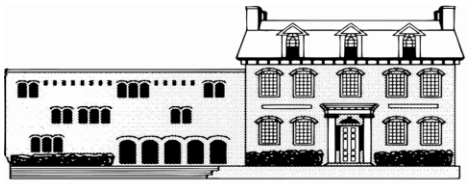

THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

Family Handbook – Day School

A Brief History of The Sonia Shankman Orthogenic School

The early beginnings of the Sonia Shankman Orthogenic School can be traced back to the establishment of The Orthogenic Clinic in 1912 at Rush Medical College under the guidance of Dr. Frank Billings. This occurred during an era when there was an actively collaborative relationship between Rush Medical College and The University of Chicago. The initial mission of the Clinic was to conduct the mental examination of children with "doubtful mentality" and to serve as a base for the instruction of Rush medical students about the care of such children in their future practices. Josephine Young, M.D., was engaged by Dr. Billings to do the cognitive testing, as well as to teach the medical students. At that time, Dr. Young was also the University of Chicago Medical Advisor for Women and the physician for children at the university's School of Education, as well as an assistant professor of neurology at Rush.

Not much later, Dr. Young approached Mrs. Cyrus Hall McCormick, Sr., to request a donation to support the work being done with children in this new program. A gift from Mrs. McCormick, an extremely wealthy and generous philanthropist, allowed the Clinic to open as The Orthogenic School in 1915, housed in a sparsely furnished, five-room apartment near Rush Medical College. As the school's enrollment grew, at that time operating as a day program, it became clear that it was necessary to expand the school's physical setting. Mrs. McCormick then provided additional support, purchasing a two-story house about three blocks from Rush, consisting of eight rooms that Mrs. McCormick allowed The Orthogenic School to use rent-free. In addition, Mrs. McCormick pledged a sum of $9,000 annually to provide better equipment for both students and staff members. By the early 1920's, the school had become financially self-supporting and was attracting annual donations from other benefactors in the Chicago business community.

In 1923, a decision was made to move The Orthogenic School closer to the University of Chicago, and in 1924 a house was rented at 5644 South Parkway Avenue, near the university's campus. At its new location, the school added a boarding school component, with an initial student population consisting of 9 residential students and 7 day students. A report released around that time by Dr. Young pointed out that one of the most important contributions of the school's work was research that had discovered, contrary to the prevailing beliefs of the time, that I.Q. is not static, but can increase with

proper teaching approaches. Representatives from Chicago's Institute of Juvenile Research visited the school and verified this conclusion by reviewing student files containing the results of Binet I.Q. tests that had been administered annually to all of the school's students.

In 1928, Professor Charles H. Judd, Director of the School of Education at the University of Chicago, proposed that the school relocate to property across from the School of Education on the south side of the Midway. In the summer of 1930, a memorandum of Lease and Affiliation was prepared between The Orthogenic School and The University of Chicago, and the school subsequently moved into the church building at Dorchester and Sixtieth Street in November of 1930. The school was advertised as having a capacity for thirty residential students, as well as being able to serve some day students. The student population represented an unlikely mix of difficulties: cognitive retardation, reading difficulties, and severe behavioral problems.

In 1934, The University of Chicago formally provided the status of full affiliation with the university to The Orthogenic School, which was beginning to shift its treatment focus that had been largely upon the care of cognitively impaired children, to a program designed for the study and treatment of children with adjustment difficulties resulting from educational, emotional, social, and personality disturbances. By that time, the majority of children at the school were residential students, with only a few remaining day students.

In August of 1944, Bruno Bettelheim was appointed the new Principal of The Orthogenic School, becoming the fifth leader of the school since its original establishment as the Orthogenic Clinic at Rush Medical School. Under his direction, the school acquired the remaining buildings of the church complex, constructed additional inter-connected buildings, and dramatically intensified the focus of work at the school to the treatment of children with severely disturbed emotions. Under Bettelheim's influence the theoretical framework of treatment became a psychoanalytic one, at times reflecting a classical Freudian psychosexual stance, while at other times emphasizing ideas based more upon developments in the area of ego psychology.

Bettelheim's tenure also included a phase, supported by a large grant from the Ford Foundation, where a major focus was directed toward the treatment and study of

autistic children. Bettelheim's theories about the development and treatment of autism were highly controversial and heatedly denounced by many renowned mental health professionals who were more convinced that the source of the disorder was biological or neurological, rather than psychological. Nevertheless, in one way Bettelheim's ideas provided a major contribution to the treatment of autism; the arguments provoked by his theories served as a strong impetus to conduct research about and develop clinical treatment approaches for persons with autism, rather than simply leaving them to languish much of their entire lives on the back wards of state hospitals.

After Bettelheim's final retirement from the school in 1973, there have been five subsequent Directors of the school. In more recent years, the school has experienced a significantly renewed sense of vigor, with a strong emphasis upon the value of family involvement and participation, psychopharmacological interventions, the provision of more contemporary models of individual psychotherapy, the introduction of formal group therapy experiences for students, the implementation of family therapy services at the school, the establishment of a transitional living program and the encouragement of a more progressive reorganization of the academic program for students (including the re-establishment of a day school component). Some observable results clearly reflect the value of the new directions and treatment advances being developed at the school, including: a markedly more solid base of financial solvency, a highly increased rate of referrals for admission to the school (which now is consistently operating at full capacity) and a more visible and rich reputation that is more frequently attracting students from an ever-widening national base of referral sources.

In July 2014, the Orthogenic School relocated from Dorchester and 60th Streets to a brand new facility at the location of 63rd and Ingleside Avenue. The new facility allows for a space created specifically to address the needs of the students as well as 21st century amenities.

II.

The Sonia Shankman Orthogenic School: Description of Residential and Day School Treatment Services

The Orthogenic School is a coeducational residential treatment program for children and adolescents in need of support for behavioral or emotional issues; a limited number of applicants are also accepted as day school students. It provides young people, ages five to twenty, with a therapeutic and educational environment that recognizes their strengths and needs, while challenging them to grow by achieving important developmental and behavioral outcomes. Founded as the Orthogenic Clinic at Rush Medical College in 1913 and formally becoming The Orthogenic School in 1915, a dynamic team of professional staff members utilizes a wide variety of treatment modalities in the care and support of students at the school.

As an affiliate of the University of Chicago, the school is committed to fostering inquiry into the clinical and treatment needs of troubled children and youth. The school is also dedicated to the education and training of its staff as the next generation of clinical scholars in the mental health field. The interrelated missions of clinical care, inquiry, scholarship and training assist the Orthogenic School in creating the best possible therapeutic and education model for its students.

Milieu Therapy

For almost seventy years, the Orthogenic School has defined one of its primary missions as the carefully planned provision of intensive milieu therapy for students with special emotional needs, who are in residential care at the school. This is also the case for students attending our recently established day school program. During many of those years, the school aimed to provide a psychodynamically oriented model of living and learning environment to facilitate the emotional, interpersonal and educational growth of its students. The beginning of that long-standing tradition can be traced from the early collaborative work done in the 1940's between Bruno Bettelheim at the Orthogenic School and Fritz Redl in Detroit, both of whom were indebted to the pioneering group work with young people done by Anna Freud in Vienna and London, and somewhat earlier by August Aichhorn in Austria.

