

The Sonia Shankman Orthogenic School

Family Handbook

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I.

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, there have been four 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 already 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.

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.

Psychiatry and Medical Services

In addition to the modifications in the school's overall milieu structure, over the years there have been striking advances in the field of psychopharmacological management and treatment of emotional disturbances. Accordingly, the school provides detailed psychiatric assessment and treatment for the residential students who can benefit from this type of medical intervention. These services are provided by a team of psychiatric fellows associated with Rush University Medical School, under the direction and supervision of Louis Kraus, M.D., Director of Psychiatry.

The cost of psychiatric service is not included in either the tuition or room and board rates that the O-School receives from the state and local school districts. In order for the O-School to provide quality milieu treatment for our students, we utilize a "consultative psychiatric model". Dr. Kraus is contracted to work at the O-School ten hours per week. Typically, he spends five hours per week on site (Mondays 7am-12pm) meeting with students individually, as well as observing them in the milieu (that is, classroom and/or dining room), updating medical charts, supervising two resident psychiatrists, and consulting with school staff. In addition, Dr. Kraus spends five hours per week off-site writing psychiatric reports, speaking with parents, making contact with school districts, and taking phone calls from the O-School staff 24/7 for crisis situations. A fee schedule for psychiatric services is included in the admission paperwork at the end of this binder. A psychiatric bill for services will be generated every other month by the billing department of the O-School and sent to each student's home. It is the responsibility of the parent to pay the bill and then submit it to insurance for reimbursement. The O-School will not be billing third-party insurers for our services.

Dr. Kraus is the Chief of Child & Adolescent Psychiatry Services at Rush University Hospital. If your child needs admission to Rush, Dr. Kraus can help to facilitate the process. However, once admitted, it is likely that your child may be seen by a different attending inpatient psychiatrist. As a result, if your child is hospitalized, your communication would be with the attending psychiatrist.

At times when Dr. Kraus is not immediately available, coverage will be provided by Dr. Duboskus, the Medical Director of Inpatient Services at Rush. In addition, a second-year Fellow or an appropriate designee will be assigned to be on call in Dr. Kraus' absence.

In the event that a family is not satisfied with the psychiatric services that are offered by Dr. Kraus, parents are encouraged to seek outside consultation with a psychiatrist if they feel it is indicated. In complex situations, outside consultation can be very helpful to the overall treatment plan and it is welcomed by Dr. Kraus and the staff of the school. Dr. Kraus wants parents to feel free to call him at any time, and he provides his cell phone number, (847) 217-7755. If he is unable to answer when you call, he has given assurance that he will call back as soon as possible. He has indicated that parents should call a second time if he has not responded within 24 hours. In addition, Dr. Kraus is making himself available for scheduling appointments to meet with parents at Rush Hospital. His secretary, Lorraine Mason, can be reached at (312) 942-7315 to schedule appointments. Day school students continue medication management with their own community consulting psychiatrist.

In the event that a parent is unable to reach Dr. Kraus after following the above steps, or in an emergency that cannot wait 24 hours, please call Dr. Pete Myers.

The school's Medical Director is Peter Smith, M.D., from the Department of Pediatrics at The University of Chicago. Dr. Smith is hired in a similar "consultative medical model" to address the students' medical concerns. Dr. Smith, a specialist in both Neurodevelopmental Disabilities and Developmental & Behavioral Pediatrics, has been contracted to work as the Medical Director of the Orthogenic School since June of 2005. He visits the students on-site weekly (currently, this occurs on Tuesday afternoons) and provides 24/7 phone-call coverage. In addition, one fellow (who, like Dr. Smith, has already completed a full residency in General Pediatrics) also visits the school for a full day (currently, this occurs on Tuesdays). Also, Dr. Smith's attending colleagues (in the Section of Developmental and Behavioral Pediatrics) provide coverage for those periods when he is unavailable. Together, Dr. Smith and his team help to ensure that all the students have both their acute illnesses/injuries and their long-term health needs fully addressed.

