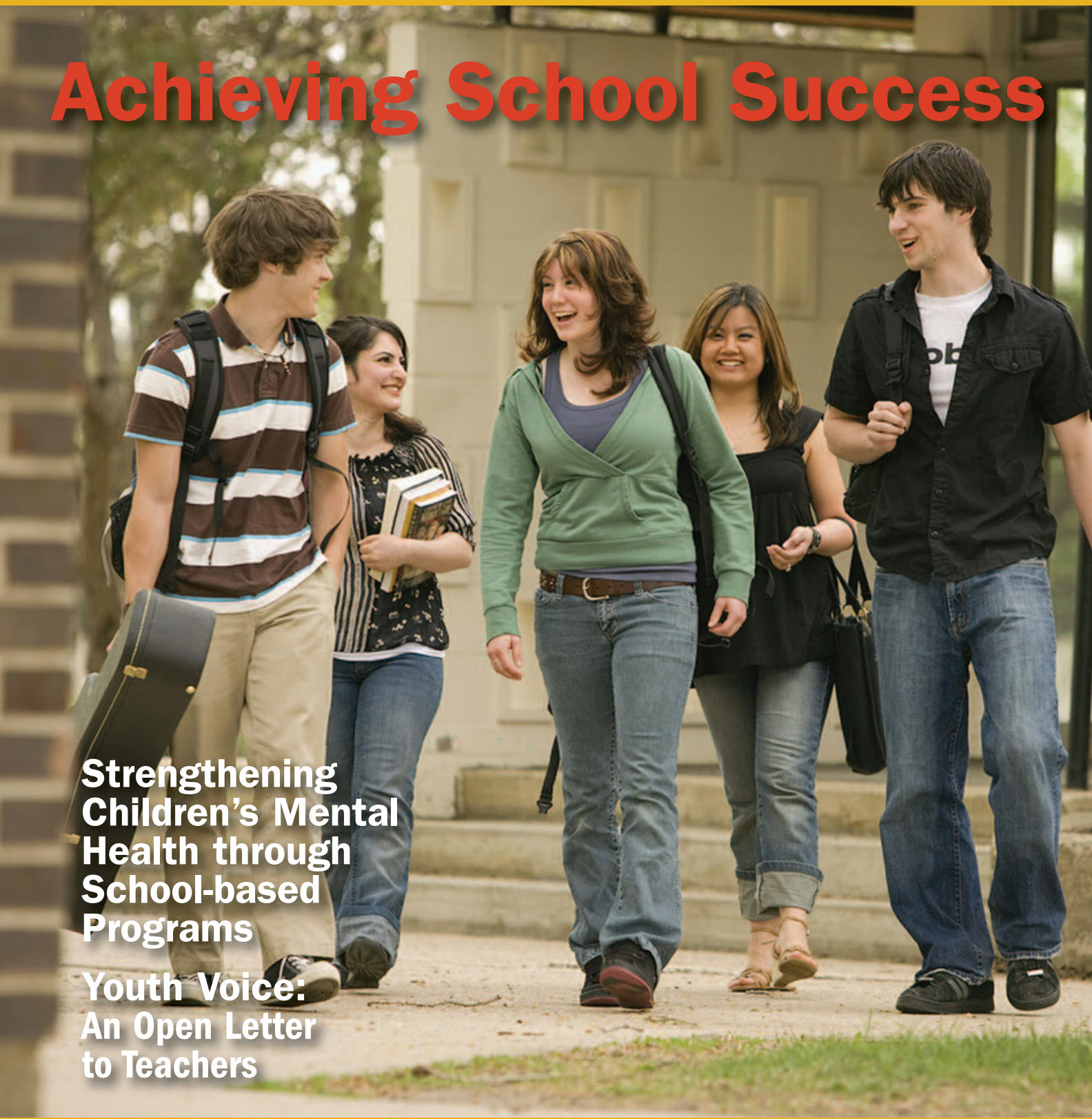
Winter 2012 • Issue 19

# NAMI Beginnings

National Alliance on Mental Illness

A Publication Dedicated to the Young Minds of America from the NAMI Child and Adolescent Action Center

# Achieving School Success



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NAMI Beginnings
National Alliance on Mental Illness

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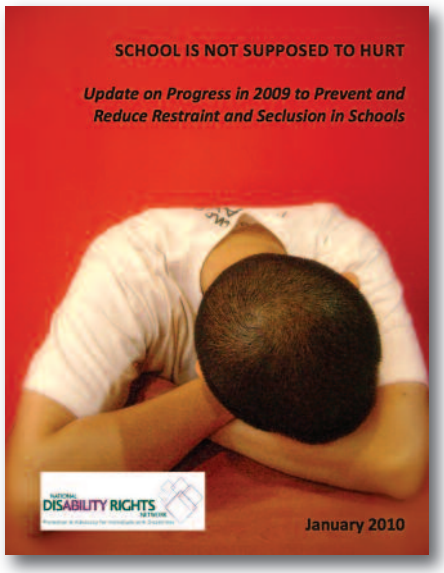
# Capitol Hill Watch

**by Darcy Gruttadaro, J.D.,**
director, NAMI Child and Adolescent Action Center

## Urge Congress to Act to End Abusive and Deadly Use of Restraint and Seclusion in Schools

In December 2011, U.S. Sen. Harkin (D-Iowa) introduced The Keeping All Students Safe Act (S. 2020). U.S. Rep. George Miller (D-Calif.) introduced similar legislation in the House (H.R. 1381). These bills impose sharp restrictions on the use of restraint and seclusion in our nation's schools. NAMI strongly supports these bills and urges swift action to pass them. Currently, there are no federal laws that regulate the use of restraint and seclusion in schools. State laws in this area vary widely.




Physical restraint and seclusion have resulted in physical injury, psychological trauma and death to children in public and private schools. The inappropriate and harmful use of restraint and seclusion has disproportionately impacted students with disabilities, including those with mental illness. Media stories around the country have documented many of these tragic cases.

