

# **Components of a Comprehensive Program to Address Non-Academic Barriers to Learning**

Evidence-Based Counseling Techniques

(including school based counseling groups for trauma)

Social Skills Training Program (Second Step Program, etc.)

Staff Training on Emotional and Mental Health Needs of Students

Connection to Community Resources

Parent Engagement

## A. Trauma/Loss Exposure History

Trauma Type (Definitions attached)					Age(s) Experienced (Check each box as appropriate – example sexual abuse from ages 6–9 would check 6, 7, 8, and 9)																				
	Yes	Suspected	No	Unknown	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
1. Sexual Abuse or Assault/Rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
2. Physical Abuse or Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3. Emotional Abuse/Psychological Maltreatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
4. Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
5. Serious Accident or Illness/Medical Procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
6. Witness to Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
7. Victim/Witness to Community Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
8. Victim/Witness to School Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
9. Natural or Manmade Disasters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
10. Forced Displacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
11. War/Terrorism/Political Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
12. Victim/Witness to Extreme Personal/ Interpersonal Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
13. Traumatic Grief/Separation (does not include placement in foster care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
14. Systems-Induced Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

## Part A.

People may have stressful events happen to them. Read the list of stressful things below and circle YES for each of them that have EVER happened TO YOU. Circle NO if it has never happened to you.

Do not include things you may have only heard about from other people or from the TV, radio, news, or the movies. Only answer what has happened to you in real life. Some questions ask about what you SAW happen to someone else. And other questions ask about what actually happened to YOU.

SAMPLE:

a. Have you EVER gone to a basketball game? (Circle YES or NO)	Yes	No
--	-----	----

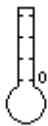
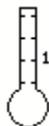
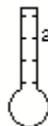
### Have any of the following events EVER happened to you? (Circle Yes or No)

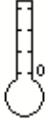
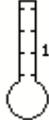
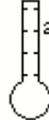
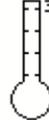
1. Have you <b>been in</b> a serious accident, where you could have been badly hurt or could have been killed?	Yes	No
2. Have you <b>seen</b> a serious accident, where someone could have been (or was) badly hurt or died?	Yes	No
3. Have you thought that <b>you or someone you know</b> would get badly hurt during a natural disaster such as a hurricane, flood, or earthquake?	Yes	No
4. Has <b>anyone close to you</b> been very sick or injured?	Yes	No
5. Has <b>anyone close to you</b> died?	Yes	No
6. Have <b>you</b> had a serious illness or injury, or had to be rushed to the hospital?	Yes	No
7. Have <b>you</b> had to be separated from your parent or someone you depend on for more than a few days when you didn't want to be?	Yes	No
8. Have <b>you</b> been attacked by a dog or other animal?	Yes	No
9. Has anyone told <b>you</b> they were going to hurt you?	Yes	No
10. Have you seen <b>someone else</b> being told they were going to be hurt?	Yes	No
11. Have you <b>yourself</b> been slapped, punched, or hit by someone?	Yes	No
12. Have you seen <b>someone else</b> being slapped, punched, or hit by someone?	Yes	No
13. Have <b>you</b> been beaten up?	Yes	No
14. Have you seen <b>someone else</b> getting beaten up?	Yes	No
15. Have you seen <b>someone else</b> being attacked or stabbed with a knife?	Yes	No
16. Have you seen someone pointing a <b>real</b> gun at <b>someone else</b> ?	Yes	No
17. Have you seen <b>someone else</b> being shot at or shot with a <b>real</b> gun?	Yes	No

**PART B:**

Below is a list of problems that kids sometimes have after experiencing something scary like we were just talking about. Of all the things that we just talked about, try to remember the thing that bothers you the most.

Now these next questions ask about the thing that bothers you most (whether it was getting hit, beaten up, threatened, or anything else). Listen carefully and circle the word that best describes how often these problems have bothered you IN THE PAST TWO WEEKS.