In more recent years, the school has adapted its milieu to incorporate techniques that recognize the value of using of positive reinforcements to help promote student achievement and growth in areas such as emotional life and affect regulation, positive behaviors, self-esteem, sense of personal responsibility and educational performance. With these changes, however, the school still aims to provide a structured, predictable milieu environment for its students, while at the same time attempting to balance this aspect of structure with a recognition of and respect for the unique, particular needs of its individual students.

Nursing and Medical Services

Day school families give consent to receive routine health and wellness monitoring and first aid provision by the Orthogenic School Nursing Department, under the supervision of the Orthogenic School Medical Director – Dr. Peter Smith, M.D. from the Department of Pediatrics at The University of Chicago (or his designee), in collaboration with program staff.

Day school families will consent for their child to be administered medication prescribed by his/her **external** community psychiatrist, and specific over-the-counter medication as agreed to at admission, while he/she is in the care of the Orthogenic School. Day school families agree to keep Orthogenic School staff (Case Manager) informed of any changes in prescription medication, as they occur – and ensure the school maintains a current record of prescriptions.

Day school families agree to work to ensure communication between the Orthogenic School staff and the child's external psychiatrist in relation to the signing of consents (as necessary) and the sharing of information regarding ongoing and emergency psychiatric care.

Psychiatric and Medical Emergency Interventions

Day school families consent for their child to be provided with appropriate interventions by the clinical and medical staff of the Orthogenic School in the event of psychiatric or medical emergencies. Any intervention would be made only in cases of imminent risk of severe harm to self or other, and/or in situations that exceed the capacity

of the school to keep the student safe. Such interventions include, but are not limited to, the authorization of transportation by ambulance and communication with ambulance and hospital staff regarding the student's condition. We understand that in emergencies parents/guardians may not be informed of the treatment until after the care has been rendered and the student's condition is more stable.

Therapeutic Classroom Services

In addition to the attention paid to the school's overall milieu, students' educational needs are addressed in small classroom settings that are staffed by fully certified special education Teachers, who work closely with a number of Teaching Assistant personnel to facilitate even greater individualized attention. Educational services are provided in both self-contained classroom arrangements for younger students and in de-compartmentalized small group subject area classes for high school level students.

Additionally, during school times, there are a variety of specialized therapeutic group activity experiences available to the students of the school. These therapeutic activities include planned programming in area of creative arts, literature, music, drama, horticulture, student-run business opportunities, and self-government.

Individual Psychotherapy Services

The school also provides formal Individual Psychotherapy to all day school students. The Individual Psychotherapy services are provided either by licensed clinical professionals (psychologists, social workers, and professional counselors) or by other therapists receiving ongoing supervision by licensed clinicians. Individual psychotherapy is scheduled for twice-weekly, 45-minute sessions; however, the frequency and length of session times can be adapted according to a particular student's therapeutic needs.

At the present time, the major modes of individual psychotherapy provided at the school are psychodynamic (ranging from introspective to relational models) and cognitive-behavioral therapy. Attempts are made to reach a determination of the particular mode of treatment most suitable for a particular student based upon attention to the particular student's target issues, as well as upon a consideration of the student's psychological resources and suitability for a particular model of therapy.

Group Psychotherapy

Recognizing that formal Group Therapy experiences can have a major constructive effect upon young people, the school offers a range of weekly, 60-minute therapy groups for all of our students. These therapy groups include longer-term process groups for those students capable of achieving an awareness of group process, and of benefiting from realizing the relationship implications in therapeutic group interpersonal interactions and learning experiences. In addition to process groups, the school provides more structured therapeutic groups that are aimed at a variety of more particular issues, such as the promotion of more effective ways to cope with and alleviate feelings of depression, the acquisition of anger management skills, the development of basic to more complex social skills, and the enhancement of life skills/transitional living capacities.

Family Therapy Services

Ongoing Family Therapy services are provided at the school by licensed Masters and Doctorate level clinicians and are a required part of the Day School Program. Families meet with the family therapist for family therapy at a minimum of two sessions per month.

The Parent's Association

You are invited to become a member of The Parent's Association. The Parent's Association welcomes the parents of the day school students. A main objective of the association is to offer an opportunity for parents to meet each other and talk with one another. Many parents share similar experiences and can be a strong resource to one another. Another objective is to maintain the communication link between school staff and parents. The school will inform the Parent' Association about any upcoming events, training courses, or important information and the Parent's Association in turn sends out the information to all parents. The Parent's Association has sponsored many events for the children and families of the school over the years. It has enabled the school to enhance gardening opportunities, organize DJ's for dances, fulfilled wish lists for classrooms or dormitories and assisted in many other ways. Upon admission to the school, you will be informed how to become a member of the Parent's Association.

III. Description of the Orthogenic School Academic Program

Administrative Contacts:

Jerry Martin, M.A., Principal
Telephone: (773) 420-2898
Email: jmartin@oschool.org

Michelle Zarrilli, Academic Coordinator
Telephone: (773) 420-2887
Email: mzarrilli@oschool.org

Caitlin Brisbois, School Secretary
Telephone: (773) 420-2889
Email: cbrisbois@oschool.org

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As the approach to the therapeutic and residential aspects of the Orthogenic School has evolved in recent years, the approach to the academic process has undergone considerable change as well. As the composition of the student population and external requirements have undergone notable transformations, important changes in the structure of the academic program have been made to satisfy the needs associated with those transformations. Currently, the structure of the academic program looks quite different:

- There are five high school level classrooms (offering a wide range of departmentalized educational opportunities).
- There is one self-contained elementary school classroom.
- There are two self-contained junior high school level classrooms, with opportunities for participation in some departmentalized coursework made available for those students when appropriate.
- Foreign language courses are available (Spanish) for both high school and other students (provided by a foreign language instructor)

- Physical Education classes (in a well-equipped gymnasium), with sports and exercise activities directed by a highly trained and creative physical education instructors).
- An impressive and extensive fine arts program that offers art courses and activities to all students in a wide range of art mediums, including after-school activities for students.
- A formalized set of curricula.
- A standardized academic reporting schedule involving transcripts, report cards and mid-term updates.
- Mailings of the above documents to parents and the home schools of record.
- Each high school student's schedule of coursework is designed to follow the particular curriculum requirements of the student's home school. Credits earned for coursework at the Orthogenic School are then recorded on the student's home school transcript. Upon completion of the credits required for graduation by the students home school, the student receives an official graduation diploma from his/her home school and is eligible to participate in the home school's graduation ceremonies.
- Scheduled parent/teacher conferences.
- Open House events for parents.
- Recognition as an official ACT testing site.
- Special school-wide family events such as dramatic performances and Prom
- A ten-week summer program of community-based activities (Summer Fun)
- Accreditation by AdvanED and licensed by Illinois Board of Education, The Orthogenic School to autonomously grant course credits and issue its own officially recognized graduation diplomas.

IV. The Admissions Process

Initial contacts regarding admission to the school are directed to the Admissions Department. Contact may be initiated by telephone (773) 420-2891. Referrals are received from a wide range of sources, including: special education departments from students' home school districts, the Illinois Care Grant office, professional clinicians in the child care field, other child welfare agencies, educational consultants, special education advocates and by parents seeking placement for their own children. Those persons making an admission inquiry are informed about whether openings are currently available, or when placement openings might be reasonably expected to occur. In order to determine whether placement at the Orthogenic School could be helpful and appropriate for the applicant, individuals making a referral are asked to send a packet of clinical materials to the Director of Admissions, including: copies of the latest psychological assessment (including results of IQ and academic achievement testing), the most recent psychiatric evaluation including current medications, discharge summaries from any in-patient psychiatric hospitalizations, the student's most current IEP, and (if a high school age student) an educational transcript showing all credits earned.

