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National Alliance on Mental Illness

Beginnings

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

**Goldie Hawn
Joins NAMI
in Standing
Up for
Children's
Mental
Health**

**Crisis
Intervention
and
School
Resource
Officers**



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Capitol Hill Watch

by **Darcy Gruttadaro, J.D.**, Director, NAMI Child & Adolescent Action Center

Goldie Hawn Joins NAMI in Standing Up for Children's Mental Health

NAMI played a key role in organizing a legislative briefing on May 7th on Capitol Hill in honor of National Children's Mental Health Awareness Day.

The theme for this year's briefing was *Investing in the Educational Future of Youth with Mental Health Needs*. The presentations focused on raising awareness about school and community-based programs that effectively promote positive youth development, increase resiliency and support recovery, and demonstrate how youth with mental health treatment needs can thrive in their school and communities.

Goldie Hawn, Academy-Award Winning Actress and Children's Mental Health Advocate, brought her star power to this year's briefing. Her celebrity status and commitment to children led to a standing-room only crowd and strong attendance by Congressional members and staff.

Ms. Hawn spoke during the briefing about the critical need for schools to better address the needs of students with mental illness and how school-based programs can effectively benefit the health and well-being of all students.

She was followed by Kathryn Power, Director of the Center for Mental Health Services (CMHS). Ms. Power shared newly released data from systems of care grant sites around the country. The data show that about 65% of youth in systems of care grant sites received some mental health services in school. These youth achieved many positive outcomes as a result of those services including improved access to mental health services, improved school attendance and performance, reduced drop-out rates, reduced rates of students changing schools, and more.



Goldie Hawn, Founder of The Hawn Foundation, Academy Award Winning Actress, and Children's Mental Health Advocate

The final speaker was Howard Muscott, Ed.D., Director of the New Hampshire Center for Effective Behavioral Interventions and Supports. Dr. Muscott talked about the importance of investing in positive behavior supports (PBS) and the positive outcomes they have achieved in New Hampshire through this program. In New Hampshire, they continue to develop strong links between schools and the community mental health system. This is essential so that schools can refer students that require more intensive mental health services that go beyond the expertise of school-based mental health professionals.

After the briefing, Goldie Hawn joined NAMI and other advocacy groups for a "meet and greet" with Congressional mental health champions. She shared information with Congressional members and staff about an education program developed by The Hawn Foundation for grades K-7 that helps students develop key, practical skills to address their

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The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country that engage in advocacy, research, support, and education. Members of NAMI are families, friends, and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

NAMI Web site: www.nami.org
NAMI HelpLine: 1.800.950.6264


emotional, mental, and social well-being (learn more about this program at www.thehawnfoundation.org).

The briefing was a tremendous success. To learn more about it, visit the Child & Adolescent Action Center on NAMI's Web site at www.nami.org/caac. Mark your calendars for next year's National Children's Mental Health Awareness Day on May 6, 2010. Stay tuned for more details!

Shifting gears to health care reform, Congressional leaders are working on legislation to reform our nation's health care system. They are moving toward universal coverage. This critical national debate involves drafting complex legislation that is expected to move forward in separate House and Senate Committees this summer and possibly to the White House this coming fall.

NAMI supports the overarching goals articulated by President Obama and congressional leaders on the following issues:

- Universal health care coverage;
- Health care cost containment;
- Health care quality improvement; and
- Protecting existing coverage for those who have it.

Beyond these principles, NAMI is also supporting a range of priorities to address the needs of children and adults living with mental illness. As part of this process, NAMI has submitted detailed recommendations to Congress and is supporting a range of discreet legislative proposals that are expected to be a part of the debate in Congress. You can review NAMI's agenda for health reform, including principles for health reform, federal legislation that NAMI is supporting, and related information on our Web site at www.nami.org (click on *Inform Yourself About Public Policy*, and *Current Policy News and Alerts*). Stay tuned for frequent updates on developments related to health care reform! 

Back to the Chalkboard: Redefining the Role of Schools in Children's Mental Health

by Knute Rotto, CEO, Choices, Inc.

Schools are charged with the difficult task of educating a breadth of students with diverse needs and learning styles. This is especially difficult in the current economic times when school funding is being cut, educational staff are being downsized, and classes are getting larger. Schools are having much more difficulty meeting the needs of all students.

