

Distracts Others/Disrupts Lessons

- Proximity control
- Removal to a study carrel to work
- Token economy
- Reduced socialization time
- Remove the distracting object
- Time out
- Contract
- Earn extra social time for not disrupting/distracting
- Teach more appropriate methods of gaining attention
- Teach appropriate times for asking questions
- Call on the student frequently
- Reinforce appropriate behaviors
- Provide cues when questions or discussion are appropriate
- Teach to write down questions

Major Depressive Disorder (296.xx)

Clinical Issues: A single episode or recurrent

- may be mild, moderate or severe
- may include psychotic symptoms
- may be suicidal

Diagnostic Criteria: 5 or more of the following during the same two-week period

- depressed mood, may report feeling sad, empty, or may be irritable
- decreased interest in activities
- weight loss or gain
- insomnia or hypersomnia
- psychomotor agitation or retardation
- fatigue or loss of energy
- feelings of worthlessness or inappropriate guilt
- diminished ability to think or concentrate
- recurrent thoughts of death or suicide

Symptoms significantly effect social, academic functioning

Dysthymic Disorder (300.4)

Clinical Features: Depressed or irritable mood for at least 1 year in children

Diagnostic Criteria: while depressed/irritable, 2 or more of the following are present

- poor appetite or overeating
- insomnia or hypersomnia
- low energy or fatigue
- low self-esteem
- poor concentration or difficulty making decisions
- feelings of hopelessness

Depressive Disorder Not Otherwise Specified (311)

Occurs equally in children before puberty and more frequently in females following puberty.

May include features of new categories currently under study:

- Premenstrual Dysphoric Disorder
- Minor Depressive Disorder
- Recurrent Brief Depressive Disorder
- Postpsychotic depressive disorder of Schizophrenia

Bipolar Disorder (296.xx)

Clinical Features: Characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episodes.

Manic Criteria: at least 1 week of persistently elevated, expansive, or irritable mood and 3 or more of the following:

- inflated self-esteem or grandiosity
- decreased need for sleep
- more talkative than usual or pressure to keep talking
- flight of ideas or feels thoughts are racing
- distractibility
- increased goal directed activity or psychomotor agitation
- excessive involvement in pleasurable activities that have a high potential for painful consequences

Hypomanic is similar but symptoms last at least 4 days.

- Bipolar I, Single Manic Episode
 - Most recent episode Hypomanic
 - Most recent episode Manic
 - Most recent episode Mixed
 - Most recent episode Depressed

Mixed episode includes both Manic and Major Depressive symptoms nearly every day during at least a 1 week period.

Bipolar Disorder may occur in a range of severity, may have seasonal patterns, rapid cycling, and may occur due to postpartum.

- Bipolar II Disorder includes recurrent Major Depressive Episodes with Hypomanic Episodes.

Bipolar occurs more frequently in women. Heredity is a factor.

Manic Episodes in adolescents are more likely to include psychotic features and may be associated with school truancy, antisocial behavior, school failure, or substance use.

Cyclothymic Disorder (301.13)

Features: For children, at least 1 year of periods with hypomanic and depressive symptoms with absence of symptoms lasting no more than 2 months. Symptoms are not severe enough to diagnose Major Depression or Bipolar Disorder.

Often seen as a precursor to Bipolar I or II disorder.

Intervention Ideas

Disorders: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder Not Otherwise Specified, Bipolar Disorder, Cyclothymic Disorder

Depression in Children

- Must remember agitation is a sign of depression. Do not interpret short, rude remarks as intentional disrespect, but rather explore current affect.
- Check for suicidal ideation
 - Have you thought of hurting yourself?
 - How would you hurt yourself? / Do you have a plan?
 - How would your life be different if you hurt yourself?
 - Have you known anyone who killed him/herself?
- Children who sleep
 - Keep child engaged in high interest activities.
 - Change seating arrangement to effectively use proximity control.
 - Allow to earn a “nap” time for task completion.
- Withdrawn children
 - Move seat to front of room
 - Reward any attempts to participate
 - Teach basic interactions skills
 - Assign a “buddy”
 - Allow child to “earn” preferred staff
 - Build from successes, begin with mastered skills and then build on more challenging work
 - Reward “play”
- Manic children
 - Help set realistic goals
 - Monitor child more on playground or other less supervised areas
 - Notify parent/guardian
 - Make lists of consequences of specific behaviors
 - Document all “high risk” behavior
- General interventions
 - Social Skills Groups
 - Support groups related to issues creating symptoms
 - Cognitive Restructuring: Positive Affirmations, Address Irrational Beliefs
 - Individual Therapy
 - Music Therapy/Art Therapy
 - Address patterns of self-blame
 - Teach anger management skills