Dr. Smith will order regular blood draws to monitor medication levels, X-rays, and other routine hospital procedures through the University of Chicago Hospitals in Chicago, IL. **It is the parents' responsibility (before admission to the O-School) to confirm with their health insurance policy that these indicated services will be covered under the health insurance plan. In the event that the insurance company will not cover services at The University of Chicago Hospitals, it is the parents' responsibility to inform the O-School as to which hospitals will accept their provider's policy.**

In the event that a family is not satisfied with the medical services that are provided by Dr. Smith, parents are encouraged to seek a second opinion with a pediatrician of their choice if they feel

this is necessary. Dr. Smith and the staff of the school are open to other professional medical opinions in difficult cases.

Therapeutic Classroom and Dormitory Services

In addition to the attention paid to the school's overall milieu and to the provision of psychopharmacological services for students in residential care, 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.

The residential students' dormitory living experiences are enriched by groups of counselors assigned to work full-time in each student's dormitory; these counselors receive ongoing clinical supervision with respect to their work with students at the school. In addition, during both school and dormitory 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 areas of creative arts, literature, music, drama, horticulture, student-run business opportunities and self-government.

Individual Psychotherapy Services

In addition to the provision of milieu therapy, psychopharmacological treatment, special education services, dormitory counseling, and specialized therapeutic group activities, the school also provides formal individual psychotherapy to all residential and day school students. The individual psychotherapy services are provided either by licensed clinical professionals (psychiatric fellows, psychologists, social workers) 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, 90-minute therapy groups for all of our students. These therapy groups include longer-term process groups for those students capable of achieving 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

It is our expectation that all families engage in ongoing family therapy services that are provided at the school by master's level clinicians. The Dormitory Manager or Day School Case Manager will schedule the first family therapy session on the day of admission.

The Parent's Association

Dear Parents and Guardians,

You are invited to become a member of the Parent's Association. The Parent's Association meets at the school, and the early evening meetings are generally scheduled on a Sunday evening following a visit weekend. We try to hold a meeting approximately once a month from September to June, but there are no meetings during the summer period.

We welcome the parents of the day school students, as well as those of the residential students. A main objective of the association is to offer an opportunity for parents to meet each other and talk to one another. Many parents share similar experiences and so they can understand what you are going through. We found it a huge relief not to have to explain ourselves or our child's behaviors when meeting new people.

Another objective is to maintain the communication link between the school staff and the parents. The school will inform the Parent Association about any upcoming events, training courses or important information and the Parent Association in turn sends out this information to all parents.

The Parent Association has sponsored many events for our children and families at the school over the years. It has enabled the school to enhance the garden project, organize DJ's for parties, fulfilled wish lists for staff or dormitories and assisted in many other ways.

Please look for further information about "The Sonia Shankman Orthogenic School Parent Association". We hope to meet you and please do not hesitate to contact us if you have any questions.

Best regards,

The Orthogenic School Parent Association
Alison and Per Andersson – Co-Presidents
(andersson16@comcast.net)

III.

Description of the Orthogenic School Academic Program

Administrative Contacts:

Jerry Martin, M.A., Principal
Telephone: (773) 834-1191
Email: Jmartin1@midway.uchicago.edu

Michelle Zarrilli, Academic Coordinator
Telephone: (773) 834-3646
Email: michellz@uchicago.edu

Caitlin Brisbois, School Secretary
Telephone: (773) 834-3519
Fax: (773) 834-3561
Email: cbrisbois@bsd.uchicago.edu

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 is one self-contained junior high school level classroom, with opportunities for participation in some departmentalized coursework made available for those students when appropriate.
- Foreign language courses are available (Spanish and French) 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 instructor).
- An impressive and extensive fine arts program that offers art courses and activities to all students in a wide range of art media, including after-school activities for students.
- A formalized set of curricula.
- A standardized academic reporting schedule involving transcripts, report cards and mid-term updates.
- Annual standardized testing.
- 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.
- Open House events for residential treatment staff members.
- Recognition as an official ACT and PSAE testing site.
- Special school-wide family events, such as:
    1. Dramatic Performances
    2. Prom/Spring Celebration
- A day school program that is presently configured to accept a limited number of day students and which includes a family therapy.
- A ten-week intensive summer program of community-based activities (Summer Fun)
- North Central Association Accreditation with a *Comprehensive* status designation, which authorizes The Orthogenic School to autonomously grant course credits and issue its own officially recognized graduation diplomas.