You can learn more about this legislation and this issue through the following resources:

- Visit Thomas.loc.gov to read the legislation (search by bill numbers S. 2020 and H.R. 1381)
- Review the Government Accountability Office (GAO) report on this issue at www.gao.gov/products/GAO-09-719T
- Review the National Disability Rights Network report, *School is Not Supposed to Hurt,* at www.ndrn.org (Click on "Issues," "Abuse and Neglect," and "Restraint and Seclusion")
- Review Section 4.3 of NAMI's Policy Platform at www.nami.org (Click on "Inform Yourself," "Public Policy Issues" and "NAMI Policy Platform")

### Act Now

It is critical for all U.S. Senators and House Representatives to hear from you about the importance of moving S. 2020 and H.R. 1381 forward to protect children from these harmful practices. Advocates are strongly encouraged to urge U.S. Senators and House Representatives to support immediate passage of S. 2020 and H.R. 1381, both titled The Keeping All Students Safe Act. Call them by using the Capitol Switchboard at (202) 224-3121 and email them by using NAMI's Legislative Action Center at http://capwiz.com/nami/home. Thank you!

# Strengthening Children's Mental Health Services through School-based Programs

**by Mark Sander, Psy.D.,** Hennepin County/Minneapolis Public Schools, **Tom Steinmetz,** Washburn Center for Children, **Anna Lynn,** Minnesota Department of Human Services, **Glenace Edwall,** Minnesota Department of Human Services and **Marcia Tippery,** Minnesota Department of Human Services

**Introduction and Background**

School success and positive mental health are critical for later success in life. The dropout rate for students living with serious mental illness is approximately twice that of other students. Mental health and school success are closely related since untreated mental health issues can be significant barriers to learning. One in five children has a diagnosable mental illness, yet 70 to 80 percent do not receive treatment or receive inadequate levels of care. The need to improve access to mental health services is urgent. Fortunately, schools provide significantly improved access to students and families. Schools are an ideal place for mental health promotion, prevention and early intervention activities such as Positive Behavioral Interventions and Supports (PBIS) and social emotional learning. When students have a more serious mental illness, research has shown that having a licensed mental health provider on-site at a school can dramatically increase these students' access to and participation in needed mental health services and supports.

Nationally, the school mental health movement has grown over the last 15 years. Minnesota has had more than 20 years of school and mental health collaboration, fostered by an investment of state funds in 2007 as part of larger mental health reform legislation. Minnesota's school-based mental health efforts include 21 School-Linked Mental Health (SLMH) grant programs serving urban, suburban and rural areas. These programs serve 63 counties, about 200 school districts and more than 550 schools. The purpose of these programs is to increase access to children's mental health services in school and community settings.

Additionally, Washburn Center for Children has been providing services in Minneapolis Public Schools (MPS) since 2005 through a partnership with Hennepin County and MPS. Currently, Washburn provides services in seven schools in the Minneapolis Public School District as well as ten suburban schools in the nearby Bloomington and Eden Prairie School Districts.

As the provider in these schools, Washburn Center for Children collaborates with school staff and parents to help identify children who are struggling with mental health issues and to ensure that they receive assessment and treatment services in a timely manner. Services are available and accessible to all children and families, whether they have health insurance or not, due to state and county grants.

Washburn clinicians provide a comprehensive diagnostic assessment and a range of therapeutic, care coordination and consultation services. These clinicians partner with teachers and parents to help them effectively work with a child who is experiencing social, emotional and behavioral problems, to provide consultation so parents and teachers understand mental health issues and interventions better and to coordinate services with other professionals serving the family. School staff members are able to consult with clinicians and receive guidance on how to provide an environment that is conducive to a student's learning and how to respond when issues arise.

**How the Program Works**

In Minnesota, school-based mental health programs integrate a broad continuum of mental health services and supports into the schools by locating a mental health professional at the school and partnering with student support staff already in the schools. Through a contractual relationship with the school district, a community mental health agency places a licensed mental health professional at each school participating in the program. This professional provides a range of services on-site at the school from prevention and early intervention (including teacher training and consultation) to diagnostic evaluation and therapy.

The school-based mental health programs are designed to provide both mental health services and ancillary supports (*e.g.*, teacher consultation, care coordination, classroom presentations). Most of the clinical services are

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Mental health and school success are closely related since untreated mental health issues can be significant barriers to learning.

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funded by health insurance reimbursement. The financial model is based on maximizing reimbursement for treatment through families' health insurance. Program leaders have found that up to two-thirds of their costs can be captured through health insurance reimbursement and the county paying for the uninsured, leaving one-third of the funding needed from grants and other funding sources. Work continues on collaborative financing and long-term sustainability strategies that braids health insurance reimbursement and county, state and school district financial support to create a strong financial base for the programs.

**Brief Portrayal of Data**

Outcome data has been critical to building school-based mental health programs across Minnesota. Program leaders have used data to guide the development and implementation of their programs as well as to assess individual student improvement and indicators of overall program success.

Bringing mental health providers into the schools to provide services offers a range of benefits, including:

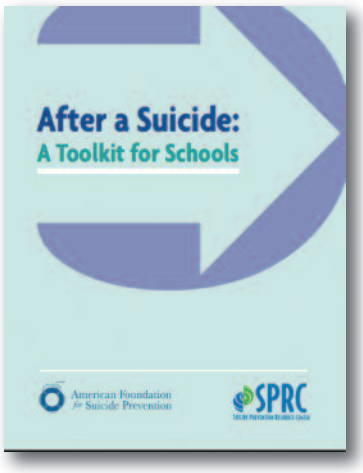
- Reduced barriers to learning, both for children living with mental illness and their classmates
- Increased accessibility to mental health services and supports (especially for underinsured and uninsured children)
- Improved functioning of children living with mental illness
- Reduced symptoms
- Reduced time spent out of class
- Reduced time away from work for parents
- Eliminated transportation barriers
- Improved consultation for teachers to support children in the classroom
- Reduced truancy and suspension rates

In Minnesota, from July 2008 to June 2010, more than 8,400 students in 63 counties have, with parental permission and involvement, been able to access mental health services in their schools through our state's SLMH programs. Data from the SLMH programs show that between 46 to 59 percent of students accessed mental health services for the very first time. Many children with serious mental health needs were first identified through the SLMH programs, including 45 percent of children who met the criteria for serious emotional disturbance (3,749 children total). For students from cultural and ethnic minority communities, school-based access to mental health services was especially important. Overall, students of diverse racial/ethnic backgrounds were significantly more likely to access mental health services for the first time than Caucasian students (58 percent versus 52 percent). In particular, a higher portion of Asian American (69 percent) and African American (56 percent) students accessed services for the first time compared to Caucasian students (52 percent).