Brief Psychotic Disorder (298.8)

Characteristics: One or more of the following which occur at least once a day but does not last beyond one month; often precipitated by a stressor or postpartum

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior

Delusional Disorder (297.1)

Characteristics: Nonbizarre delusions of at least one month's duration

Types:

- Erotomaniac: delusions that another person is in love with the individual
- Grandiose: delusions of inflated worth, power, knowledge, identity or special relationship to a deity or famous person
- Jealous: delusions that the individual's sexual partner is unfaithful
- Persecutory: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way
- Somatic Type: delusions that the person has some physical defect or general medical condition
- Mixed: delusions characteristic of more than one of the above

Schizophrenia (295.)

Clinical Characteristics: Two or more of the following present for a significant portion of the month which effect major areas of functioning. Symptoms last over 6 months with variations in severity.

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms such as flat affect

Schizophrenia Subtypes:

Paranoid Type:

- preoccupation with one or more delusions or frequent auditory hallucinations
- may not have disorganized speech, flat or inappropriate affect, disorganized or catatonic behavior

Disorganized Type:

- disorganized speech
- disorganized behavior
- flat or inappropriate affect
- cannot be catatonic

Catatonic Type: at least two of the following:

- motoric immobility as evidenced by catalepsy or stupor
- excessive motor activity that is purposely and not influenced by external stimuli
- extreme negativism (i.e. Motiveless resistance to all instructions, mutism, or maintaining a rigid posture)
- bizarre posturing, stereotypical behaviors, prominent mannerisms, or prominent grimacing
- echolalia or echopraxia

Causes: strong genetic links, chemical imbalance, stress may increase symptoms

Schizotypal Personality Disorder (301.22)

Characteristics: A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for close relationships as well as by cognitive distortions and eccentric behavior (includes 5 or more of the following)

- ideas of reference (incorrect interpretation of causal interactions)
- odd beliefs or magical thinking
- unusual perceptual experiences including bodily illusions
- odd thinking and speech
- suspiciousness or paranoid ideation
- inappropriate or constricted affect
- behavior that appears odd or eccentric
- lack of close friends
- excessive social anxiety that does not diminish with familiarity

Schizoid Personality Disorder (301.20)

Characteristics: a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings including 4 or more of the following:

- neither desires nor enjoys close relationships
- almost always chooses solitary activities
- has little, if any, interest in having sexual experiences with another person
- takes pleasure in few, if any, activities
- appears indifferent to praise or criticism of others
- shows emotional coldness, detachment or flattened affect

Asperger's Disorder (299.80)

Characteristics: Impairment in social interactions in at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye gaze, facial expressions or gestures
- failure to develop peer relationships
- lack of spontaneous seeking to share enjoyment or interests of others
- lack of social or emotional reciprocity

Restricted repetitive and stereotyped behaviors, interest, and activities as seen by at least one of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- apparently inflexible adherence to specific nonfunctional routines or rituals
- stereotyped and repetitive motor mannerisms
- persistent preoccupations with parts of objects

Intervention Ideas

Disorders: Brief Psychotic Disorder, Delusional Disorder, Schizophrenia, Schizotypal Personality Disorder, Schizoid Personality Disorder, Asperger's Disorder

- Constant contact with family regarding potential stressors
- Reduce stress at school
- Help set realistic goals
- Consistency
- Insure Medications are taken
- Social Skills Instruction
- Differential Reinforcement of Lower Rates of Behavior
- Honor and adapt rituals and routines
- Life Skills Curriculum
- Isolation and Separation (for safety)

Posttraumatic Stress Disorder (309.81)

Characteristics: Child's response to extreme stress and psychological trauma involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others. This response involved intense fear, helplessness, or horror (may include disorganized or agitated behaviors) and is reexperienced in one or more of the following ways for more than one (1) month:

- repetitive play reenacting trauma event
- frightening dreams (of event or without recognizable content)
- acting or feeling as if the event were recurring
- somatization

Acute Stress Disorder (308.3)

Characteristics: Symptoms which occur within 1 month of exposure to an extreme traumatic stressor which resulted in horror, fear or helplessness.