	<b>0</b> 	<b>1</b> 	<b>2</b> 	<b>3</b> 
1. Have you had upsetting thoughts or images about the event that came into your head when you didn't want them to?	Not at all	Once in a while	Half the time	Almost always
2. Have you had bad dreams or nightmares?	Not at all	Once in a while	Half the time	Almost always
3. Have you been acting or feeling as if the event was happening again (for example, hearing something or seeing a picture about it and feeling as if you were there again)?	Not at all	Once in a while	Half the time	Almost always
4. Have you been feeling upset when you think about or hear about the event (for example, feeling scared, angry, sad, guilty, etc.)?	<u>Not at all</u>	Once in a while	Half the time	Almost always
5. Have you had feelings in your body when you think about or hear about the event (for example, breaking out in a sweat, heart beating fast)?	Not at all	Once in a while	Half the time	Almost always
6. Have you been trying not to think about, talk about, or have feelings about the event?	Not at all	Once in a while	Half the time	Almost always
7. Have you been trying to avoid activities, people, or places that remind you of the event (for example, not wanting to play outside or go to school)?	Not at all	Once in a while	Half the time	Almost always

	<b>0</b> 	<b>1</b> 	<b>2</b> 	<b>3</b> 
8. Have you not been able to remember an important part of the event?	Not at all	Once in a while	Half the time	Almost always
9. Have you had much less interest or not wanting to do things you used to do?	Not at all	Once in a while	Half the time	Almost always
10. Have you not felt close to people around you?	Not at all	Once in a while	Half the time	Almost always
11. Have you not been able to have strong feelings (for example, being unable to feel very happy)?	Not at all	Once in a while	Half the time	Almost always
12. Have you been feeling as if your future plans or hopes will not come true (for example, you will not go to high school, have a job, get married, have kids,)?	Not at all	Once in a while	Half the time	Almost always
13. Have you had trouble falling or staying asleep?	Not at all	Once in a while	Half the time	Almost always
14. Have you been feeling irritable or having fits of anger?	Not at all	Once in a while	Half the time	Almost always
15. Have you had trouble concentrating (for example, losing track of a story on television, forgetting what you read, or not being able to pay attention in class)?	Not at all	Once in a while	Half the time	Almost always
16. Have you been overly careful (for example, checking to see who is around you and what is around you)?	Not at all	Once in a while	Half the time	Almost always
17. Have you been jumpy or easily startled (for example, when someone walks up behind you)?	Not at all	Once in a while	Half the time	Almost always

# Belly Breathing

Belly breathing is a great way to calm down when you are upset.

Imagine that there is a balloon in your belly.

As you take a big breath in through your nose, try to fill up the balloon so that your belly puffs up.

Now breathe out through your mouth (like blowing bubble) and let all of the air out of the balloon.

Take slow breaths. Try to count to 4 as you breathe in and count to 4 as you breathe out.

Inhale...2...3...4

Exhale...2...3...4

Repeat until you are calm.

Remember to practice every day until it becomes easy to use when you need it.



# Parent Engagement in the School Environment

## How to engage parents

- Focus on building a relationship and developing trust and understanding
- meet the parent where they are at, find out what their needs are, take a survey
- Seek out parents at school events and develop relationships
- develop a parent group to help plan events at the school, start with going to a PTO meeting
- encourage parents that their child's education is a partnership with the school
- attend teacher meetings with anxious or difficult parents to offer support

## How to connect parents to resources

- Post local resources on a bulletin board near the office
- Post on school Facebook page or website, especially local events
- research local resources and create a resource sheet of places a family can call
- follow-up with parents with a quick email or text, show you care