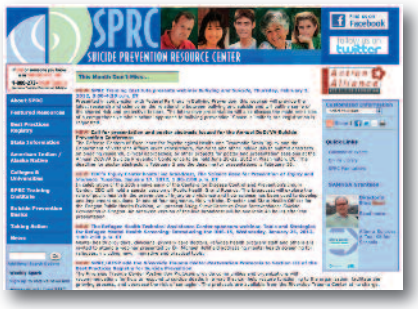
The Strengths and Difficulties Questionnaire (SDQ) is a behavioral health questionnaire that gauges the perspectives of the child, parent and teacher. The SDQ is useful clinically and has been reported by SLMH clinicians to be an important tool to discuss treatment progress with teachers and parents. SLMH students who had SDQ subscale scores in the abnormal range made significant movement to borderline or normal range scores from all raters. However, the greatest portion of student movement from abnormal to normal and borderline was for prosocial behaviors and emotional symptoms.

The MPS program has collected data since the beginning of the program in 2005 and trends have been fairly consistent over the years and similar to SLMH data. The MPS data has shown that about 85 percent of students were seen at least once face to

## After a Suicide: A Toolkit for Schools




The American Foundation for Suicide Prevention and the Suicide Prevention Resource Center released a comprehensive toolkit, *After a Suicide: A Toolkit for Schools*. This resource provides step-by-step guidance on how schools should respond to a suicide.




The toolkit provides information on how schools should communicate with parents, students and the media when a suicide occurs and how to best prevent suicides. The toolkit includes sample press releases, best practices for responding to crises and how schools can help students cope, work with their community, use social media and move forward after a suicide happens.

To access the toolkit, visit www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf.

face by a mental health professional, more than 70 to 85 percent of students were seen within two weeks and 50 to 65 percent of these students never received mental health services before. Program data also documents that students are receiving an appropriate level of treatment, averaging 15 face-to-face contacts during the year.

The MPS program has helped students improve their mental health and educational outcomes over the past several years. Both teachers and parents report improvements in students' mental health on the SDQ, which is similar to the outcomes reported in the SLMH programs. MPS program data also identified a decrease in school suspensions and an increase in attendance for some students. In addition, principals reported that they believed the program significantly reduced office referrals and student suspensions.

School-based mental health programs are reaching children at critical times in their lives and are reaching children with mental health symptoms that are more obscure than disruptive behaviors in the classroom.

Approximately 79 percent of SLMH students began services with moderate mental health service needs, typically requiring outpatient services and brief interventions. Conversely, 19 percent of students in the SLMH program started services with needs consistent with intensive services, case management and even inpatient level of care. Among the students with higher needs, 57 percent moved to a lower, less intensive level of care. Many students presented with low overall service needs but one or two areas of acute need such as day-to-day functioning, a stressful living environment or a co-occurring substance use disorder. For SLMH children with severe impairment in one of these areas, between 66 to 80 percent moved to minimal or moderate level of need in that area. These changes occurred in an average of seven months of service.

### Lessons Learned

Recognizing that no one system can meet the mental health needs of youth alone, communities, schools and mental health providers created programs to develop services when they did not exist and better align mental health services and supports with schools. Establishing strong relationships with schools and parents is critical to the success of the SLMH programs.

The challenges faced by the 21 SLMH providers across the state are varied, related to the size and geographic location of the school they serve.

As a provider in the urban setting of Hennepin County, Washburn Center for Children has encountered one lesson that is undoubtedly key for all school-based mental health programs: investing in comprehensive planning with all key stakeholders to create clear agreements about boundaries, roles, expectations and policies among the various organizations involved, particularly between providers and school personnel. For example, policies related to data privacy, mandated reporting and parental consent may be different across systems and it is crucial to discuss these differences at the very start of the collaboration so a clear process can be defined. MPS and Hennepin County invested and supported this type of initial planning and collaboration and it benefited the project enormously.

Another challenge Washburn Center for Children has encountered through its school-based mental health program is supporting services for the large number of families needing services who are uninsured or underinsured. This financial challenge is more prominent in the school-based mental health program than in Washburn's other therapeutic programs due to the higher percentage of uninsured children served and families with large deductibles and co-pays. Since one goal of bringing mental health services into the school setting is to ensure that all families have access to services their child needs, providers must work proactively with uninsured/underinsured families to ensure that services remain available and affordable for all children who need them. Ultimately, this fiscal pressure necessitates public contributions to guarantee sustainability.

### Looking Toward the Future

School-based mental health programs can significantly increase access to services and supports and help sustain effective engagement in treatment, especially for families who in the past have had difficulty accessing the community-based mental health system. School-based mental health programs —when done well—are based on strong partnerships and provide the opportunity to leverage the expertise and resources of several major systems that touch children's lives to help achieve the best possible outcomes for children.

Establishing strong relationships with schools and parents is critical to the success of the SLMH programs.

This important work can only be sustained through strong effective partnerships that have, at their core, the shared vision of school-based mental health and a fierce commitment to the well-being of children and their families. School districts, mental health providers, health plans and county and state governments all have a role. No one organization or system can do this work alone.

To learn more about the Minneapolis and Hennepin County school-based mental health programs, contact Dr. Mark Sander at Mark.Sander@co.hennepin.mn.us. To learn more about the Department of Human Services' state-funded grants, contact Dr. Marcia Tippery at marcia.tippery@state.mn.us.

# Left Behind, Left Out or Kicked Out: Strategies for Protecting Children's Rights in School

**by Matt Cohen, J.D.,** Matt Cohen and Associates, special education, disability rights and human services law

The IEP must address a student's developmental and functional needs, based on present level of performance and measurable goals and objectives.