Overt behaviors:

- avoidance of situations that trigger recall
- anxiety

Separation Anxiety Disorder (309.21)

Characteristics: Developmentally inappropriate and excessive anxiety concerning separation from home or from other person of attachment. (Includes 3 or more of the following lasting at least 4 weeks and must impair general functioning.)

- recurrent excessive distress when separated
- persistent and excessive worry about attachment figures
- persistent and excessive worry regarding forced prolonged separation
- persistent reluctance or refusal to leave attachment figure
- persistent reluctance or refusal to sleep without being near attachment figure
- repeated nightmares involving separation
- repeated physical complaints when separation is necessary or expected

Adjustment Disorders (309.)

Characteristics: Emotional or behavioral symptoms due to an identifiable stressor. Symptoms occur within 3 months of the event. May be acute (lasts less than 6 months) or chronic (longer than 6 months).

Types: With Depressed Mood

With Anxiety

With Mixed Anxiety and Depressed Mood

With Disturbance of Conduct

With Mixed Disturbance of Emotions and Conduct

Unspecified

Typical Stressors:

- changing schools
- parental separation
- significant illness or death in family; natural disasters
- abuse

Defense Mechanisms

- Regression: Avoids thoughts/feelings from past through return to behavior typical of younger child, may include infant or child-like crying, and temper tantrums
- Fixation: Remains at developmentally earlier stage to prevent thinking about a stressful event
- Repression: Locking away of traumatic memories
- Identification: Defends feelings of stressor by developing a strong link with others
- Projection: Attributes personal feelings on others
- Reaction Formation: Refuses to experience specific feelings toward a person
- Sublimation: Uses negative energy in positive areas
- Rationalization: Justification for irrational or unconscious reactions to situations

Dissociative Amnesia (300.12)

Characteristics: Inability to recall important personal information, usually of a traumatic or stressful event, that is too extensive to be explained by ordinary forgetfulness. Child may have a series of gaps in childhood memory.

Dissociative Identity Disorder (300.14)

Characteristics: Presence of two or more distinct identities or personality states which cannot be attributed to imaginary playmates of fantasy play. Identities emerge due to specific coping mechanisms needed at that time.

Behavioral patterns:

- inconsistent behavior
- changes in handwriting
- self-mutilation
- impulsivity
- paired passivity and aggression

Depersonalization Disorder (300.6)

Characteristics: Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body.

Intervention Ideas in Abuse

Disorders: Posttraumatic Stress Disorder, Acute Stress Disorder, Separation Anxiety Disorder, Adjustment Disorders, Dissociative Amnesia, Dissociative Identity Disorder, Depersonalization Disorder

- Theme of Safety: goal - even when a child needs to be restrained is “I need to help keep you/ others safe”. Never threaten restraint as a punishment.
- Documentation
- Consistency
- Prioritize!! Many low levels of behavior need to be ignored to work on the more problematic behaviors.
- Trust Activities: This child often does not trust adults, respecting the child’s fear of being touched can be a start in this area.
- Level Systems: systematic expectations of a concrete system helps reduce anxiety for some children
- Shaping
- Differential Reinforcement
- Natural Consequences, Limited Punishers
- Schedule conflicts: a child that argues often, schedule the time and place for this daily argument
- Token Economies
- Teach Social Skills, especially boundaries, body space, interpreting nonverbal cues

Oppositional Defiant Disorder (313.81)

Characteristics: A recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures that persists at least 6 months, and is characterized by the frequent occurrence of at least 4 of the following behaviors:

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults’ requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- often touchy or easily annoyed by others
- often angry or resentful
- often spiteful or vindictive

Conduct Disorder (312.8)

Characteristics: A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate society norms or rules are violated, including 3 or more of the following in the past 12 months with at least one in the past 6 months:

Includes two types: Childhood Onset before age 10 and Adolescent Onset indicating no problems before age 10.