IV.
The Admissions Process

Pre-Admissions

Initial contacts regarding admission to the school are directed to the Admissions Coordinator. Contact may be initiated by telephone (773) 702-1203. 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 the admissions coordinator, including: copies of the latest psychological assessment (including results of I.Q. 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 I.E.P., and (if a high school age student) an educational transcript showing all credits earned.

The members of the admissions 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 coordinator 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 student will meet and talk with at least three senior staff members, and the admissions coordinator will discuss with the parent(s) 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's residential and academic facilities, discussing any additional questions that might arise during that tour.

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

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.

The Admissions Process

Residential Students

Admissions of new residential students usually are scheduled for Thursday afternoons, beginning at 1:30 p.m. Families can anticipate that the admissions process may take up to three hours to complete. Initially, the family members and new student are greeted by the Admissions Coordinator and the Dormitory Manager. The family then meets the dormitory counselors who accompany the student, along with his/her belongings, to the dormitory. The admissions process then proceeds to a meeting with the school nurse in order to obtain a detailed narrative of the entering student's medical history. Following this, the school's Admissions Coordinator will review the forms and documents that were included (and others that were requested) in the admissions packet originally sent to the parent(s). During the time period allotted for the review of forms and documents, the parent(s)/guardians will be given a packet containing a description of and contact information for The Parents Association. The admissions process concludes by meeting with the Dormitory Manager in order to obtain a social history of the student.

After completion of the social history, the Dormitory Manager will provide a more in-depth orientation experience for the parent(s). This includes a review of important classroom and dormitory information, details regarding the dormitory's particular visitation policies, communication guidelines, the medical plan, financial responsibilities, the behavioral management plan, and explanations of the manner in which the school's general policies and procedures are implemented in the dormitory

(Appendix A provides more specific descriptions of routines and particular manners in which the school's general policies/procedures are implemented in different components of the program).

During the Dormitory Manager's informational review, family members should feel confident that requests for further explanations about any particular issue would be met with cordial efforts to provide more detailed responses to promote a richer understanding of the issue. In addition, the parent(s) can expect to be welcomed and strongly encouraged to inquire about any additional information that would contribute to a sense comfort about feeling adequately oriented to the school's therapeutic environment.

Day School Students

Families of new day students should schedule an appointment with the admissions director before the scheduled admission date to review the completed forms and documents sent to them earlier. That appointment will include scheduled times for staff members to obtain the student's social and medical histories.

V.

Items to Bring/Leave Home

Residential students at the Sonia Shankman Orthogenic School live at the school year-round, with the exception of scheduled weekend visitation, holidays, and school breaks. Items/supplies that should be brought at the time of admission:

Essential Items

1. A one-month supply of all prescribed medications.
2. Two weeks supply of clothing appropriate for the season, and labeled or (permanently) marked with the student's name or identifying initials.
3. Gym shoes with white soles for physical education activities (to help avoid leaving dark markings on the gymnasium floor).
4. Shoes and outerwear (sweaters, sweatshirts, and coats) appropriate for the seasons.
5. Pajamas, slippers and robe.
6. A supply of personal hygiene products, such as shampoo, soaps, toothbrush (es), deodorant, appropriate make-up products for older girls.
7. If student shaves, it must be an electric shaver.
8. Laundry bag or container. No wire rim on the laundry bag please.

Optional or Suggested Items

1. Small bedside rug.
2. Book bag, favorite personal school supplies, favorite personal art supplies.
3. Personal books, magazines, puzzles, etc.
4. A limited selection of favorite toys or games.
5. A limited selection of favorite, age-appropriate music.
6. Favorite stuffed animal, personal comforter, blanket, favorite pillow (if no special comforter, blanket or pillow is brought from home, the school will provide them).
7. Small flashlight for nighttime reading, with a supply of batteries.
8. IPOD, Diskman, Gameboy and/or small desktop stereo system (with headphones that fit all or each of these items).
9. Favorite posters (with supply of "poster putty" used to display them on the student's area wall space).
10. Address book with family and (parent-approved) friends' contact information.