The members of the admission committee will review those materials. Admissions decisions are made on a case-by-case basis and are dependent upon several qualifying factors which include but are not limited to the admission team's assessment of the student's ability to benefit from the program, the ability and willingness of the student and family unit to participate in and support the treatment, and finally, the consideration of other related variables such as staff suitability and existing group/milieu and classroom dynamics.

If a decision is made that the referral might be appropriate in terms of the student's needs and the clinical services offered by the school, the Admissions staff will contact the parent(s) to arrange a date to bring the applicant to the school for an admissions interview appointment. At this interview appointment, the family will meet and talk with several clinical and academic members and discuss the major policies/procedures of the school

and answer particular questions that they might have about the school. Subsequently, the parent(s) and prospective student will be given a tour of the school, discussing any additional questions that might arise during that tour.

After that appointment, the Director of Admissions will obtain feedback from the staff members who talked with the applicant and will review their recommendations, along with the applicant's clinical materials with Dr. Pete Myers, Co-Executive Director, and the educational materials with Diana Kon, Co-Executive Director. A decision about whether or not to offer admission will then be made, and the Director of Admissions will convey that decision to the parent(s). If the parent(s) accept the offer of admission, a formal admission date will be arranged.

Families of new day students should schedule an appointment with the Director of Admissions before the scheduled admission date to review the completed forms and documents sent to them earlier. That appointment will also include scheduled times for the Day School Case Manager and nurse to obtain the student's social and medical histories.

These procedures will be conducted in a manner which minimizes barriers to the timely initiation of services, serve as a basis for placement on a sequential waiting list if no openings are currently available, and give priority, when possible, to applicants with urgent needs or in emergency situations. Finally, all applicants will be treated equitably and without favoritism.

V. Items to Bring/Leave Home

Items/supplies that should be brought to the school at the time of admission:

Essential Items

1. A one-month supply of all prescribed medications if necessary.
2. Gym shoes with white soles for physical education activities (to help avoid leaving dark markings on the gymnasium floor).
3. Shoes and outerwear (sweaters, sweatshirts, and coats) appropriate for the seasons.

School Supply List

The following is a general list of school supplies, which may vary as the year progresses based upon each student's academic program.

4-5 Notebooks
4-5 Double Pocket Folders
Binder
Ruler
6-8 No.2 Pencils
6-8 Black/Blue Pens
Lined Paper (Wide Rule)

- Some H.S. students may use laptops, or other computer devices, please arrange this with your child's teacher. *See Electronic Device Policy.
- Students will be provided with an assignment book that will be completed daily as a means of maintaining ongoing communication with parents. **Please check this each day.**
- **Please ensure that all personal items are labeled.** A locker will be made available for any items that will need to remain in school.

Please do not bring the following items to school:

- Scissors/Glue
- Any item that would be inconsistent with the Orthogenic School Dress Code (attached) or general philosophy.

A. Items to Leave at Home

It is imperative that the school environment be free of items that might undermine the therapeutic milieu and/or endanger the safety and well being of students and staff members. Staff members of the Sonia Shankman Orthogenic School would appreciate your cooperation in preventing your child from bringing any of the following items to the school. This list is not exhaustive, and at any time staff members can exercise clinical judgment and prohibit a student from possessing a particular object. If a parent has a question about the appropriateness of an object, please contact the designated Day School Case Manager prior to bringing the item to the school. When an item that is prohibited is found, it will be kept for safe-keeping by the Day School Case Manager or classroom personnel until a timely opportunity arises for the item to be safely and securely returned home.

List of Personal Items That Cannot Be in the Possession of Any Student.

1. No weapons, or weapon-like objects, regardless or their size or type.
2. No glass (including framed pictures with glass picture coverings—please substitute clear plastic or Plexiglas for glass), glazed pottery or sharp objects.
3. No prescribed, over-the-counter medications or illicit narcotics.
4. No tobacco products, matches, or lighter.
5. No parental advisory music.
6. No pornography or sexually explicit literature.
7. No clothing with explicitly provocative writings or graphics.
8. No materials or clothing with designs or messages suggestive of gang or drug-related themes.
9. Cell phones – must stay in front office during the school day. Please refer to Electronic Device Policy.
10. No pets
11. Laptop computers – See Electronic Device Policy

**All musical equipment and listening devices must be functional with headphones.

VI.

ORTHOGENIC SCHOOL GENERAL INFORMATION

Bus Information:
Please provide our office with the name and telephone number of the bus company that will be responsible for your child's transportation each day. In the event of an absence, or schedule change, it is the responsibility of the parents/legal guardians to notify the bus company. Our school day begins at 8:50am and Day School students usually arrive 20 minutes prior to the start of school. Our school day ends at 3:15pm daily, the only exceptions being after school activities/special programs that are by arrangement only.

Absence:
In the event of an unscheduled illness or absence, please send an email to **dayschooldailycommuncation@oschool.org** immediately. Additionally, please notify the bus company as well. Case managers attend a daily education staff meeting at 8:15am and then are occupied with student arrival between 8:30-9:15am. This email account will be checked by all Case Managers, which will ensure all important information about your child is being communicated to your child's treatment team in order to provide the support needed to assist the child in having a successful day.

Staff Contact Information:

Day School Case Managers:

Dane Davlantis, *LPC*
773-420-2876; ddavlantis@oschool.org

Samantha Prague, *MS, LPC*
773-420-2874; sprague@oschool.org

Raquel Rossi, *LCSW*
773-420-2875; rrossi@oschool.org

Ronda Skilton, *MS, LCPC*
773-420-2873; rskilton@oschool.org

Other helpful people to call if a day school case manager is not available:

Jerry Martin, Principal (IEP Question and School Concerns)
773-420-2898; jmartin@oschool.org

Michelle Zarrilli, Academic Coordinator (Academic Programming and School Concerns)
773-420-2887; mzarrilli@oschool.org

Caitlin Brisbois, Student Services Coordinator (Scheduling needs)
773-420-2889; cbrisbois@oschool.org

Coverage Phone, Crisis Intervention Leaders in the evening
773-203-9550

Main office
773-420-2900

VII. The Medical Program

General Health Care Services

1. The School Nurse

The school has a full-time nurse who monitors the general health of the students.

- The school nurse supervises medication delivery.
- The school nurse coordinates care with physicians and other healthcare providers.
- The nurse is available throughout the day to attend to students who report feeling ill, as well as to students that staff members describe as appearing to feel ill or otherwise in need of the nurse's attention.
- The school nurse maintains communication with families and staff members about the general health of the students.

2. The Medical Director

- Peter Smith, M.D., serves as the school's Medical Director. The Medical Director reviews all student medical needs, meets with students regularly and makes arrangements for medical care when immediate attention is required.
- The Medical Director discusses the students' healthcare needs with families and staff members.
- The Medical Director supervises the school nurse.

Emergency Medical Services

On Call

1. Medical

- The attending physician on call is Peter Smith, M.D., from The University of Chicago Hospital's Department of Pediatrics. Dr. Smith holds a medical clinic at the School every Wednesday.
- The physician on call has access to all of our students' records documenting medical treatment and healthcare plans.
- If there are any problems, the Director or Medical Director can be contacted immediately by the nurse.