- Aggression to People and Animals
 - often bullies, threatens, or intimidates others
 - often initiates physical fights
 - has used a weapon that can cause serious physical harm to others
 - has been physically cruel to people
 - has been physically cruel to animals
 - has stolen while confronting a victim
 - has forced someone in to sexual activity
- Destruction of Property
 - has deliberately engaged in fire setting with the intention of causing serious damage
 - has deliberately destroyed others' property
- Deceitfulness or Theft
 - has broken into someone else's house, building or car
 - often lies to obtain goods or favors or to avoid obligations
 - has stolen items of nontrivial value without confronting victim
- Serious Violation of Rules
 - often stays out at night despite parental prohibitions, beginning before age 13
 - has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy stay)
 - often truant from school, beginning before age 13

Intervention Ideas

Disorders: Oppositional Defiant Disorder, Conduct Disorder

- Study Skills to Improve Academic Performance and Competence
- Social Skills to improve teacher, peer, and self-related adjustment
- Health Awareness to identify the consequences of a high-risk life-style
- Strategies for resisting involvement in drugs and alcohol
- Behavior Specific Praise
- Group and Individual Positive Reinforcement Contingencies
- Contracts
- Time-out
- Response Cost
 - may include police/probation contacts
- In-school suspension
- Out of school suspension

Factors Supporting Intervention

- Positive, friendly, kind and cooperative interactions
- Academic competence
- Global intervention
- Peer counseling/tutoring
- Establish effective school-wide discipline procedures that define behaviors on 3 levels: minor, serious, and illegal. Have staff agree on what behaviors fit under each category.
 - Examples of minor behaviors: tardy, talking too loud, not having materials, minor swearing, truant
 - Examples of serious behaviors: sustained noncompliance, extended verbal abuse toward staff/peer, low levels of physical aggression, vandalism
 - Examples of illegal behavior: weapons, drugs, theft assault, threats and intimidation toward others

Attention Deficit Hyperactivity Disorder

DSM-IV Codes

314.01 Attention Deficit/Hyperactivity Disorder, Combined Type

314.00 Attention Deficit/Hyperactivity Disorder, Predominately Inattentive Type

314.01 Attention Deficit/Hyperactivity Disorder, Predominately Hyperactive-Impulsive Type

Key Issues in Diagnosis

Difficult to diagnose in children younger than 4/5.

Young children with ADHD are often difficult to contain.

ADHD in school-aged children usually affects academic performance.

Prevalence: 3%-5% in school-aged children.

Criteria for diagnosis:

The following are necessary for diagnosis:

- Some symptoms before age 7
- Present in 2 or more settings
- Clear evidence of significant impairment in social or academic functioning.

Inattention Criteria (6 or more of the following, persistent for 6 months)

- fails to give close attention to details
- difficulty sustaining attention in tasks/play
- does not seem to listen when spoken to directly
- does not follow through or finish tasks
- difficulty organizing tasks/activities
- avoids tasks requiring sustained mental effort
- often loses things
- often easily distracted
- often forgetful

Hyperactive/Impulsive (6 or more of the following, persistent for 6 months)

Hyperactive

- fidgets or squirms in seat
- leaves seat at inappropriate times
- runs or climbs excessively in situations where inappropriate. In adolescence, may be limited to subjective feelings of restlessness.
- difficulty playing quietly
- acts as if "driven by a motor"
- talks excessively

Impulsivity

- blurts out answers before questions completed
- difficulty waiting turn
- interrupts or intrudes on others

Intervention Ideas

Disorders: Attention Deficit Hyperactivity Disorder

- Structure and consistency, reduce amount provided as behavior decreases or effective medication level is found
- Establish rituals and routines
- Color code class materials to assist in keeping track of belongings
- Pace the work in short segments, twelve 5 minute assignments rather than one long one
- Provide graduated assignments from easy to more difficult to allow for early success
- Teach self-management strategies for managing on-task behavior
- Provide directions in concrete rather than abstract terms
- Contract for increased in-seat, on-task, etc. behavior
- Token economy
- Use multiple cues such as visual and verbal
- Integrate more kinesthetic activities into instruction
- Provide a timer
- Verbally remind the class of the amount of time left to complete an assignment
- Work in a study carrel to reduce distractions (this should not be used as punishment)
- Reinforce increasing the amount of time the child remains in-seat/on-task systematically
- Use a “quiet minute” to prep the student to be ready to listen
- Use time out only if becomes significantly disruptive to others

Medications

These charts provide the side effects of most of the drugs frequently used by children with disabilities.