Children with emotional, social and behavioral conditions experience unique challenges within public schools. Their disabilities impact their behavior and academic functioning and make them more likely to be subject to school discipline even if their behavior is a result of their disabilities. Many children with these emotional, social and behavioral issues are entitled to special services and protections within public schools through two laws, the Individuals with Disabilities Education Act (IDEA), the law governing special education, and Section 504 of the Rehabilitation Act of 1973. IDEA is a funding statute that requires all states to comply with the federal special education regulations. Section 504 is a civil rights statute requiring all recipients of federal funds to provide non-discriminatory services, including reasonable accommodations.

Both IDEA and Section 504 have a requirement called "Child Find," which requires schools to identify all children aged 3 to 21 who are suspected of having a disability, including a mental illness. Because mental illness is sometimes less visible than some other disabilities, the Child Find rules are very important in mandating that schools assess children having behavioral, emotional or social problems. As part of the Child Find requirement, a parent or member of the school staff may also refer a child for evaluation for special education or Section 504 services.

When a child is referred for evaluation, the school must first obtain written parent consent before conducting the evaluation. In addition, the school must inform parents if the school does not believe that an evaluation is appropriate and must tell parents the reason the evaluation is being refused and that parents have the right to challenge the refusal. When a school and parent agree that an evaluation should be conducted, it must include a variety of different evaluation procedures and must be non-discriminatory. The IDEA now requires that schools evaluate a child in a manner and form which:

- Yields accurate results
- Identifies what the child knows and can do
- Assesses the child's developmental, functional and academic progress

These requirements are particularly important for children living with mental illness since it makes clear that they may be entitled to services and legal protections for these issues, even if the issues are not directly impacting their academic performance, but are affecting other areas of their development and functioning at school.

Several of the IDEA disability categories may be applicable to children living with mental illness, including the categories of "emotionally disturbed" (ED) and "other health impaired" (OHI). In order to be eligible under the ED category, a child must meet one of the following criteria:

- Inability to learn due to emotional factors
- Inability to build or maintain interpersonal relationships
- Inappropriate types of behavior or feelings under normal circumstances
- General pervasive mood of unhappiness or depression
- Physical symptoms or fears

Furthermore, the condition must be present over a long period of time to a marked degree and must adversely affect the child's educational performance (including non-academic school performance). ED eligibility is based on the child's general functioning in school, social relationships, ability to complete work or ability to conform to school rules and classroom expectations. ED includes both aggressive-externalized behaviors and internalized behaviors.

Children with behavior challenges may also be eligible for special education based on having attention deficit/hyperactivity disorder (ADHD), tourette syndrome, bipolar disorder or other health conditions that cause behavioral symptoms. The OHI criteria requires that the student display limited strength, vitality or alertness, including heightened alertness to environmental stimuli that results in limited alertness in the educational setting and adversely affects educational performance.

All IDEA eligibility categories require that a student meet criteria for a specific disability category that adversely affects educational performance and requires special education intervention, including specialized services in the regular classroom. If the student meets the criteria for eligibility for special education, the student is entitled to a Free Appropriate Public Education (FAPE). A student's special education program is defined by the content of his or her Individualized Education Program (IEP), which identifies the special education services and supports that he or she needs to stay in school and learn. These services and supports should be provided in the least restrictive environment. FAPE requires necessary services, but not necessarily the best services, so it is important for parents and clinicians to focus on what the student needs and why, rather than on what would be ideal or desirable.

*Matt Cohen, J.D.*

While a student should be based in the regular classroom whenever possible, the student may also be entitled to services in a specialized classroom, a therapeutic day school or even a residential placement. The student is also entitled to receive related services that are necessary for them to benefit from their education, including counseling, social work, parent training, positive behavioral supports, social skills training, use of an aide, positive reinforcement systems, medication administration and any other non-medical services necessary for the child to benefit from education.

Some useful additional strategies for students living with mental illness can include:

- Training programs for staff and students
- Monitoring strategies
- Services to address the academic consequences of emotional and behavioral problems
- A caring/trusted adult or peer buddy to provide support
- Adjusted class schedules and extended time for homework and tests
- Possible homebound tutoring plans as needed
- Planning for homework backup plans

Parents have a right to participate in the IEP process. The IEP must be reviewed at least annually or more often if the parents or school request it. The IEP must address a student's developmental and functional needs, based on present level of performance and measurable goals and objectives.

The IEP must be based on peer-reviewed research to the extent possible and, for children with social or behavioral issues, should include consideration of positive behavioral interventions and supports as well as supports the staff need (*e.g.*, training on behavioral management or access to a behavioral consultant). If a child is having behavioral issues, the school should consider conducting a Functional Behavioral Analysis (FBA), which helps to examine problem behaviors, and developing a Behavior Intervention Plan (BIP), which describes services and supports to help a child improve his or her behavior. If a student with an IEP is being suspended for more then ten days, the school must conduct a FBA and must develop a BIP.

Positive behavioral interventions that can be provided by schools and can be included in a BIP include the following:

- Exceptions to discipline codes
- Counseling
- Positive re-enforcement systems
- Accommodations to meet the individual needs of the student
- Behavioral and social skills training
- Staff support and/or one-on-one aides
- Use of the IEP process to clearly identify student's behavioral challenges and needs
- Building a hierarchy of positive behavioral supports and interventions into the IEP
- Limiting the use/availability of restrictive/punitive/exclusionary measures
- Writing behavioral goals
- Finding a trusted ally in the school

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- Training for staff about the child's condition and about proper intervention
- Promoting positive behavioral support school-wide

Section 504 is a much less detailed law that provides protection from discrimination for children and adults with disabilities. A child is entitled to the protection of Section 504 if he or she has an identified physical or mental disability that substantially limits a major life activity, such as learning, concentrating, thinking or social interaction. Unlike IDEA, a child can qualify for the protections of Section 504 if he or she requires special education or related services. Furthermore, Section 504 has no categories or criteria for a specific type of disability or label.

Although many people are unaware of it, Section 504 not only requires the provision of "reasonable accommodations," but also requires the provision of other services necessary for a student to receive FAPE. While the Section 504 definition of FAPE is somewhat different than that under IDEA, it can also include specialized instruction and/or related services as well as accommodations. Many students who do not meet the criteria for eligibility for IDEA services may still be entitled to the services and protections of Section 504. In fact, if a child is evaluated for special education services and found not eligible, the school should also consider whether they meet the criteria for Section 504.