2. Emergency Room

- The University of Chicago's Emergency Room is one mile from the school.
- Transport to the Emergency Room is available in vehicles owned by the school, by officers from the University of Chicago Campus Security Department or by ambulance service.
- The University of Chicago Hospital's Emergency Room is fully staffed 24 hours/day, 365 days/year.
- Emergency in-patient psychiatric services are recommended through Rush Medical Center, depending upon availability.

VIII.

Financial Responsibilities

The following expenses, not included in tuition, are the responsibility of the parent(s) and /or guardian:

1. Families from more immediate areas are encouraged to have their child's routine medical, dental/orthodontic and optical/ophthalmological care continue to be provided by practitioners in the home community, with whom the student already has a history of treatment. In these cases, parents should make prior arrangements with the classroom teacher to take the student for appointments and to return them to the school afterwards.
2. A $150 school activity fee will be incurred each semester for school field trips.
3. Individual lessons, such as private music or art lessons, that are not part of the child's Individual Educational Program, are billed to the parent(s).
4. A certain amount of damage to Orthogenic School property is expectable in the course of our work. When damages to school property were made in a deliberate and avoidable manner, the individual student is held accountable for all of the damage. In some instances, the responsibility might also need to be shared by the parent(s).

If you should have any other billing questions, please contact our Chief Financial Officer, Abby Simon at (773) 420-2883.

IX. Confidentiality

Confidentiality

The right to privacy and confidentiality of students and their families is carefully protected however the Orthogenic School will have limits with regard to confidentiality. The staff of the Orthogenic School may periodically consult with outside consultants. The staff will also periodically release reports of the student's progress and treatment to applicable funding, accrediting, and licensing agencies. The Orthogenic School will ensure that these entities are fully aware of the provisions of HIPAA (Health Insurance Portability and Accountability Act), and of their requirement to maintain confidentiality of this information.

X. Clothing Guidelines

General Principles or Plan

The Sonia Shankman Orthogenic School has developed dress guidelines as an integral part of the treatment program for the School. The purpose of the guidelines is to provide the framework within which students can learn a broad spectrum of social behaviors necessary for successful adaptation in the community. These guidelines represent an important part of the more school's more general expectations for its students, especially as it pertains to clothing, grooming and body adornments.

The School recognizes that attire, grooming and body adornments can represent expressions of personal values and interests, as well as creativity. While not wishing to stifle this free expression, there is also a recognition that one's individual appearance can reflect particular types of attitudes and values as well, which in turn influence the responses that he/she will receive from others. The school does not wish to have such reactions be negative or adversely impact the individual student's ability to achieve his or her goals, treatment or ability to be an integrated member of the larger community. Therefore, a dress guide is in place for students to use in planning and measuring their own behavior with regard to their personal appearance, while also serving as a set of boundaries that can serve as one source of learning to manage the frustrations of not being able present themselves in ways that they might find personally desirable.

It is the hope of the school that these guidelines will serve as an important part of the treatment process. It is fully expected that they will change over time as styles and tastes evolve. Members of the school's Student Council are responsible for maintaining the currency of these guidelines. From time-to-time, the Student Council, through its governing processes may suggest revisions to the Director for his review and approval.

General Guidelines

In general, it is the full expectation of the school community that students will maintain their personal hygiene and appearance in a manner that is reflective of self-respect towards themselves and others. Students must also dress in a manner that is appropriate for the particular environment and activity in which they are engaged, with special attention to safety, neatness and modesty. Similarly, a particular student's dress

appearance should not promote reactive distractions or feelings of disturbance to other students.

It is generally expected that students are individually and collectively responsible for maintaining adequate standards of dress. That is to say, the school anticipates that each student will develop the judgment necessary to groom and dress him/herself according to acceptable standards. In addition, members of the community should help each other in meeting the standards for appearance, and students develop feelings that they can rely upon their peers for help in meeting those standards.

Clothing should be tasteful, neat and appropriate. As a general rule, modesty should prevail for both males and females. Wearing clearly damaged clothing is not acceptable; there are stronger prohibitions against wearing any clothing with gang signs or advertisements for cigarettes, tobacco, drugs and drug paraphernalia, as well as representations of these products or materials.

More Specific Guidelines

1. Shirts and Blouses
    a. Shirts and blouses should not be excessively tight fitting, and necklines revealing cleavage are not acceptable.
    b. See-through materials are not acceptable.
    c. Shirts and blouses should cover the midriff at all times.
    d. Sleeveless shirts must have modest sleeve holes.
    e. “Baby-tees” are not allowed.
    f. Muscle-type tank tops must be worn with a shirt or blouse over or under them.
    g. Sleeve lengths must be short enough to not interfere with activities or pose a safety risk.
2. Shorts
    a. Shorts should be worn at the waist
    b. Shorts should not be shorter than mid-thigh.
    c. Shorts should be worn during periods of time when the weather is appropriate.

3. Skirts
    a. Skirts should be worn at the waist
    b. Skirts should be not more than approximately 2.5 inches above the knee; another measure could be that they should be as long as the point at which fingertips touches the legs when arms are held at one's sides.
4. Pants
    a. Pants should be worn at the waist
    b. Pants cannot be worn in an excessively baggy or low manner.
    c. Pants must be short enough so that they are not dragging on the ground, posing a potential safety risk.
5. Jewelry
    a. Modest amounts of jewelry are acceptable.
    b. Excessive (quantity or expense) jewelry is not encouraged.
    c. Jewelry that puts the student, other students or staff members at safety risk will not be permitted.
6. Tattoos
    a. Students are not permitted to add tattoos while in the School, even when they are on concealed body parts.
    b. Pre-existing tattoos should be covered when possible.
    c. Drawing on the body is strongly discouraged.
7. Personal Hygiene (Hair, Make-up, Nails, etc.)
    a. Hair should be neat, clean and well groomed.
    b. Hair length depends upon the student's ability to maintain the hair.
    c. Excessively short or excessively long hair is not encouraged.
    d. Hair should be preferably of natural color (black, brown, blonde, red).
    e. Excessive make-up discouraged; students under 14 years of age must have approval of the parent(s)/guardian(s) and dormitory Program Manager.
    f. Nails must be kept clean, well groomed, and at and cut to a length that minimizes the ability to cause harm to one's self or others.

8. Shoes
    a. Shoes must be worn at all times.
    b. Shoes must of appropriate size and be in good repair.
    c. All shoes should be appropriate for the situation.
    d. Dress shoes or black- soled athletic shoes are not permitted in the gymnasium at any time.
    e. Athletic shoes, with socks, must be worn for athletic activities.
    f. High heel or stacked heels/soles are generally discouraged, but can be worn with permission from staff members.
    g. Slippers can only be worn in the residential areas of the school.
9. Piercings
    a. Ear piercing is permitted only with permission of the student's parent(s)/guardian(s) and the student's dormitory Program Manager.
    a. Piercing of other body parts is not permitted.
    b. Pierces of other body parts or piercing(s) done without permission must be removed.
10. Hats and Kerchiefs
    a. Hats are not to be worn in the dining room or classrooms.
    b. Hats are not to be worn during meetings or other official activities of the school, without explicit permission of school staff members.
    h. Kerchiefs or headbands may be worn when deemed appropriate.

Decisions about Dress Guidelines

1. Final responsibility for decisions about clothing rest with the Director.
2. Responsibilities to make decisions about clothing and grooming are delegated to the Case Manager.
3. Students are advised to be familiar with the dress guidelines and to comply with them.
4. If a student is unsure about whether a particular item of clothing is appropriate, he/she is encouraged to seek advice from the Case Manager.