Schools struggle with providing effective educational opportunities for students with mental health treatment needs even under ideal circumstances. In Washington, D.C., lawsuits have led to schools being required to ensure that students with mental health treatment needs are provided with the services they need to remain in school and achieve academic progress.

The national reform efforts on improving the delivery of mental health services to youth that began in the 1980s, recognized schools as a natural entry point for addressing the mental health of students. Schools, recognizing the importance of sound mental health as an essential support for academic success, often led the charge for school-based mental health programs as part of broader school reform efforts.

Much of the recent research on the mental health status of children and youth points to public schools as the

major providers of mental health services for school-aged children. *School Mental Health Services in the United States, 2002–2003*, the first national survey of school mental health services, documents that schools are responding to the mental health treatment needs of their students; however, it also highlights the increasing need for mental health services and the multiple challenges

Schools struggle with providing effective educational opportunities for students with mental health treatment needs even under ideal circumstances.

schools face in addressing this need. For example, virtually all schools reported having at least one staff member whose responsibilities include providing mental health services to students, however that staff member is typically a guidance counselor, psychologist, or social

2008 IPS Dawn Referral Annual Report Outcomes

Outcome Measure	Percent
Girls with ADHD Emotional needs addressed at discharge	100
Behavioral needs addressed at discharge	75.6
Youth who did not engage in delinquent behaviors or exhibit behaviors that place others at risk for harm	100

worker with multiple obligations and too often little training or experience in providing mental health services.

In Indiana, Indianapolis Public Schools (IPS) intentionally reaches out to local community mental health centers (CMHC) to invite them into the schools to provide services. IPS provides welcoming atmospheres for community mental health professionals and space for therapists and case managers. Treatment is funded primarily through the child's insurance, most often Medicaid. CMHC staff work closely with school staff, especially school social workers and school nurses, to ensure that children's primary health care and other needs are met.

However, IPS found that even these efforts were not effective for a relatively small subset of children. One-on-one support was necessary to keep many of these children in school, so IPS employed full-time school aides but found that increasingly more of these children were placed in expensive, restrictive settings. In mid-2002, a partnership developed between IPS and Choices, Inc., which helped to change the story in these children's lives. Choices, Inc. operates the Dawn Project, an Indianapolis-based system of care initiative that was developed with a Center for Mental Health Services (CMHS) systems of care grant (to learn more about these grants, visit www.systemsofcare.samhsa.gov). A community-based system of care includes a wide range of mental health and related services and supports that are coordinated to meet the needs of children and families. It is designed to help children and adolescents with

mental illness, with the active participation of their families, get the services they need without being placed out of their home and community.

The Dawn Project has served 216 IPS referred children. The success of this collaboration is attributed in large part to the strong commitment from the school district to provide treatment and support for children in their homes and schools instead of more restrictive settings and their willingness to invite community partners into the schools to make this happen.

In 2003, Choices, Inc., PASSWORD Community Mentoring, a community-based program that links professionally trained mentors with youth who are in crisis, and IPS worked together to develop a school-based system of care model. This model, titled the *Full-Purpose Partnership* (FPP), was piloted in three IPS elementary schools in 2003. By 2008, FPP had expanded to 12 elementary schools. FPP schools do the following:

1. Intentionally merge home, school, and community to create the conditions necessary for academic and behavioral success for all students.
2. Serve the strengths and needs of all students, while enhancing individualized support options for students in need and their families.
3. Provide full access to necessary resources and supports for all students and their families.
4. Provide opportunities for success through individualized and coordinated combinations of resources and supports that are not driven solely by predetermined entry criteria.


“The primary difference between customary schools and a FPP school is that we have really worked toward inclusion of all students,” said Themise Cruz, a parent of two students attending a FPP school. “Our principal has provided a sense of openness and safety that brings together parents and teachers.”

Dr. Jeffrey Anderson of Indiana University and principal investigator for the external evaluation of FPP, has shared that the research clearly shows that when parents and teachers are better connected, student outcomes improve, “preliminary evaluation of the school-based system of care model shows that parents and teachers are satisfied and feel more connected to each other.”