There are many advantages to both IDEA and Section 504 eligibility. Parents should learn as much as they can about the two laws, so they are sure that they and the school are making the best choice as to which law applies to the student.

Parents should learn as much as they can about the two laws, so they are sure that they and the school are making the best choice as to which law applies to the student.

**Web-based Resources on IDEA and Section 504**

- www.mattcohenandassociates.com
- www.disablethelabels.blogspot.com
- www.nami.org/caac
- www.ndrn.org
- www.nichcy.org
- www.copaa.org

More in-depth information about this topic is available in Matt's book, *A Guide to Special Education Advocacy: What Parents, Advocates and Clinicians Need to Know.* To order a copy, email Matt Cohen at mdcspedlaw@gmail.com.


*www.disablethelabels.blogspot.com*


*www.ndrn.org*


*www.nami.org/caac*


*www.copaa.org*

# A Plea for Compassion, Understanding and Patience

**by Savannah T.,** age 14

*Editor's Note: Savannah wanted to make a contribution to our magazine so she chose to speak to the school professionals in her life. We greatly appreciate her wonderful letter that captures the voice of so many youth across our nation.*

*Savannah T.*

Dear teachers and staff members,

I, Savannah T., am writing this letter to help you understand me a little better. This is a plea for your compassion, understanding and patience. I understand that you cannot know what no one has told you. This is very difficult for me to explain since I am only 14 years old and do not understand most of it myself. Please do not mistake my mental illness as a way for me to get out of doing my work because I really do want to do well in school and in life. Being a teenager is hard enough and worse with a mental illness.

I was born with a mental illness. This is an illness of the brain and body. My illness affects the way I think, hear, feel and behave. When I say that my illness affects the way I think, feel, hear and behave, I should offer more explanation. Let me start with the fact that I may or may not hear you. Sometimes when you are speaking, there are other voices in my head or a roaring noise and your words just seem like mumbo jumbo. I have to try and clear the other voices so I can get what you are saying. Sometimes it seems as though you are speaking backwards or writing backwards. It takes me awhile to get it or sometimes I just never get it. Also, when I read, the words are all scrambled and mangled or I see them backwards. I know that you might think that I am just clowning around in your class. I want you to know that I have the utmost respect for you and your classroom. These effects are sometimes very difficult for me to deal with and I just want to shut down and give up (since I am frustrated). It seems as though everyone is saying mean things about me.

I am very sorry if the effects of my illness have made it difficult for you to teach or understand me. However, I would like to take this time to thank you for being great teachers. I know it must be very stressful to deal with us teenagers and the period of life that we are in. Most children living with a mental illness never get the treatment that we so desperately need. We just get labeled as bad, defiant, rebellious and/or disrespectful because our illness goes unrecognized. Most of the time, we are too ashamed or embarrassed to say that we have serious learning problems. We sometimes choose negative behaviors and make bad choices to cover up the fact that we do not learn the same way others do.

We need your help and our parents' help to recognize our cry for help. Our biggest fear is that we will be laughed at or called dumb. Most of the time, we are not even treated for our mental illness until after the age of 18. By that time, we have struggled so much in school or struggled to graduate (if we graduate) and we cannot go any further than drugs, child welfare, jail or death. I choose not to take that path. Therefore, I want to be a part of you learning about my illness. This is an illness that I will have to live with for the rest of my life. My goal is not to use it as a handicap, but to learn how to conquer my negative behaviors, the out-of-place feelings I have, the way I learn, my frustration, and most of all, to clear the voices I hear. I also want to learn good coping skills.

Learning about my illness may help you to understand some of the things I go through. I am taking the time, with the help of my mother, to learn how my brain works. My other goal is to understand my own illness so that I might be able to help other children living with mental illness, but I have a long way to go before I get there.

Please understand I am not trying to disrupt your class. Understand that I need you to help me accomplish my dreams and goals. You are a gift from God to my learning. Know that I want to do well and I need your help and understanding.

Sometimes I get angry that this has happened to me but then I have to accept that it did happen to me. With the support of my mother, my teachers, my church, my doctors and my saxophone, I know I will be okay.

Thank you for your support and compassion and, most of all, for taking the time to read my letter to you. Your understanding will make the path to reaching my goals so much easier.

Thank you,
Savannah T.

# Key Ministry: Welcoming Youth and Their Families at Church

**by Stephen Grcevich, M.D.,** president, Key Ministry and child and adolescent psychiatrist in private practice in Chagrin Falls, Ohio

One challenge churches face in serving families with children living with mental illness is that many families have had negative experiences with churches in the past.

Key Ministry believes it is not okay for youth living with mental illness and their families to face barriers to participation in worship services, educational programming and service opportunities available through local churches.

The church represents an area of American culture in which a lack of understanding of the causes and the needs of families impacted by mental illness pose a significant barrier to full inclusion. A study published recently by investigators at Baylor University examined the relationship between mental illness and family stressors, strengths and faith practices among nearly 5,900 adults in 24 churches representing four Protestant denominations.

The presence of mental illness in a family member has a significant negative impact on both church attendance and the frequency of engagement in spiritual practices. When asked what help the church could offer families, the need for support for mental illness was ranked second out of 47 possibilities by the 27 percent of families surveyed who are impacted by mental illness, but forty-second by unaffected families in the church.[1]

Key Ministry was established to help connect families of children with "hidden disabilities"—significant emotional, behavioral, developmental or neurologic conditions lacking outwardly apparent physical symptoms—with local churches. The hidden disability that poses a barrier to church participation for the vast majority of youth and families we serve is mental illness.

Our team at Key Ministry is seeking to address the fact that families with a child with mental illness are less likely to be active participants in a local church. To help individual churches *pursue* families with children living with mental illness, Key Ministry suggests three general strategies:

- Serve them
- Create welcoming environments for the children, their siblings and their parents
- Include them in the activities vital to the life of the church

One challenge churches face in serving families with children living with mental illness is that many families have had negative experiences with churches in the past. For example, a parent of two boys treated for attention deficit/hyperactivity disorder (ADHD) expressed to me that "people in the church feel they can judge when a disability ends and bad parenting begins." One of the strategies that we have found most effective for churches seeking to reach out to these families in their communities is having regularly scheduled, high-quality respite care available for free.