Psychostimulants

Drug Name (Brand Name)	Indications	Side Effects
Methylphenidate <i>Short-acting</i> (Ritalin, Methylin)	ADHD	Insomnia Decreased appetite GI pain
Methylphenidate <i>Intermediate-acting</i> (Ritalin SR, Metadate ER, Methylin ER)	ADHD	Insomnia Decreased appetite GI pain
Methylphenidate <i>Long-acting</i> (Concerta, Metadate CD, Ritalin LA)	ADHD	Headache Stomach ache Vomiting Loss of appetite Insomnia
Amphetamine <i>Short-acting</i> (Dexedrine, Dextrostat)	ADHD	Irritability Increased heart rate
Amphetamine <i>Intermediate-acting</i> (Adderall, Dexedrine spansule) <i>Long-acting</i> (Adderall-XR2)	ADHD	Tachycardia Palpitations Elevated blood pressure Restlessness Insomnia Dry mouth Unpleasant taste
Pemoline (Cylert) <i>used by special permission only</i>	ADD	Insomnia Anorexia Stomach ache Rash Risk of liver impairment
Strattera	ADHD	Drowsiness Stomach ache Agitation Headache

Antihypertensives

Drug Name (Brand Name)	Indications	Side Effects
Clonidine (Catapres)	ADHD Anger secondary to ADHD Insomnia secondary to ADHD Anxiety	Dry mouth Drowsiness Dizziness Constipation Rebound Blood Pressure
Guanfacine (Tenex)	ADHD Anxiety	Same as above

Tricyclic Antidepressants

Drug Name (Brand Name)	Indications	Side Effects
Imipramine (Tofranil)	Enuresis ADHD School phobia Obsessive-compulsive Depression	Cardiac Psychosis Mania Seizures Hypertension Confusion Insomnia/nightmares Tics Tremors Anxiety Photosensitivity Rash

Novel Antidepressants (SSRI's)

Drug Name (Brand Name)	Indications	Side Effects
Fluoxetine (Prozac)	Depression Dysthymia ADHD Obsessive Compulsive Disorder Panic Disorder Prader-Willi Anorexia Bulimia Self-Injurious Behavior	GI Problems Decreased appetite Weight gain or loss Nervousness Insomnia Excessive sweating Sedation Motor restlessness Dry mouth
Sertraline (Zoloft)	Same as above	Same as above
Paroxetine (Paxil)	Same as above	Same as above
Bupropion (Wellbutrin, Wellbutrin SR)	ADHD Depression (Should not be used in students with seizure disorder)	Stomatitis Mania Edema Tremor Agitation Dizziness Constipation
Venlafaxine (Effexor)	Anxiety Depression	Nausea Dizziness Sleepiness Sweating Dry mouth

Antipsychotics (Neuroleptics) - Subgroups of Antipsychotics

Drug Name (Brand Name)	Indications	Side Effects
Phenothiazines (Thorazine) (Mellaril) (Stelazine) (Trilafon) (Serentil) (Compazine)	Severe Behavior Disorders Psychosis ADHD Mania Nonpsychotic anxiety Tourette's Disorder Nausea/vomiting Intractable hiccup Preoperative Restlessness Allergic reaction Motion sickness Sedation and sleep	Extrapyramidal symptoms Tardive dyskinesia Acute dystonia Cardiac arrhythmias Akathisia Affective blunting Cognitive blunting Social withdrawal Hepatic toxicity Neuroleptic malignant syndrome Sudden death
Quetiapine Fumarate (Seroquel)	Psychotic disorders Schizophrenia Mood Stabilization Anxiety	Headache Sleepiness Dizziness Orthostatic hypotension Type II Diabetes
Risperidone (Risperdal)	Schizophrenia Other psychotic disorders Mood Stabilization	Drowsiness Insomnia Change in concentration Blurred vision Dizziness Low blood pressure Type II Diabetes
Ziprasidone (Geodon)	Schizophrenia Mood Stabilization	Unusual tiredness Nausea Constipation Dizziness Restlessness Type II Diabetes
Abilify	Schizophrenia Mood Stabilization	Weight gain Type II Diabetes