5. If, on a particular occasion, a staff member views a student's attire or grooming as inappropriate, the student should remedy the situation as quickly as possible.
    a. The student may appeal the staff member's opinion at a later time to the appropriate Case Manager.
    b. Arguments about or refusals to comply with requests to change clothing or to give additional attention to the noted grooming/hygiene needs will lead to a denial of the appeal.

XI. Individual Treatment Planning Process: Development, Review and Modification Policy and Procedure

The Orthogenic School believes strongly that the development of a student's treatment plan should be a collective effort which involves the student, family and team of clinicians. It is understood that, without the input and partnership of the family, the treatment plan will not accurately reflect the student's service needs, goals, strengths and future opportunities.

A student's treatment plan is developed within the first 30 days of his intake, but remains a living document which will be modified as service needs and abilities transform over time. The original treatment plan results from a collaborative planning process between all previously mentioned participants. Goals, objectives and related strategies (for all aspects of the milieu – classroom and therapy) are determined with input from all those involved so that they accurately reflect the individual student and the types of treatment strategies which will most effectively respond to the student's current needs.

The initial treatment plan will be modified at several points throughout the year so that it may continue to reflect the most updated needs and strengths of the student. At the student's quarterly meetings (which include the student, his family and the clinical team), the treatment plan will be reviewed and modified. Participation from the student and family is strongly encouraged at these meetings.

In addition, apart from the four annual meetings, if there are any extenuating circumstances in the child's life which necessitate a change in the treatment plan, a clinical meeting will be scheduled (involving the student and his family) in order to adapt the treatment planning process and make any urgent modifications. Parents and guardians are encouraged to discuss their opinions, thoughts and concerns in regards to the child's treatment plan with the school's clinicians throughout the year.

XII. The Behavior Management Plan

UPDATED OCTOBER 2014

Purpose:

The Sonia Shankman Orthogenic School's therapeutic goal is to assist the emotionally disturbed children and adolescents in their care to function emotionally, socially, and behaviorally at their highest capacities. The school's Behavior Management Plan serves to ensure the safety and well-being of each student, staff members, and the community as a whole. Given that the school's population is comprised of students who suffer from severe emotional disorders, the milieu is designed to be highly structured and supportive of the students. Nevertheless, there are times that arise when a student's behaviors require the utilization of specialized behavioral intervention techniques. Only approved behavioral interventions are implemented, and only the least restrictive measures necessary to ensure safety and well-being will be employed.

Description of the Behavior Management Plan:

Treatment Procedures Employed

The school recognizes that students' emotional and behavioral crises may be related to either situational or longer-term precipitants. At times, behaviors may become overtly aggressive and/or potentially explosive, including the use of threatening verbal or behavioral expressions, or the display of verbal or physical threats. These behaviors may include being invasive of another student's or staff member's personal space in an intimidating manner, putting hands on another person after having been clearly warned against doing so, running at another person in an aggressive manner, and resorting to aggressively threatening body postures. The specialized behavioral interventions approved and employed by the Sonia Shankman Orthogenic School include: crisis prevention, non-physical verbal and non-verbal de-escalation behavioral interventions, and/or behavior management techniques.

On an on-going basis, the staff members positively guide students' behaviors through monitoring, supervision, verbal redirection, and the application of natural consequences

for inappropriate, maladaptive, disrespectful, and disruptive behaviors. For example, if a student is unable to follow staff members' directions within the structured milieu of the building, the student may not be permitted to go on a planned off-grounds activity. Natural and logical behavioral consequences help to develop internal capacities for decision making and behavioral control. Similarly, the therapeutic environment at the school is designed to frequently and consistently incentivize and reinforce desirable behavior with natural and logical rewards, most importantly those rewards that are relationally based. The employment of natural consequences and rewards are at the discretion of the assigned staff members and is reviewed on an on-going basis with Senior Staff members (QMHP, LPHA).

A frequent natural consequence for students' disruptive and/or disrespectful behaviors is their separation from the immediate location within the milieu in which they are acting inappropriately. Such separations are time-limited and do not involve the student being out of the direct visual monitoring by a staff member. These separations are considered to be "Time-Outs." The duration of the time out will not exceed 10 minutes following the child regaining self-control, unless expressed authorization is given by the Senior Staff member responsible during the period of the shift. Non-exclusionary time-outs, requiring the student to remain in the same room but away from others, are employed first.

Exclusionary time-outs require the student to leave the area to a new area that is unlocked and with an unrestricted exit. It must be clearly emphasized that the school does not have or use either a locked or unlocked "seclusion room." The direct care staff member is responsible for maintaining visual contact with the student for the duration of the time-out. If a student has required more than 3 exclusionary time-outs within a 24-hour period, a member of the Senior Staff must be notified, and the student's clinical is status reviewed.

Clinical discussions should also be employed to influence students' behaviors and to aid in de-escalating an emotional or behavioral crisis. Talking with the student, ranging from being empathic to being more directive, can prevent the escalation to openly physical displays of aggression. In those instances in which discussions with the student and/or natural consequences are not sufficient to maintain and/or restore the safety and well-being of students, staff members, and the milieu as a whole, approved and practiced

behavior management techniques can and should be employed. The behavior management techniques approved and employed by staff members is limited to specific manual restraints, as clearly described by the Therapeutic Crisis Intervention (TCI) non-violent crisis intervention program. Physical restraints must be employed as a last resort and only when there is imminent risk of harm to self or other.

When staff members are not successful in being able to verbally defuse the situation and they have determined that it is necessary to employ a TCI behavior management technique, the direct care staff member responsible for the distressed and/or disruptive student will immediately notify the Crisis Intervention Leader staff member of the situation and request assistance. The staff member should begin making preparations to ensure the safety of other students if a physical escalation should occur. These preparations include making sure that the other children are safe and away from the immediate proximity of the crisis, communicating to staff persons that a problem may be imminent, and making a visual safety check of the physical arrangements of the classroom or dormitory.

There are two Crisis Intervention Leaders assigned to the classrooms during the school day, with support from other available Senior Staff members. During the afternoon and evening dormitory times, one or two Crisis Intervention Leaders are present in the building, also with support from other available Senior Staff members. All of the Crisis Intervention Leader personnel have been trained and periodically re-certified in TCI techniques. In addition, all direct care staff are trained and periodically updated in TCI techniques by a certified TCI trainer, who is employed full-time at the school.

If at all possible, the Crisis Intervention Leader should be called before the student becomes physically aggressive. All direct care staff are trained in identifying crisis cycles and are encouraged to call for a Crisis Intervention Leader’s assistance before a crisis reaches serious proportions. The earlier that crisis prevention techniques are employed, the better the chance for preventing physical escalation and assaultive acts.

The approved behavior management techniques employed by the school are clearly defined in the non-violent physical crisis intervention program (TCI). Non-violent

physical crisis intervention consists of the use of predetermined and coordinated physical contact and/or constraint to prevent students from harming themselves or others. Only those staff members who are fully trained and certified in TCI are authorized to employ these techniques. Following the use of any TCI manual restraints, staff members are required to complete a required Unusual Incident Report form and to submit it for review.

The school absolutely prohibits the employment of seclusion, the use of chemical restraint, and the application of any method of mechanical restraint under any circumstances at the school. Those students appearing to require these categories of intervention will be evaluated for hospitalization by the treating psychiatrist and a member of the school's Executive Leadership Team, or their designee at that time.