Through a partnership with Key Ministry, Vineyard Community Church in Cincinnati has launched a website (www.freerespite.com) to provide like-minded churches everywhere access to respite training for staff and volunteers. Networks of churches offering free respite have been developed in the Cleveland-Akron area and in the greater Cincinnati/northern Kentucky area. Networks will be launching in Northwest Pennsylvania and Des Moines, Iowa in the coming months. We are exploring ways of making the initial respite training

[1] Rogers, Edward B., Stanford, Matthew & Garland, Diana R. (2011, May). The effects of mental illness on families within faith communities. *Mental Health, Religion and Culture*. Retrieved from www.tandfonline.com/doi/abs/10.1080/13674676.2011.573474.


available to churches everywhere over the Internet.

One church we serve has developed a model for "relational respite," in which small groups within the church will adopt a family with a child experiencing a significant mental illness or physical disability. Families within the small group take turns in providing home-based respite care and developing relationships that facilitate natural systems of support.

Other churches are reaching out to their communities by providing after-school tutoring for at-risk kids with mental health, behavioral or learning issues in low-income neighborhoods. Key Ministry was recently contacted for assistance by a church that has established an urban ministry campus with a charter school for kids who have fallen three or more grade levels behind their peers in reading achievement scores. We were asked to train volunteers who will serve as parent advocates, ensuring that students receive appropriate Individualized Education Programs and Section 504 accommodations when they are reintegrated into public schools.

In our experience, church leaders often express reluctance in launching programs to serve families of children living with mental illness. They are concerned that the unmet needs of these families are so great that their churches will be overwhelmed by the numbers of new families attending weekend worship events. Key Ministry helps address such concerns by training and equipping children's ministry staff and volunteers to welcome and include children living with mental


illness and their families who want to participate in church activities.

Key Ministry helps pastors, leaders and volunteers problem solve on ways of doing ministry consistent with their church's culture and strengths. We help churches figure out how to minister to an individual family with a child living with mental illness. We also offer help to churches by designing physical environments more friendly to families of children living with mental illness and sensory processing issues. Much of our training programs are developed in response to requests from churches that are trying to respond to a specific need. Last year, we scheduled a special training for churches in Cincinnati after they requested training to better serve kids at risk for aggressive behavior.

We also offer consultation to individual churches through video or phone conferencing to help craft solutions when families of children living with mental illness or other hidden disabilities present unique challenges. Our staff and volunteers regularly offer live observation and consultation at churches in our home areas. No church is too small to benefit from our help. While some churches opt to establish stand-alone programs to serve families impacted by mental illness and other special needs, we are also experienced in helping churches include children and families into existing church programs.

All training, consultation, resources and supports provided by Key Ministry to churches is offered free of charge. Families of children living with mental illness encounter enough obstacles in attending church that the cost of equipping churches to more effectively welcome and serve them should not pose an additional barrier.

Our team is looking forward to hearing from NAMI members and church staff and volunteers interested in doing more to transform churches in their communities into places where families of children living with mental illness will feel welcome. Please check out our website at **www.keyministry.org** and our two official blogs, Church4 EveryChild at **http://drgrcevich.wordpress.com** and Diving for Pearls at **http://katiewetherbee.wordpress.com**. Also, "like" us on Facebook for announcements of future training events.

To learn more about Key Ministry, contact Dr. Stephen Grcevich at drgrcevich@fcbtf.com.

# Fostering Independence in Our Children

**by Dawn Kebert**

I do not believe it. Here I am actually reflecting back on one of the greatest accomplishments of my life. What accomplishment is that, you might ask? Well, it is one that many readers of *Beginnings* have yet to experience: the high school graduation of a child who has battled mental illness. All the years of Individualized Education Programs (IEPs), homework, holiday breaks, beginnings and ends to each new school year, and, let us not forget, those extremely long summers, have finally paid off. Yes, there were definitely times I had to tell myself "this too will pass" and make the choice to not give up on "fighting the good fight." As I watched my son, who was full of fear and anxiety, walk across that stage on his graduation day, I felt a greater sense of pride than I had with his two older brothers. There were not enough words to express the depth of my admiration for him. He had overcome more than most of his peers and *he did it!* How did we do it? What did it take? Well, that is what I want to share with you. Hopefully, some of the mistakes that I made and the lessons that I learned will be helpful to those of you still facing the challenge of helping your child navigate his or her way through the school years.

As I reflect back on everything it took to get my son through school successfully, there is one thing that sticks out from the list of endless tasks. That one thing was the personal conviction and commitment to the belief that I had been *chosen* by God. As a result of His confidence in me, I was given the task of preparing my child for the future goal of transitioning into adulthood. Each and every parent with a child is called to be the guardians of this task whether we believe in ourselves or not. That is why I stated earlier that I made the choice daily to pick up the responsibility of this task and continue to "fight the good fight." In doing so, I had to conscientiously evaluate, and reevaluate, the decisions I made related to my son's care. I knew that everything I did would either work toward building him up for independence or cripple him with dependency on me. No matter how difficult, frustrating and exhausting it might be (and it was), I was committed to continual self-evaluation. The following are just a few of the lessons I learned through my years of trials and errors and the hard knocks of life. The earlier you implement these life management strategies for your child, the easier it is to make them a habit and a way of life for your child.

1. Keep a routine. Consistency with routine helps your child improve responsibility and life management skills.
2. Maintain some sort of schedule even on holiday breaks and summers when school is out. This requires a great deal of discipline and work. However, the attainment of anything of great value (a little sanity and a peaceful home) requires great effort.
3. Encourage purposeful and intentional involvement of your child with the tasks involved in his or her mental health care, including making appointments, picking up medications, calling in re-fills, charting sleep and mood patterns, etc. As parents, it is best to assume the role of facilitator and have your child as the owner of these responsibilities. Taking charge for your child may be easier, but in the long-run, it will hinder your child.
4. Create an environment that encourages your child to speak up and express his or her needs instead of having you speaking for him or her. We need to help nurture the confidence and skills children will need for self-advocacy. This can be very uncomfortable and painful for some of our children, but it is absolutely essential for the successful navigation of middle school and high school and transition into life after school.