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, residential and day school students, 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 your designated Dormitory Manager (or, if a day student, a 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 Dormitory Manager or Day School Case Manager until the most 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 of 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.
5. No matches or lighters.
6. No parental advisory music.
7. No pornography or sexually explicit literature.
8. No clothing with explicitly provocative writings or graphics.
9. No materials or clothing with designs or messages suggestive of gang or drug-related themes.
10. No pets.

Possession of some types of personal property is dependent upon prior discussions and agreement (involving parents, staff members and student) regarding parameters of acceptable use:

1. Laptop computers
2. Electronic instruments

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

VI.

Visitation Schedule Guidelines

This is an overview of the Sonia Shankman Orthogenic School general visit schedule guideline for family/student visits. The first section describes the schedule as it applies to students and families from more immediate areas:

I. Visitation Guidelines for Students/Families from More Immediate Locations.

1. During the first month after admission, student/family contact is by mail and weekly telephone calls scheduled for times when the parent(s) will be available. In addition, the Dormitory Manager in which your child lives will make a weekly scheduled call to the parent(s) to provide a summary of your child's progress and difficulties. Should a need for more detailed communication arise, the parent(s) can contact the Dormitory Manager by telephone or email. For a few dormitories, this initial period is three, rather than four weeks (this will be clarified for you by the assigned Dormitory Manager during the actual admission process). The main purpose of this initial period is *absolutely not* to promote a sense of separation from the family, but to provide the new student an opportunity to settle in at the school and to adapt to the structure and routines of his/her dormitory, the academic setting and the therapeutic milieu in general.
2. Immediately following this initial period, a family visit with the student to be held within the school will be arranged.
3. Two weeks later, a home day-visit will be arranged.
4. Two weeks later, an over-night home visit will be arranged.
5. If the over-night visit was deemed successful, the student will then be placed in the regular visit schedule, which consists of weekend visits at home every other week. In addition, once a part of the regular visit schedule, students receive longer home visits during certain parts of the year (two weeks at the end of August, and a longer visit around the December holidays, depending upon when the Holiday's fall for a particular year, can range up to 20 days). For these longer home periods, a family can negotiate with the Dormitory Manager to adjust the actual dates that the student might come home (often depending either upon when the parent(s) feel they can be available to adequately supervise their child, or how their child has been doing at the school). Further, if a student is doing well, it is sometimes possible to make arrangements (in consultation

with the student's Dormitory Manager and and/or a Day School Case Manager) for the student to attend important or significant family events.

6. Older students who have moved to live in the Transitional Living Center unit can go home every weekend to be with their families, as well as to have increased opportunities for involvement in their home community activities.

II. Visitation Guidelines for Students from More Distant Locations.

The school now serves students from families living in far more distant locations, such as California. For those students, the initial period of contact by telephone and letter is the same. The following family visit at the school is also similar, but recognizing that these families must fly to Chicago, the time for such visits is usually more extended. The next visit, allowing the family and student to both visit in and leave the school is also usually more extended, providing time to have a meal and perhaps visit some of Chicago's many cultural institutions. The subsequent visit usually allows the student to spend time with his/her family at their hotel accommodations in the city. This is followed by a visit where the student can spend the night with his/her family at their hotel accommodations.

If these visits have gone well, the student is available for visits according to the regular visit schedule. However, realizing the great distance that these families need to travel, individual arrangements may be made with the appropriate Dormitory Manager for the visit in the city to involve a reasonably increased number of days (compared to every other weekend visits that are available for students from the more immediate locations).

VII.

The Medical Program

General Health Care Services

1. The School Nurse

The school has two full-time nurses (Barbara Rivers, R.N. and Dorothy Burwell, L.P.N.), who monitor 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; as noted previously, he holds a medical clinic at the School every Thursday. Dr. Smith can be reached by calling (773) 702-3095.
- The physician on call has access to all of our students' records documenting medical treatment and healthcare plans.
- The on-call physician can be contacted by calling the main University of Chicago Hospital switchboard at (773) 702-1000 and requesting that Dr. Peter Smith be paged. Child and adolescent psychiatry residents are on call for the school 24 hours/day, 365 days/year.