The primary goal of FPP is to build and sustain a home-school collaborative culture that focuses on preventing and quickly intervening when emotional and behavioral difficulties develop for children, while at the same time, promoting safe and nurturing learning environments for all children.

Stephanie Ropa, IPS Coordinator for FPP and Elementary Educationally Handicapped Programs, notes that FPP schools have experienced “a huge reduction in the number of students who are on a reduced school day.” She also notes that “there has been an increase in the number of students who are able to be in the general classroom who were previously in a self-contained setting.”

Working together, schools and the community mental health system can redefine the role of schools in children's mental health. Welcoming mental health providers into the schools and partnering with the local system of care that brings families, family advocates, and natural supports to the table is how one community is accomplishing the ultimate goal—keeping kids at home, in school, and out of trouble.

For more information about Choices, Inc., contact Knute Rotto at 1 (317) 205-8202 or KRotto@choicesteam.org. 

Crisis Intervention and School Resource Officers

by **Sergeant Jon R. VanZandt**, Adams County Sheriff's Office, Colorado

School Resource Officers (SROs)¹ are faced with the challenge of wearing many different hats. The typical SRO will spend his or her day addressing a multitude of school issues. In many cases, the SRO must tread the fine line of being a law enforcement professional while also being a school staff member.

In 1992, I was placed in the school setting as an SRO. This was not a highly sought after assignment at that time. I was already involved with teaching kids anti-drug and anti-gang programs so it was suggested that I would be a "perfect fit." My first thought was sheer terror! Here I was a street cop being placed into middle schools to be surrounded by 1,800 middle school students all day long. At the time I thought this was the end of my career in law enforcement. After all, no self respecting cop wants to be referred to as a "kiddie cop." I never thought that I would last in the assignment, let alone find that it is truly the most rewarding job in law enforcement.

Being assigned to the school setting is not what most cops sign up to do. I thought that this assignment would involve teaching a few classes, helping kids through some rough times, and perhaps having the opportunity to make a difference in the life of a child. Never in my wildest dreams did I imagine that this assignment would be as challenging as it became. Working within the school setting and trying to balance the needs of the law enforcement community and the school were not the only challenges I faced. My agency was new to the SRO assignment so I had to pave my own path. In doing so, I quickly learned that school principals were in charge and I was there to assist



Sergeant Jon R. VanZandt

them in making their school the safest place possible.

When I first started out, I had no formal training. I strongly encourage that all SROs receive formal training. I was faced with new laws and procedures, school protocols, and unique problems associated with the school setting. Most cops never have to deal with state education laws, special education laws, or the multitude of mental health issues that our schools are dealing with each and every day. Normally, when a cop is called to a school, it is for a criminal report. You take the report, make the arrest, and leave. You do not have to deal with the aftereffects of the incident until your next court appearance. The circumstances are entirely different for SROs. They have to deal with problems from start to finish.

The first true test for the SRO is the counseling. Most SROs are not professionally trained mental health profes-

sionals. Yet, unfortunately, many SROs face mental health issues within their first few days in the school. Whether it is a relationship problem, a criminal matter, or a student that needs to be put back on the right path, the SRO must address it. The frightening part is knowing how to address this effectively. Fortunately, I was surrounded by some of the best school administrators in the area. I quickly learned that in order to help the students, I needed to find the necessary training in the areas of school-based policing, mental health, and school laws.

As new SROs develop their own style, many face the never-ending problems associated with students with mental illness. Schools are faced with many issues associated with young people who are truly suffering and not receiving the proper care. In some cases, this is because students do not know where to go, in others it is because their parents are in denial. The common denominator seems to be that parents are both frightened and fed up with their child's actions. These students often cause a great deal of disruption in school and in their homes. In many cases, these disruptions result in a call to the local law enforcement agency for assistance. One thing is clear, law enforcement officers need to be educated in how to address the needs of these young people.

Several years ago, I attended a *Crisis Intervention Team* (CIT) training class. The CIT program is a dynamic collaboration of law enforcement and community organizations committed to ensuring that individuals with mental health treatment needs are referred to appropriate services and supports rather than thrust into the criminal justice system. CIT has several essential components,

¹SROs are law enforcement officers employed by law enforcement agencies to collaborate with school and community organizations. Some SROs are directly employed by schools.

including: training to help law enforcement better understand and address individuals experiencing a psychiatric crisis; collaboration between law enforcement and community systems to create effective linkages with mental health services instead of arrest and incarceration; and inclusion of people with mental illness and their families at every level of the program. CIT originally focused on adults but has

expanded to better meet the needs of youth experiencing a psychiatric crisis in the school or community setting.