The more that we do to minimize our natural inclination to "just take care of things ourselves," the more prepared our children will be when they come face to face with life after high school. Whether our children's transition from high school involves them moving away from home or staying put, they need us to do all we can to help prepare them for what lies ahead. There is a great big world of opportunities waiting for them!

## Bipolar Disorder Brochure


NAMI released a new brochure focused on bipolar disorder across the lifespan. This comprehensive publication serves as a valuable, practical resource for individuals living with bipolar disorder and their families. The brochure includes information on the following topics:

- Symptoms
- Risk factors
- Co-occurring disorders
- Diagnosing bipolar disorder
- Treatment
- What does recovery look like
- Coping strategies
- Friends and family
- Becoming an advocate

This information-rich brochure is available for purchase through the NAMI Store at www.nami.org/store.

# Delivering Parents and Teachers as Allies in Connecticut

**by Paloma Dee,** family and professional education program manager, NAMI Connecticut

We all know that involved school professionals are crucial for student success, especially for children living with a mental illness and those in the process of getting evaluated. We also know that most young people with mental health problems do not get treatment early. In some cases, early intervention is hampered when school professionals are unaware of the early warning signs of mental illness in youth.

This is where NAMI's Parents and Teachers as Allies program comes in. NAMI Connecticut began to offer Parents and Teachers as Allies in 2006. Connecticut was one of the first pilot states for the program. We knew we wanted the program to be a success in our state so one of the first things we did was apply to our State Department of Education for Continuing Education Credits (CEUs) for the program. This helps us to reach out to educators who need to complete a set number of CEUs each year.

Parents and Teachers as Allies is a two-hour, in-service program that focuses on helping school professionals and families within the school community to better understand the early warning signs of mental illness in children and adolescents and how to best intervene so that youth with mental health treatment needs are linked with services. The program also offers insight into the lived experience of mental illness and how schools can best communicate with families about mental health related concerns. Our panel of parents, consumers, school teachers and facilitators exchange and share their personal stories, information and resources in order to help school personnel to better understand the symptoms of an emerging mental illness and how to effectively address mental health. In most instances, we try to schedule presentations during a time when school staff would be at the school anyway (*e.g.*, on an in-service day). While the program is offered for free, we always ask schools if there is a budget for training that can help pay for the program. Often we receive some funding from schools that helps to cover the costs of the program.

My hope is that after taking the in-service program, school professionals will bring a special perspective to students and their families to help them understand and find support for mental health services. I hope that school professionals learn skills on how to collaborate with parents and providers to fight against stigma, better understand early intervention and guide children and adolescents to a better future. I also hope educators can help reduce myths and misconceptions about mental illness in their local communities and to improve school settings for children living with mental illness.

Along with the Parents and Teachers as Allies program and monograph, we bring resources to each school that we visit. We use the opportunity to share information on other NAMI Connecticut programs for parents and caregivers as well as our support group network. Many teachers have come up after the presentation requesting information on programs and services to offer to parents. They are eager to learn about what we have to offer.

I have learned over the years that many times the tensions or misunderstandings between parents and teachers can be greatly minimized when information and tools to effectively address mental illness are available to school professionals and parents. When school professionals and parents learn to work together to promote wellness and recovery, miracles can happen and we can find a system of care that really works for our youth and families in the classroom and in the community.

To learn more about NAMI Connecticut's Parents and Teachers as Allies program, contact Paloma Dee at familyeducation@namict.org.

## The National Parent Helpline

The National Parent Helpline provides support and assistance in English and Spanish to parents and caregivers. The helpline is not specifically designed for parents and caregivers of children living with mental illness. Rather, it is for parents and caregivers who are seeking advice or guidance on parenting. NAMI State Organizations and NAMI Affiliates may wish to reach out to The National Parent Helpline to share information about the important work that they do and to offer resources and information on mental health related topics.


For more information about The National Parent Helpline, visit their website at www.nationalparenthelpline.org.

# Providing Peer Support to Students Impacted by Mental Illness

**by Christi Farmer,** director of programs for young families, NAMI Lake County, Ohio

In November 2010, Christie Brubaker, a social worker for Mentor High School, contacted NAMI Lake County seeking resources and information for a student who was struggling with school and mental health related issues. During our conversation, Christie shared her thoughts on how we can make a positive difference in the lives of her students living with mental illness. As we spoke, the idea of a NAMI Lake County/Mentor High School collaboration to provide ongoing support for students affected by mental illness began to take shape.

That initial conversation led to a unique relationship between NAMI Lake County and Ohio's eighth-largest high school, Mentor High, which has a student population of approximately 3,000. We decided to develop a support group for students impacted by mental illness. Christie and I were the perfect team from the beginning. I am a parent of a child living with attention deficit/hyperactivity disorder, a NAMI Lake County staff person, a parent advocate and a facilitator for various NAMI Lake County support groups and education programs. Christie loves working with teens and is well-respected by Mentor High administration and students. Christie was confident she could gain the support of the administration. Between the two of us, we knew we could successfully share our vision and develop a plan to support students impacted by mental illness. We shared this vision with Joe Spiccia, Mentor High principal, and Carole Jazbec, NAMI Lake County director, and both immediately gave us the go-ahead.

Plans began to take shape quickly. Our first step was to arrange NAMI Support Group Facilitator training for Christie. Second, we determined the focus, purpose, goals and guidelines of the group. This was followed by choosing a name, developing a student referral process and making a plan to gain parental buy-in. Christie worked with administration to secure permission for the group to be held during school time. Structuring the group was easy since we used the NAMI Support Group model. We decided to call the group E!, which stands for empowerment.

To get started, Christie emailed teachers and guidance staff explaining the program and inviting referrals. As referrals came in, we interviewed each student in order to explain the purpose, goals and guidelines of E! and introduce NAMI's Principles of Support and Group Guidelines.