- Associate Directors of the residential program are on call each month on a rotating basis. If there are any problems, the Associate Directors can be contacted immediately by the Crisis Intervention Leaders.

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 and will always accept the school's students for treatment.
   - Emergency in-patient psychiatric services are available through Rush Medical Center.
3. Disaster Procedures
   - The University of Chicago Facilities Services Department is available to manage any potential facility-related emergencies in the school.
   - The disaster plan includes arrangements for transportation of the school's students to the University of Chicago Hospitals, where medical treatment, emergency power, food and water are available.
   - Emergency transportation to the University of Chicago Hospital is available by vehicles owned by the school or by The University of Chicago Campus Security officers.

Medicaid and SSI

All students who receive the Individual Care Grant (ICG) are required by the ICG program under Illinois Code - Rule 34R to apply for Medicaid 90 days after being enrolled in the residential program. With written permission and consent to release information from the parents or guardians, the staff at the Orthogenic School apply for Medicaid on behalf of each student in order to help the family meet this requirement IF they have not done so prior to admission to the Orthogenic School. Once received, Medicaid serves as a secondary insurance for any child that already has a private, primary insurance coverage.

Any student who receives SSI is required to submit this payment directly to the Orthogenic School. This SSI payment amount is then deducted from the total cost of care that is billed directly to the funder. Please feel free to discuss this matter directly with your ICG caseworker and/or the staff at the Orthogenic School.

VIII.

Financial Responsibilities

The following expenses, not included in tuition, room and board, 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 student's Dormitory Manager to take the student for appointments and to return them to the school afterwards.
2. The billed services for formal monthly consultations with the school's residential students by the Rush University Psychiatry Fellows are sent directly through the School to the parents. In some cases, it might be necessary to obtain medical, dental or optical services in the university community or Chicago metropolitan area. These services are generally billed directly to the parent(s) and/ or guardian(s) by the provider. We ask that you remit payment for these bills promptly as an aid to continuation of the special care and services that are rendered to our students by these professionals. It is our policy to use health care professionals who are acquainted with our students and their special needs:
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. Transportation costs for out-of state students' home visits (including costs for staff member accompaniment if necessary) are billed directly to the parents, (unless such costs have been included in the original school agreement).
5. In unusual circumstances, reasonable purchases may need to be made for a student.
6. 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 or part of the damage via the weekly allowance. In some instances, the responsibility might also need to be shared by the parent(s).
7. You will receive a statement of any "incidental expenses" on a monthly basis. If you should have any questions about the nature of certain purchases of personal items for your child, please contact your child's Dormitory Manager. If you should have any other billing questions, please contact our Chief Financial Officer, Abby Simon at (773) 834-5077.

IX.

Confidentiality, Mail and Student Allowances

Confidentiality

The right to privacy and confidentiality of students and their families is carefully protected. However, these rights are not absolute. The Orthogenic School is required by law to communicate otherwise confidential material in particular circumstances, such as: suspected child abuse, the presence of potential physical danger to others or self-harm, and some court orders. The Orthogenic School also shares (with parental consent) necessary information with other professionals who are responsible for the care of our students (e.g., physicians, psychiatric and psychological consultants, and funding sources personnel). Please refer to our Notice of Health and Educational Information and Consent Practices Notice for more detailed information.

Mail

Students are permitted to post and receive uncensored mail. Exceptions are only permitted when contraindicated by the treatment plan and/or by court order or when it is suspected that it contains unauthorized, dangerous, or illegal material or substances. Any restriction (as well as its clinical rationale) of mail must be documented in the student's clinical record. Any and all restrictions will be reviewed by the student, family, and treatment team on a quarterly basis.

All mail will be distributed and opened by the student in the presence of staff to ensure that there is no contraband included. However, the staff member will not read the contents of the mail unless doing so is indicated in the student's treatment plan or the student asks to staff to do so.