---

## Parent Survey

1. Would you be interested in attending any parent events at the school? Yes \_\_\_\_\_  
no \_\_\_\_\_
- If yes, what time of day is good for you? (Circle) During school day after school evening weekend
2. Would you be able to pay a small fee for available services (i.e. tutoring) Yes \_\_\_\_\_  
no \_\_\_\_\_
- Suggestions: \_\_\_\_\_
3. Would you be interested in attending one of these trainings?  
a. Information about foreclosure programs? Yes \_\_\_\_\_ no \_\_\_\_\_  
b. Information about learning disabilities and how to help your child? Yes \_\_\_\_\_ no \_\_\_\_\_  
c. Parenting techniques to help with behavior? Yes \_\_\_\_\_ no \_\_\_\_\_

other training suggestions: \_\_\_\_\_

**For example.....Please circle topics you would like to know more about:**

Tutoring	ADHD	after school program	Metroparks
Girl scouts	mental health resources	utility programs (gas/electric)	health care
Housing	employment resources	summer programs	food resources

Name: \_\_\_\_\_ children: names & ages \_\_\_\_\_

Contact information: phone/email: \_\_\_\_\_

**What is your preferred method of communication regarding school news, Please circle all that apply.**

Email phone One-calls newsletter website texting Facebook

# Family Needs Assessment

Date \_\_\_\_\_ Contact \_\_\_\_\_ School \_\_\_\_\_

Guardian: \_\_\_\_\_ phone: \_\_\_\_\_ txt \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Supports: \_\_\_\_\_

## Children:

Name \_\_\_\_\_ DOB \_\_\_\_\_ age \_\_\_\_\_ grade \_\_\_\_\_ School \_\_\_\_\_ Sz \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ age \_\_\_\_\_ grade \_\_\_\_\_ School \_\_\_\_\_ Sz \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ age \_\_\_\_\_ grade \_\_\_\_\_ School \_\_\_\_\_ Sz \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ age \_\_\_\_\_ grade \_\_\_\_\_ School \_\_\_\_\_ Sz \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ age \_\_\_\_\_ grade \_\_\_\_\_ School \_\_\_\_\_ Sz \_\_\_\_\_

Presenting needs: \_\_\_\_\_

## Goal(s): review every 3 months

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Goal review date: \_\_\_\_\_

Progress: Achieved \_\_\_\_\_ Partially Achieved \_\_\_\_\_ Not Achieved \_\_\_\_\_  
Action: Continue Goal \_\_\_\_\_ Modify Goal \_\_\_\_\_ Discontinue Goal \_\_\_\_\_

Goal review date: \_\_\_\_\_

Progress: Achieved \_\_\_\_\_ Partially Achieved \_\_\_\_\_ Not Achieved \_\_\_\_\_  
Action: Continue Goal \_\_\_\_\_ Modify Goal \_\_\_\_\_ Discontinue Goal \_\_\_\_\_

Goal review date: \_\_\_\_\_

Progress: Achieved \_\_\_\_\_ Partially Achieved \_\_\_\_\_ Not Achieved \_\_\_\_\_  
Action: Continue Goal \_\_\_\_\_ Modify Goal \_\_\_\_\_ Discontinue Goal \_\_\_\_\_

**Family Resources/budget**

Employment/School \_\_\_\_\_

Monthly Income: \_\_\_\_\_

(work , student loans, SSI, SSDI, family, child support)

Food Assistance \_\_\_\_\_ Health insurance \_\_\_\_\_

Legal issues/Child Support \_\_\_\_\_

Family history: social, emotional, physical, legal

Home computer/printer: \_\_\_\_\_

**Bills/ Budget**

School fees/Ed Choice \_\_\_\_\_

Rent/Mortgage \_\_\_\_\_ Sect 8/GDHA

Gas \_\_\_\_\_ Electric \_\_\_\_\_ PIPP/HEAP (circle) Water \_\_\_\_\_

Phone/Cell \_\_\_\_\_ Cable/Internet \_\_\_\_\_

Car \_\_\_\_\_ Insurance \_\_\_\_\_ gas \_\_\_\_\_ food/home \_\_\_\_\_

Own or loan

Other (credit card, student loans etc.) \_\_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_ = \_\_\_\_\_  
Income bills

X \_\_\_\_\_  
Parent Signature date

X \_\_\_\_\_  
Family Advocate Signature date