After a student is admitted, he or she is given a Parent Permission Packet bearing both Mentor High and NAMI Lake County logos. The letter states that the child was referred to E! and contains the purpose, goals and guidelines of the program, including a copy of NAMI's Principles of Support and Group Guidelines. Before any student participates in E!, we must have a signed authorization from his or her parent or guardian.

E! is designed to allow students to normalize their feelings and day-to-day experiences. At the same time, they are learning healthy, effective coping skills to use when addressing stressors that oftentimes trigger relapse. We have found that students participating in the support group are surprisingly open about the impact of mental illness on their day-to-day lives.

We learned that while facilitating a student support group, emotionally charged "hot potato" issues arise that cannot be resolved in a 48-minute class period. It is necessary to set aside time immediately after the group for students whose emotions or issues are more complex. There are instances when we see a need to question something further or sense that there may be more going on than meets the eye. It is critical to make time for follow-up immediately afterwards. There have been times when serious topics arise and parents and appropriate authorities had to be contacted.

Having a co-facilitator for this type of group is crucial. Christie and I regularly use nonverbal communication throughout the group. We have learned to read each other well and pick up on each other's concerns. It is helpful to have two sets of ears to ensure the accuracy of what is being discussed since reports to Children's Services may be part of a follow up to this type of support group. The school social worker will typically be the lead reporter but the co-facilitator's input is often needed.

E! has proven to be a huge success at Mentor High. Students have given us very positive feedback. Comments like, "It is helpful to know there are other people in the hallway who understand what I am going through," "I do not have to pretend with them," "You should publicize this more," and "There are probably a lot more students who have a mental illness who could use this group" have been shared with us. Students faithfully ask if we are having "group" this week. Students are now self-referring to the group and a senior student came back during his early dismissal for a senior project to attend the last meeting of the school year.

To learn more about NAMI Lake County's E! program, contact Christi Farmer, at cfarmer@nami.org, or Christie Brubaker at (440) 255-5817.


# *Lost at School: Why Our Kids with Behavioral Challenges Are Falling Through the Cracks and How We Can Help Them*

**by Ross W. Greene, Ph.D.**

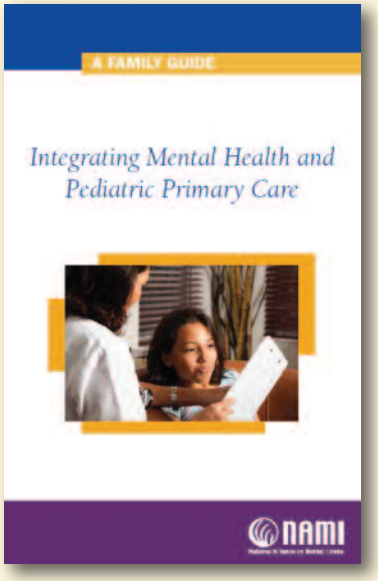
**List Price:** $25
**Hard Cover:** 303 pages (2008)
**Publisher:** Scribner

Any parent of a child who acts out at school will find answers and relief in the eye-opening book, *Lost at School: Why Our Kids with Behavioral Challenges Are Falling Through the Cracks and How We Can Help Them,* by Ross W. Greene, Ph.D. In the book, Dr. Greene explains that most kids who misbehave at school want to do well, but get into trouble because they lack the skills, such as managing emotional responses or expressing their concerns, necessary to respond to challenging situations in appropriate ways. Detentions and trips to the principal's office, according to Dr. Greene, do not improve problem behaviors because these punishments do not teach students the skills they need to improve their behaviors.

Dr. Greene's book will be a game-changer for any parent or educator who has been struggling to address a child's challenging behavior. The book provides valuable information about an approach for effectively addressing challenging behaviors called Collaborative Problem Solving (CPS). CPS is a proactive approach to working with children in identifying skill deficits, triggering situations and alternative methods to manage stressful situations. This collaborative approach allows children to express their concerns and to suggest behavior plans they find helpful and realistic. It also helps teachers and parents understand what they can do differently to facilitate skill development and to reduce stressful situations. The book guides students and adults through developing a response plan that can be put into place to prevent challenging behaviors and to avoid triggering events that cause these behaviors.

The book also includes frequently asked questions, a narrative story of how CPS might look in real life and skill evaluation and collaborative problem solving plan worksheets so parents, teachers and students can develop their own CPS plan together and put it into action. The book is a great tool for understanding and addressing challenging behaviors. It is a groundbreaking contribution to child behavior literature and provides a voice for thousands of misunderstood children with challenging behaviors and their parents and all those struggling to help them.

## A Family Guide: Integrating Mental Health and Pediatric Primary Care




NAMI has developed a new family guide, *Integrating Mental Health and Pediatric Primary Care*, to provide families with practical information on how to become more involved in the integrated care movement to improve the quality of care that their child receives.

Integrated care refers to the practice of incorporating mental health care into primary care settings and primary care into mental health care settings for the purpose of improving the quality of care. Interest in integrated care is growing and many communities have begun to pilot innovative approaches to integrated care that promise to provide higher quality, comprehensive and coordinated care for youth and their families. It is important that youth and families are part of these community efforts.

Integrated care presents youth and families with opportunities to actively participate with both primary care and mental health providers in the integration of their care. This guide informs families about what integrated care means, the benefits of integrated care, what it looks like in practice, how it impacts youth and families and what they can do to become involved in the integrated care movement.

To access the family guide, visit www.nami.org/primarycare.

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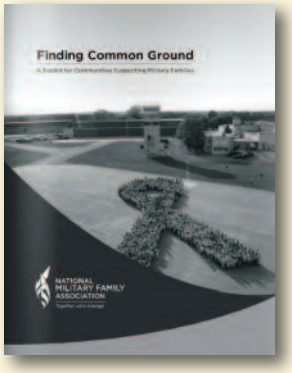
## Finding Common Ground: A Toolkit for Communities Supporting Military Families




The National Military Family Association (NMFA) has published a comprehensive community toolkit that was developed by leading experts in the fields of military family support, childhood development, women's issues and behavioral health. *Finding Common Ground: A Toolkit for Communities Supporting Military Families* includes recommendations on action items and useful resources for community organizations, including schools, to use in supporting military families.

To access the community toolkit, visit **www.militaryfamily.org/publications/community-toolkit**.