Should a piece of mail be suspected of containing dangerous or illegal material or substances, the mail may be opened by a staff member, preferably in the presence of another staff member. If the mail is not in any way dangerous, it should be re-sealed and delivered appropriately with an explanation to the client. If appropriate, the student may open the mail with a clinician present.

If confiscated, the contents of the mail should be noted in a progress note, signed and dated by the supervisor, then handled in a manner appropriate to the material (e.g. filed in the student's record, given to the student's parent/guardian, discarded, etc.).

Telephone Use

Students are permitted to make telephone calls to parents, probation officers, judges, friends as approved by student's parents/guardians, and clinical personnel during specific hours based on the

routine of the dormitory. Exceptions are only permitted when contraindicated by the treatment plan and/or court order.

Any restriction of telephone use must be with parental permission and input and documented in the student's record. Any and all restrictions will be reviewed by the student, family, and treatment team on a quarterly basis.

Length of time, supervision level (e.g. on or off speaker phone, staff present, etc.), and frequency of phone usage and whom the student is calling should be determined and agreed upon by the treatment team.

Students may not carry beepers or cellular phones unless they are living in the Transitional Living Center.

Money

We request that students not have significant sums of money available to them, generally no more than $20.00 given to them by the family at any particular time). This guards against the potential for loss, while helping to equalize the amount of money available to each student. All money is kept in a safe, locked closet. The Orthogenic School meets all food and other basic needs. Students receive a weekly allowance of $6.77/wk. The allowance is included in the monthly bill for incidentals that is sent to parents. Older students can also earn money at job in the school ($3.50/hr.) or at part-time jobs in the community.

X.

Clothing Guidelines

General Principles or Plan

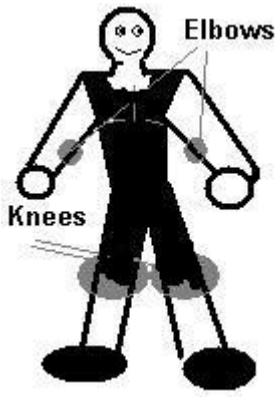
The Sonia Shankman Orthogenic School has developed dress guidelines as an integral part of the treatment program for the School. The purpose of the guidelines is to provide the framework within which students can learn a broad spectrum of social behaviors necessary for successful adaptation in the community. 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 code 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.

General Guidelines:

- The Orthogenic School Dress code has no gender-bias.
- Students may not wear anything that contains images of (or references to) drugs, alcohol, violence, gang references, or any other inappropriate or explicit items.
- Students may not wear any apparel in a style/fashion that is representative of any affiliation with a gang.
- The drawing below illustrates which areas of the body must be covered at all times.



I. Clothing:

- Undergarments must be totally covered, as well as stomachs.
- Belts should be used if pants do not fit correctly or are falling off
- Clothes should be appropriate for daily activities (including PE, Exercise Night…)
- Shoes should be worn at all times, should be appropriate for the student's daily activities (including physical activity or PE Class), and should be suitable and safe for the weather.

II. Accessories/Misc:

1. **Tattoos**
    - Students are allowed show tattoos if they are over 18 or if the tattoo is already there upon O-School admission.
    - Tattoos can only be shown if they are appropriate and are on appropriate parts of the body
    - The Illinois law says no one under 18 may get tattoos, so that is the internal rule as well. While we do not actively encourage getting tattoos, students who are 18 or older may make this decision outside of the school (preferably with his/her parents/guardian), as that would be outside the Dress Code's jurisdiction.
    - Tattoos should be done only while students are away from the school (for students 18 and over) and must be administered in a safe, sanitary and professional environment.
2. **Make Up**
    - Students over 12 years old (with permission from parent/guardian) and Dorm Manager (or Bitsy/Ronda for Day School students) may wear make up.
    - Make up should not be used to mask one's identity.