Administrative Monitoring of Implementation:

Following each unusual incident and/or the employment of a restrictive intervention, the staff responsible for the student at that time will complete an Unusual Incident Report and, if necessary, a Physical Management Report (for manual restraint), within the school's electronic medical record (EMR) for each student. This will be completed by the end of the particular shift during which the event occurred. This Unusual Incident Report will be reviewed by the Quality Assurance Manager. Dorm Managers (QMHP, LPHA), and members of the Executive Leadership staff (LPHA) review the UIRs as well. A copy of the Unusual Incident Report will also be faxed/mailed/emailed to the parent(s)/guardian(s) .The original report will be filed in the student's clinical file.

Data from the Unusual Incident Reports will be collected daily and aggregated on a monthly basis. Factors will include the type of incident by child, dormitory, classroom and type of response. These reports will assist in identifying trends in the program, so that interventions and responses to these critical events can be informed, decisive, and timely.

Managing and Reporting Behavioral Emergencies:

For all unusual behavioral events, the direct care staff member is responsible for completing the Unusual Incident Report form (and, in the case of manual restraint, a Physical Management Form). It is important to note that staff members of the Orthogenic

School are trained and practiced in when and how to complete a UIR form. As part of this training, staff members are encourage to write a UIR if uncertain as to whether or not such a report is needed. It is our belief that it would be better over report rather than under report such events. In addition to completing the UIR/PMR, the direct care staff member or the Crisis Intervention Leaders will notify the Senior Staff person that a behavioral emergency has occurred, how the immediate crisis was resolved, and carry out any further intervention as instructed at that time. During regular business hours, the Dorm Manager of the student's dormitory or the Principal should be notified; during off-business hours the on-call Senior Staff members will be called as necessary. For those instances in which students display a serious threat to their own safety or to that of others, the student's psychiatrist or psychiatric fellow must be notified and a psychiatric screening completed. Once the student has been screened, the Associate Director of Residential Services, Principal, and/or Co-Directors of the school will be informed of the student's status. Once the incident has been safely resolved, the student's parent(s)/guardian(s) and funders will be notified of the event.

Implementation with Disabled Students:

The Orthogenic School is fully ADA compliant and, as such, might work with students that have physical motor or sensory limitations. These limitations must be considered when developing the best individualized Behavior Management Plan for those particular students. Input from the school's Medical Director and Director of Psychiatric Services will be included as well. At admission to the Orthogenic School, an Individualized Crisis Management Plan (ICMP) and Individualized Treatment Plan (ITP) is completed for each student. With regard to the implementation of the agency's Behavior Management Plan, for those students with an identified disability, the ICMP will state what components of the Behavior Management Plan may or may not be applied to this particular child, and will note any modification and how it is to be implemented. For students with disabilities, at no time will the Orthogenic School employ any aspect of the Behavior Management Plan that would either take advantage of, or further impair, a disabled student's functioning and level of safety.

Personnel:

Required Credentials:

Orthogenic School staff members are highly trained and experienced in child mental health. The Senior Staff members, who are responsible for designing, approving, monitoring, and overseeing the implementation of the behavior management procedures, have Master's or Doctoral degrees and are licensed, or licensed eligible, in their particular professions. Those members of the Senior Staff who have not completed graduate work must have at least 5 years of experience in the mental health field. All members of the Senior Staff are equivalent to QMHP or LPHA.

Training:

All new direct care staff members must complete a minimum of 2 weeks of observation and training, with experienced staff members prior to being made responsible for the safety and well-being of any particular student or groups of students. This requirement enables new staff members to become familiar with the structured format of the milieu and to learn crisis prevention and verbal intervention techniques to resolve conflicts. All staff members are required to complete the extensive standardized TCI training and certification course upon being hired and prior to any participation in manual restraints. Attendance at refresher courses and training updates are required of all staff members during each year. Documentation of initial training and certification, and participation in required supplemental training will be maintained in each staff member's personnel file.

The school's nurse will receive training on a yearly basis regarding the potential consequences, complications, and/or physical side effects associated with being physically restrained while taking any medications. The nurse assumes responsibility for communicating this information to the school's staff members.

Code of Ethics:

Upon hiring, Staff members are presented with a copy of the DCFS Code of Ethics for Child Welfare Employees. With their signature, each new employee acknowledges receipt, understanding of, and obligation to adhere to the principles set forth in the document regarding their obligations to conduct themselves respectfully and

professionally when interacting and having contact with students. The signed acknowledgements will be kept in each staff member's personnel file.

Disciplinary Policy for Violations of the Behavior Management Plan:

Staff members are expected to follow the policies and procedures of the Sonia Shankman Orthogenic School at all times, which includes the school's Behavior Management Plan. When staff members violate the school's policies and procedures, appropriate and timely corrective action shall occur. For those instances involving minor infractions of the Behavior Management Plan, progressive action will occur with verbal and then written notice of deficiency, followed by disciplinary action.

As a component of each of these corrective actions, a plan of corrections will be established between the identified staff member and his/her direct supervisor, and the completion of this plan will be monitored by the school's Associate Director of Residential Services, Principal, and/or Co-Directors. For new staff members who are on the standard 3 or 6 month probation, if there are any corrective actions taken regarding the staff's implementation of the Behavior Management Plan, their probation will be automatically extended for an additional 3 months.

For more serious infractions of the school's Behavior Management Plan, such as intentionally and/or purposefully using a manual restraint other than those approved by TCI, or intentionally and/or purposefully inflicting pain or causing harm to a student, will result serious disciplinary action ranging from suspension without pay to immediate termination of employment. Likewise, staff members who are found be to be verbally abusive towards students will similarly face severe disciplinary action. Lastly, as Mandated Reports, the school staff will complete a DCFS Hotline call if a student injury caused by a staff member (whether specifically intentional or not) crosses the threshold described in the law.

Quality Assurance Program:

Medical Clearance:

Upon admission, students are medically screened within 24 hours of their admission to the school. Based upon pre-admission documentation and the medical examination, the consulting physician will determine if there are any specific medical factors relating to that particular child in the implementation of the school's Behavior Management Plan. If any contraindications are noted regarding any aspect of the Behavior Management Plan, the consulting physician will indicate so in writing on the medical screening form, and also communicate this information to the Medical Director. Appropriate modifications will be made and indicated on the student's Individual Crisis Management Plan (ICMP). At any time during a student's treatment, if there is a change in the student's medical condition, the initial medical screening will be re-evaluated; if any adjustment needs to be made in the ICMP, the medical personnel, such as the nurse or physician, will indicate this to the Associate Director of Residential Services and Principal, who will, in turn, ensure that all pertinent staff members are notified of the change.

Clinical Clearance:

Upon admission, students are psychologically screened, based upon pre-admission documentation, psychosocial interviews conducted with parent(s) and/or guardian(s), and interviews with the student. During the initial clinical staffing, it will be determined if there are any psychological or developmental reasons that the school's Behavior Management Plan, in its entirety or a component of it, is contraindicated. If such contraindications are noted, appropriate modifications will be indicated in the written record, and staff members will be notified of the modifications. For example, for a student who comes with a history that includes sexual abuse, it may be clinically indicated that the child should only be held using a team approach to minimize bodily contact and to have two adults present to observe the restraint. Throughout the year, the student's developmental and psychological status will be reviewed; if any significant changes are noted appropriate adjustments will be made to his/her ICMP regarding the implementation of the school's Behavior Management Plan.