AntiConvulsants

Drug Name (Brand Name)	Indications	Side Effects
Carbamezepine (Tegretol)	Bipolar Disorder Alcohol withdrawal Chronic pain Depression ADHD Conduct Disorders Psychotic Disorders Functional Enuresis Sleep Terror Disorder	Drowsiness Uncoordination Nausea Skin rashes Liver damage
Valporic Acid (Depakene, Depakote)	Same as above	GI upset Increased appetite/weight gain Tremors Liver damage Decrease in White Blood Count Weight Gain
Phenytoin (Dilantin)	Seizures	Excessive hair growth Gum hypertrophy Folate deficiency/psychomotor Retardation
Felbamate (Felbatol)	Seizures	Sleepiness Anorexia Vomiting Insomnia Aplastic anemia Hepatotoxicity
Gabapentin (Neurontin)	Seizures Pain control <i>Sometimes used to treat Anxiety</i>	Sleepiness Dizziness Fatigue Ataxia Gastrointestinal upset Shortness of breath
Lamotrigine (Lamictal)	Seizures Bipolar Disorder	Sleepiness Dizziness Rash, including life threatening Ataxia Blurred vision Nausea
Levetiracetam (Keppra)	Seizures	Sleepiness Dizziness Behavioral abnormalities
Oxcarbazepine (Trileptal)	Seizures Mood Stabilization	Sleepiness Dizziness Headaches Lethargy Ataxia

AntiConvulsants (continued)

Drug Name (Brand Name)	Indications	Side Effects
Tiagabine (Gabitril)	Seizures Anxiety	Confusion Dizziness GI upset Anorexia Fatigue
Topiramate (Topamax)	Seizures Tourette's Syndrome	Sleepiness Dizziness Ataxia Confusion Fatigue
Zonisamide (Zonegran)	Seizures	Sleepiness Ataxia Appetite loss Nausea Slowing of mental acuity
Lithium Carbonate (Lithobid)	Bipolar Disorder Depression	Increased urinary frequency Increased thirst Slight hand tremors

Minor Tranquilizers

Drug Name (Brand Name)	Indications	Side Effects
Alprazolam (Xanax)	Anxiety	Lethargy
Chlordiazepoxide (Librium)	Irritability	Drowsiness
Clonazepam (Klonopin)	Agitation	Dizziness
Diazepam (Valium)		Irritability
Lorazepam (Ativan)		Decreased motivation
Oxazepam (Serax)		Nausea
Prazepam (Centrax)		Headaches
Buspirone (Buspar)		Skin rashes
		Impaired sexual functioning
		Tremors
		Loss of or increased appetite

Anticholinergic

Drug Name (Brand Name)	Indications	Side Effects
Benzotropine Mesylate (Cogentin)	Counteracts unwanted side effects of some antipsychotic drugs	Blurred vision Bowel blockage Confusion Constipation

RESOURCES

Classroom Management the Works: Research-Based Strategies for Every Teacher, by Robert J. Marzano. 2003. Association for Supervision and Curriculum Development, 1703 N. Beauregard St. Alexandria, VA 22331-1714

Win-Win Discipline, by Spencer Kagan, Ph.D., Patricia Kyle, Ph.D., and Sally Scott, MA. 2004. Kagan Publishing. 1160 Calle Cordillera, San Clemente, CA 92673

The Well-Managed Classroom: Promoting Student Success through Social Skill Instruction, by Theresa Connolly, M.A., Tom Dowd, M.A., Andrea Criste, M. Ed., Cathy Nelson, M.S., and Lisa Tobias, M.S. Boys Town Press, Boys Town, NE 68010

The Tough Kid Book: Practical Classroom Management Strategies, by Ginger Rhode, William Jenson, and H. Kenton Reavis. Available from Sopris West, Inc. 1140 Boston Ave., Longmont, CO 80501

Think Time Strategy for Schools: Bringing Order to the Classroom, by J. Ron Nelson, Ph.D. and Beth Ann Carr. 1996-1999 (Second Edition)

The Explosive Child, by Ross W. Greene, Ph.D. 2001. HarperCollins Publishers, Inc., 10 East 53rd Street, New York, NY 10022

The Bipolar Child, by Demitri Papolos, MD and Janice Papolos. 2002. Broadway Books, Random House, Inc., 1540 Broadway, New York, NY 10036

Managing Anger Skills Training (MAST), by Leona Eggert. Available from National Educational Service, 1610 West 3rd Street, PO Box 8, Bloomington, IN 47402

Second Step: A Violence Prevention Curriculum for Children. 172 20th Ave., Seattle, WA 98122

Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth, by Arnold Goldstein and Barry Glick. Available from Research Press, Inc., 2612 North Mattis Ave., Champaign, IL 61821

Peer Mediation: Conflict Resolution in Schools, by Fred Schruppf, Donna Crawford, and H. Chu Usdel. Available from Research Press, Inc., 2612 North Mattis Ave., Champaign, IL 61821

Council for Exceptional Children: www.cec.sped.org

Midwest Symposium for Leadership in Behavior Disorders: www.mslbd.org/