3. **Nails**
    - Nails should be clean and cared for.
    - Nails should be at a length that minimizes safety risks.
4. **Hair**
    - Hair should be neat, clean, well-groomed and taken care of.
    - Students over 12 years old with permission from parent/guardian and Dormitory Manager (or Bitsy/Ronda for Day School students) can be dye or cut their hair in any way the student desires.
5. **Piercings**
    - All piercings must be approved by a parent/guardian and the Dormitory Manager (or Bitsy/Ronda for Day School Students)
    - No "Excessive Piercings" – as determined by a dormitory and its staff – but students can have piercings in other places besides just their ears
    - There is no age restriction for ear piercings (if ok with parent/guardian and Dormitory Manager), but only students12 years old (or older) can have other (non-ear) piercings. If a student under 12 has a cultural/religious reason for a non-ear piercing, it will be allowed.
    - If staff members think that a piercing is a safety risk, they hold jurisdiction to insist that it be removed.
    - Piercings should be done only while students are away from the school and must be administered in a safe, sanitary and professional environment.
6. **Hats**
    - Hats must not cover a student's face, if the student is not compliant with this rule they will be asked to remove it.
    - Individual teachers are able to decide if they will allow hats in their classroom (each classroom should have a "blanket rule" – either yes or no). Crisis Intervention staff holds jurisdiction in the hallways of the school.
    - Hats may NOT be worn in the dining room.
    - There is no distinction between hats and other head coverings (bandanas, scarves…)
    - If a student has a cultural/religious reason to keep his/her head covered, it will be allowed.

7. **Jewelry**
    - Jewelry that causes a risk to self/others (as determined by staff) is not allowed
    - Excessive amounts of jewelry (as determined by staff) are not allowed
    - Wearing expensive jewelry is not recommended, but may be worn at the student's own risk

III. Hygiene:

As a school, we would hope that we would not have to remind people of taking care of basic hygiene, but as good hygiene plays a large part in how we present ourselves, there must be rules for this area too.

- Students must be clean and presentable.
- Students should shower daily and should not smell offensively.
- Students should wear clean clothes.
- Students should brush and care for their teeth on a daily basis.

Closing statement:

While there are rules, it can't be stressed enough how important individuality is in this environment. So, in order to maintain this privilege of being able to continue to express ourselves, please follow these few simple guidelines. Thank you.

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 – dormitory, 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.
Behavior Management Plan

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, behavior intervention, and/or behavior management techniques.

On an on-going basis, the staff members influence students' behaviors through 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. The employment of natural consequences is at the discretion of the assigned staff members (QHP, QMHP) and is reviewed on an on-going basis with Senior Staff members (QMHP, LHPA).

A frequent natural consequence for students' disruptive and/or disrespectful behaviors is their removal from the area of the milieu in which they are acting inappropriately. Such removals are time-limited and do not involve the student being out of the direct visual monitoring by a staff member. These removals 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 (QMHP, LPHA) 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 (QHP, QMHP) is responsible for maintaining either visual or auditory 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 (QMHP, LPHA) 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.

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 Coverage 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 teacher/counselor staff persons that a problem may be imminent, and making a visual safety check of the physical arrangements of the classroom or dormitory.

There is one Coverage person assigned to the classrooms during the school day, with support from other available Senior Staff members. During the afternoon and evening dormitory times, a Coverage person is present in the building for dormitory coverage calls. All of the Coverage personnel have been trained and periodically re-certified in TCI techniques. In addition, all direct-care teaching and counseling 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 Coverage person should be called before the student becomes physically aggressive. All counselors and teachers are trained in identifying crisis cycles and are encouraged to call for a Coverage person'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, such as a basket hold or a standing team restraint. 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 the Associate Director or Director of the school. For those students in need of hospitalization, the SASS team will contacted to complete a screening for hospitalization.

Administrative Monitoring of Implementation

Following each unusual incident and/or the employment of a restrictive intervention, the staff members responsible for the student at that time will complete an Unusual Incident Report and submit it by the end of the particular shift during which the event occurred. This Unusual Incident Report will be reviewed by the Quality Assurance Manager, who is responsible for forwarding copies of the report to the Dorm Managers (QMHP, LPHA), Associate Directors (LPHA) and Co-Directors. A copy of the Unusual Incident Report will also be faxed to the parents/guardians and case managers. 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 document. Factors will include the type of incident by child, dormitory, classroom and type of response. Summative reports will be generated and distributed to the Co-Directors, Associate Directors, and Dorm Managers. 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 behavioral emergencies, the direct care staff member is responsible for completing the Unusual Incident Report form (and, in the case of restraint, a Physical Management Form). In addition to completing the UIR/PMR, the direct care staff member or the Coverage staff members 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 must be called. 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 and/or Director will be informed of the student's status. A DCFS representative will be informed of the unusual incident, its resolution, and any changes in the individual Treatment Plan, if needed. In the event it is determined that the student cannot be safely maintained at the school, SASS will be contacted to complete a hospitalization screening.