On-Going Review:

On a quarterly basis, each student's ICMP and progress towards completion of his/her ITP goals are reviewed. At this time, the appropriateness of the Behavior Management Plan is assessed for each student. Therefore, all students' ITPs, and their involvement with behavioral intervention techniques (in particular manual restraints) will be reviewed regularly.

Informed Consent:

Prior to admission, each student and the student's parent(s) and/or guardian(s) will be presented with a copy of the Behavior Management Plan. With their signatures acknowledging consent for treatment, students, parent(s) and/or guardian(s) are stating they have received and reviewed the Behavior Management Plan and its conditions. In addition, students, parent(s), and/or guardian(s) are asked to sign off to acknowledge initial receipt of the Behavior Management Plan annually (within the annual Re-Consent for Treatment), and students, parent(s), and/or guardian(s) receive an updated hard copy of the Behavior Management Plan whenever the plan is updated/changed in any way. The parent(s) and/or guardian(s) have the right to be notified of each instance in which their child, or the student for whom they are responsible, has been involved in a manual restraint.

Behavior Plan Definitions:

The "Agency Behavior Management Plan" is a child care facility document that outlines to the Illinois Department of Children and Family Services all behavior management procedures that may be employed at the facility. The plan shall include:

* A Behavioral Management Purpose Statement: This statement shall stipulate the agency's rationale for using behavioral management techniques and the appropriateness and rationale for use with the populations served, as well as its intended forms (i.e. crisis prevention, behavior interventions, and/or behavior management).

* Definitions Section: this section shall identify the facility-specific definitions for all forms of behavior management and related procedures/protocols used by the facility.

* Behavior Management Components: This section shall identify one of the five models of crisis intervention and behavior management currently allowable under this section and provide an outline of each specific method of crisis prevention, behavior intervention, and behavior management to be employed at the agency. A designee of the Director must independently review and recommend any model of crisis intervention and behavior management not outlined in this section of approval by the Director before it can be employed at any facility. This section shall also include an agency's specific response to situations in which a behavior management intervention intentionally or unintentionally results in either the child and/or the staff being prone on any surface. For each identified treatment procedure, the outline shall include: the ultimate purpose, clinical criteria/determination process, general operational details, general overview of the quality assurance and improvement mechanisms, emergency procedures, employment and training criteria, and family/guardian and child's attorney notification procedures.

* Appendices: Appendices may be included, as necessary, to describe the behavior management techniques used by the facility

* "Approved crisis intervention and prevention procedures and models" are those procedures and models approved by the Illinois Department of Children and Family Services and the governing board of the child care facility. (The approved models under this Part are listed in Appendix A.) The procedures are taught as part of mandatory training expressly for use in responding to emergency situations when a child presents dangerous behavior that could not have been anticipated, or the procedures specified in the child's current individual Treatment Plan would not successfully control the imminently dangerous behavior.

* "Behavior intervention techniques" refer to the systematic application of the methods designed to influence the behavior of one or more individuals through behavioral techniques (e.g., token economies and point systems) that have been approved in compliance with the requirements set forth in Section 384.30.

* "Behavior management techniques" are techniques that prevent or limit an individual's ability to initiate or continue presenting some specific dangerous behaviors. Behavior

management techniques include manual restraint, seclusion, and other restrictive procedures approved in compliance with the requirements of Section 384.30. Examples of this type of procedure include, but are not limited to, the re-direction of a child and/or manual restraint.

* "Behavior Management Committee" means a professional review or behavior management review committee formed by one or more childcare facilities and composed of persons with technical expertise in the use of crisis prevention and behavior management techniques. At least one member of the committee must be a person who is not an owner employee, principle shareholder owning at 5% of the stock of the corporation or member of the governing body of any of the participating child care facilities. This committee fulfills a quality assurance function and reviews for technical acceptability the use of a facility's Behavior Management Plan. This would include a retrospective examination of at least 13% of all interventions, or 25% of all grievances submitted concerning the use of restrictive intervention to determine whether this level is warranted and the standard of best clinical practice. The committee may function as the Behavior Management Committee when the committee membership meets the requirements of this definition.

* "Chemical restraint", a prohibited practice by this Part, means the use of any psychoactive medication that is not a part of a medical diagnostic or treatment procedure for the express purpose of restricting an individual's freedom of movement that is used during a behavioral crisis or behavioral emergency and results in the sedation of the child.

* "Child for whom the Department is legally responsible" means a child for whom the Department has temporary protective custody, custody or guardianship via court order or a child whose parents have signed an adoptive surrender or voluntary placement agreement with the Department.

* "Child care facility" or "facility", as used in this Part, means a child care institution, group home, youth emergency shelter (as restricted by 89 lll. Adm. Code 410, Licensing Standard for Youth Emergency Shelters), secure childcare facilities or any other facility approved by the Department to use manual restraint or seclusion.

* "Child care supervisor" means a person who supervises those persons whose primary responsibility is daily care of children, known as childcare staff, and who are qualified in accordance with 89 lll. Adm. Code 404.13.

* "Child welfare supervisor" means a person with a Masters of Social Work degree in a human services field and two years of full time supervised experience in a social work setting. At least one child welfare supervisor in a facility shall have at least two years of experience as a supervisor.

* "Dangerous behavior" means behavior that is likely to result or has resulted in harm to self or others, if not immediately contained.

* "Department" means the Illinois Department of Children and Family Services. (Section 2.02 of the Child Care Act of 1969 [225 ILCS 10/2.02])

* "Developmental disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy or autism: or any other condition that results in impairment similar to that caused by mental retardation and that requires services similar to those required by mentally retarded persons. Such disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap.

* "Director" means the Director of the Department of Children and Family Services.

* "Discipline" means providing specific consequences for infractions of the rules of a childcare facility as a means of helping children both to develop self-control and to learn they are responsible for their actions. For purposes of this Part, discipline is a behavior intervention technique.

* "Extended restriction" means periods of touching or holding by direct person-to-person contact for a period of less than five minutes. Physical restriction shall not constitute manual restraint if it is accomplished with minimum force and is used to prevent a child from completing an act that is likely to result in harm to self or others or to escort a child to a quieter environment. Extended restriction must be documented in the child's record, i.e., progress notes.

* "Human Rights Committee" means a group of three or more persons that includes an attorney, or access to any attorney, who understands mental health law. At least one member of the Human Rights Committee shall not be an owner, employee, principle shareholder owning at least 5% of the stock of the corporation, or member of the governing body of any of the participating child care facilities. Human Rights Committees may be formed by one or more child care facilities. Human Rights Committees are charged with assuring that children's rights are protected. The Committee is responsible for reviewing procedures and practices for intrusive or restrictive behavior interventions that are expressed in the child care facility's Behavior Management Plan. The committee assures that the facility's procedures guarantee, among other things, that processes and practices address informed consent, due process and grievances, least restrictive practices, and appropriateness of fit to the population served and that they broadly reflect community standards for conduct. The Committee also recommends acceptance of the facility's practices to the Chief Executive Officer for referral to the governing body for approval. The Human Rights Committee must meet at least annually.

* "Individual Treatment Plan" means the current intervention and treatment program for a specific child that has been prepared by any interdisciplinary team that may include, but is not limited to, the child, D.C.F.S. caseworker, private agency/institution caseworker, therapist or psychiatrist, foster parents and parents, as clinically and legally appropriate.