Implementation with Disabled Students

The Orthogenic School limits admissions to those students that are free from profound sensory, motor, and cognitive disabilities, given the nature of the treatment program and physical setting; therefore, there are few, if any, disabled students in attendance. Nevertheless, following admission to the Orthogenic School, an Individualized Treatment Plan is completed for each student. At that time, any students with disabilities are identified and their ITP is developed accordingly. With regard to the implementation of the agency's Behavior Management Plan, for those students with an identified disability the Treatment Plan will state what components of the Behavior Management Plan may or may not be applied to this particular child and will note any modification in 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

Staff members are highly trained and extensively 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 15 years of experience in the mental health field. All members of the Senior Staff are equivalent to 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 behavioral 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 behavioral 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 an Associate Director and/or Director. For new staff members who are on the standard 6 month probation, if there are any corrective actions taken regarding the staff's implementation of the behavioral management plan, their probation will be automatically extended for an additional 3 months.

For more serious infractions of the school's behavioral 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.

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 behavioral management plan. If any contraindications are noted regarding any aspect of the behavioral 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 Treatment Plan (ITP) and 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 ITP, the medical personnel, such as the nurse or physician, will indicate this to an Associate Director, 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 parents and/or guardians, 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 behavioral 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 abused, 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. At least 4 times per year, the student's developmental and psychological status will be reviewed; if any significant changes are noted appropriate adjustments will be made to their ITP and ICMP regarding the implementation of the school's behavioral management plan.

On-Going Review

On a quarterly basis, each student's ICMP and progress towards completion of his or her ITP goals is reviewed. At this time, the appropriateness of the behavioral management plan is assessed for each student. Therefore, all students' Treatment Plans and their involvement with behavioral intervention techniques, in particular manual restraints, will be reviewed.

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 Behavioral Management Plan. With their signature acknowledging consent for treatment, students, parents and/or guardians are stating they have received and reviewed the Behavioral Management Plan and its conditions. 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 bee 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:
    1. 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 no/does not remain locked when unattended.
    2. 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:
    1. 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).
    2. 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:

Each childcare facility that accepts children for whom the Department of Children and Family Services is legally responsible shall develop an Agency Behavior Management Plan that describes the facility's programming. In addition, each child for whom the Department is legally responsible shall have an individual Treatment 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 Plan is designed to address.

Behavior Management Chart:

Intervention	Purpose	Contra-Indications	Qualifications	Time Limitation	Monitoring	Documentation
Verbal Re-Direction	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 Staff Members	None	All Staff Members	Daily Notes
Application of Natural Con-sequences	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 Staff Members	None	All 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 Staff Members	None Rule of Thumb… Not to Exceed 2 min per year of age	All Staff Members	Daily Notes
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.). 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 Staff Members that are TCI Trained	Not to Exceed 1 min per year of age	All Staff Members Coverage to be Notified	Daily Notes UIR
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	When not approved in student ICMP or if utilization of technique would	All Staff that are TCI Trained	After 30 minutes – medical profess-ional approval required. After 60	All Staff Members Coverage Present Nurse, Senior Staff On-Call and	Must be documented in the clinical record through… UIR and Physical Management

	to self or others, or for the purpose of escorting the child to a quieter setting to prevent the completion of such an act.	result in injury		minutes, M.D. approval required	M.D Notified	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.	When not approved in student ICMP or if utilization of technique would result in injury	All Staff that are TCI Trained	After 30 minutes – medical profess-ional approval required. After 60 minutes, M.D. approval required	All Staff Members Coverage Present Nurse, Senior Staff On-Call and M.D Notified	Must be documented in the clinical record through… 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