* "Manual restraint" means a behavior management technique involving the use of physical contact or force, characterized by measures such as arm or body holds, subject to the provisions of Section 384.50.

* "Mechanical restraint", as used in this Part, means any device (including but not limited to straight jacket, arm/leg restraints, and four-point restraints), other than personal physical force, used to directly restrict the limbs, head or body of a person. The term does not include medical restraint. Mechanical restraint my not be used in facilities licensed by the Department of Children and Family Services, except as allowable under 89 lll. Adm. Code 411 (Licensing Standards for Secure Child Care Facilities).

* "Medical restraint" means a process used for the partial or total immobilization of a person for the purpose of performing or maintaining a medical/surgical procedure under the supervision of a licensed physician or registered nurse or as a physician-ordered treatment for self-injurious behavior.

* "Mental health professional (QMHP)" means one of the following as defined in 59 lll. Adm. Code 132.25 (Medicaid Community Mental Health Services Program): licensed physician, psychiatrist, psychologist, social worker possessing a master's or doctoral degree in social work, registered nurse with at least one year of clinical experience in mental health setting or who possesses a master's degree in psychiatric nursing, an occupational therapist with at least one year of clinical experience in a mental health setting, an individual with a master's degree and at least one year of clinical experience in mental health services and who is licensed to practice marriage and family therapy, or any individual possessing a mater's or doctoral degree in counseling and guidance, rehabilitation counseling, social work

vocational successfully completed a practicum and/or internship which includes a minimum of 1,000 hours, or who has one year of clinical experience in mental health services or who is a permanently licensed professional counselor under Professional Counselor and Clinical professional Counselor Licensing Act [225 ILCS 107] holding a master's degree with one year of experience in mental health services.

* "SASS" means Screening, Assessment and Support Services, and the services are provided by agencies under contract with the Department of Children and Family Services or the Illinois Department of Human Services.

* "Seclusion" means the contingent withdrawal of reinforcing stimuli by removing the child from any area to a specifically designated room from which egress is restricted. This procedure is considered a behavior management technique and as such must be used only as a therapeutic response to dangerous behavior. There are two forms of seclusion:

** Staff assisted seclusion means the room is secured by a locking mechanism that engages only when a staff member is holding a key, button, or handle. When that staff member takes his or her hand off the device, the door unlocks and the child is able to

easily and readily open the door from the inside. The door to such a room may not/does not remain locked when unattended.

** Key-locked seclusion means the seclusion room has a locking device that remains engaged without staff presence. Key-locked seclusion is prohibited under this Part.

* "Self-governance program" means an organized program that allows peers to participate in the discipline or behavior management of peers under the supervision and control of staff. Effective April 1, 2006, peers shall be prohibited from participating in the manual restraint of another child. “Self-governance program” shall be restricted to programs identified and recognized by the Illinois Association of Peer Treatment Agencies and Department of Children and Family Services as using a positive peer group treatment model.

* "Time-out", means a specific behavior intervention technique of short duration used to assist a child in regaining self-control that may be authorized by any facility staff person for a maximum of ten minutes beyond the time when the child regains self-control, if included in the agency's Behavior Management Plan submitted to the governing body and Department and approved in accordance with the requirements of this Part. Staff members are required to document in writing each incident of time-out that exceeds 10 minutes. Any series of three or more Exclusionary Timeouts during a facility's standard work shift must be reviewed by the Child Care Supervisor within 24 hours. There are two types of time-out permitted by this Part:

** Non-exclusionary or Instructional Time-out: A procedure involving the contingent withdrawal of reinforcing stimuli, while the child remains in the area (e.g., child is seated away from the group, but in the same area).

** Exclusionary Time-out: A procedure involving the contingent withdrawal of reinforcing stimuli by removing the child from the area (e.g., to the hallway or bedroom that does not involve a locked or restricted exit). A seclusion room may be used as a time-out room only if egress from the room remains unrestricted through closure or by staff and a child is appropriately supervised.

Agency Behavior Management Plans in Child Care Facilities:

As a licensed child care institution and an approved special education program, the Orthogenic School has an agency Behavior Management Plan that describes the facility's programming. Each child for whom the Orthogenic School is responsible shall have an ICMP (Individual Crisis Management Plan) that identifies those specific components of the overall Behavior Management Plan that will be applied to that child and the specific behaviors the individual Treatment is designed to address.

Behavior Management Chart:

Intervention	Purpose	Contra-Indications	Qualifications	Time Limitation	Monitoring	Documentation
Verbal Redirection	Verbal prompts or directives provided by an adult for the purpose of curtailing, limiting, or stopping a child from acting in a way that breaks school rules and/or violates normal standards of social interaction. This intervention is a meant to help children learn self-control and that they are responsible for their actions.	None	All Direct Care Staff Members	None	All Direct Care Staff Members	Daily Notes
Application of Natural Consequences	The restriction or removal of a child's privileges, such as participation in activities, or leaving the school grounds, as a result of a child's behavior being out of control and/or dangerous. This intervention is meant to help children learn self-control and that they are responsible for their actions and that their actions have consequences.	None	All Direct Care Staff Members	None	All Direct Care Staff Members	Daily Notes
Non Exclusionary "Time-Out"	A procedure involving the contingent withdrawal of reinforcing stimuli, while the child remains in the area (e.g., child is seated away from the group, but in the same area.)	None	All Direct Care Staff Members	None Rule of Thumb… Not to Exceed 2 min per year of age	All Direct Care Staff Members	Daily Notes

Exclusionary "Time-Out"	A procedure involving the contingent withdrawal of reinforcing stimuli by separating the child from the area (e.g., to the hallway or bedroom that does not involve a locked or restricted exit.). The child placed away from the area must be visible by at least one adult at all times.	When a student requires immediate super-vision and close proximity to minimize safety risks	All Direct Care Staff that are TCI Trained	Not to Exceed 1 min per year of age	All Direct Care Staff Members Coverage Notified	Daily Notes UIR, if needed
Extended Restriction	Physical intervention by an adult involving direct person-to-person contact for a period of less than five minutes, employing minimal force, and only to be used to prevent a child from completing an act that otherwise would result in harm to self or others, or for the purpose of escorting the child to a quieter setting to prevent the completion of such an act.	When not approved in student ICMP or if utilization of technique would result in injury	All Direct Care Staff that are TCI Trained	Based on TCI Procedure	All Direct Care Staff Members Coverage Notified, Present if Possible Senior Staff Notified Nurse/M.D Notified, if necessary	Daily Notes UIR and Physical Management Report
Manual Restraint	The use of controlled and practiced physical contact or force, characterized by measures such as arm or body holds, for the purpose of preventing a child from endangering themselves or others. ****MAXIMUM TIME FOR STUDENTS UNDER 9 = 15 MIN.*	When not approved in student ICMP or if utilization of technique would result in injury	All Direct Care Staff that are TCI Trained	After 30 minutes – medical profess-ional approval required. After 60 minutes, M.D. approval required	All Direct Care Staff Members Coverage Notified, Present if Possible Senior Staff Notified Nurse/M.D Notified, if necessary	Daily Notes UIR and Physical Management Report
Chemical Restraint	The Sonia Shankman Orthogenic School does not employ this technique.	N/A	N/A	N/A	N/A	N/A
Mechanical Restraint	The Sonia Shankman Orthogenic School does not employ this technique.	N/A	N/A	N/A	N/A	N/A
Seclusion	The Sonia Shankman Orthogenic School does not employ this technique.	N/A	N/A	N/A	N/A	N/A