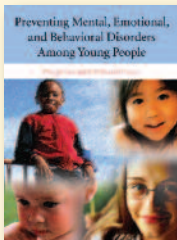
CIT training was one of the most challenging classes I have ever taken. It is also easily adaptable to the school setting. Ms. Keri Fitzpatrick, Colorado CIT Manager, Mrs. Heather Cameron, and Commander Joe Cassa, Wheat Ridge Police Department, were instrumental in combining veteran SROs

with the CIT staff to build a program designed for law enforcement officers working in schools. After a year of planning, *Children in Crisis* (CIC) was formed. This 24-hour training program takes officers who have already taken the 40-hour CIT training class, through a program that addresses the mental health needs of children and adolescents. Officers who have gone through this training have commented that it has given them a better understanding of how to help these young people and their families. It is essential that SROs be trained in the CIT and CIC programs because of their constant interactions with young people struggling with mental illness.

Training officers in the CIT and CIC programs is the easy part. The more challenging part comes when these officers need to help schools address the needs of students with mental health issues. Many schools without SROs have had less than positive results from officers coming into their schools and being asked to deal with a child in crisis. This is extremely difficult because the officer does not have the history, background, school interactions, or daily contact with students. SROs can often better address the needs of students because they know them better from seeing them on a regular basis.

Implementing the CIC philosophy in the school setting is not always easy. It takes a positive relationship with school administrators and mental health professionals in the community. In my case, this was a pleasant experience. Our local county mental health center is staffed by a person who is committed to the CIT program and to providing constant assistance to law enforcement professionals trying to help those in need of mental health services. I would be remiss in this article if I did not mention Mrs. Mary Ann Hewicker. She has been instrumental in assisting Adams County law enforcement officers with their CIT and CIC training. I can only imagine how much assistance law enforcement officers across the United States could give people with mental health needs if

Institute of Medicine Releases Report on Preventing Mental, Emotional, and Behavioral Disorders Among Young People




The Institute of Medicine (IOM) recently released a report titled *Preventing Mental, Emotional, and Behavioral Disorders Among*

Young People: Progress and Possibilities. The report discusses the research base on the potential lifetime benefits of preventing mental, emotional, and behavioral disorders in youth. It also shares information about early promotion and prevention interventions and programs that can be effective in delaying or preventing the onset of mental, emotional, and behavioral disorders.

The report calls for the implementation of the best available evidence-

based interventions with at risk youth before the onset of a mental illness and also calls for the promotion of positive mental, emotional, and behavioral development for all children, youth, and young adults.


Mental health problems affect large numbers of young people. Almost one in five young people have one or more mental health disorders at any given time. Among adults, half of all mental, emotional, and behavioral disorders have onset by age 14.

To learn more about the IOM report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, visit www.iom.edu (click on *Mental Health*). 

U.S. Preventive Services Task Force Recommends Depression Screening for Adolescents

The U.S. Preventive Services Task Force (USPSTF) recently released recommendations urging physicians across the United States to perform routine depression screenings for adolescents between the ages of 12 and 18 when appropriate services are in place to ensure accurate diagnosis, treatment, and follow-up care. The panel also recommended not limiting screening to high risk groups because youth struggling in silence would be missed. The task force is an extremely

influential independent panel of experts convened by the federal government to establish guidelines for treatment in primary care.

The task force indicated that screening, when followed by treatment, including psychotherapy, can help improve symptoms and help youth cope. Undiagnosed depression can lead to persistent sadness, social isolation, academic problems, and suicide. 


they had someone like Mary Ann to assist them!

Once officers are trained in the CIT and CIC programs, the next step is to get schools to commit to program use. SROs are constantly working on ways to improve their relationship with school administrators. The school administrator in the school district I was assigned to was quick to accept the benefits of the CIT and CIC programs. Any responsible school administrator should welcome assistance with students in crisis. After all, the SRO philosophy is based on the triad system; teacher, counselor, and cop. The cop part is easy for SROs. The teacher part takes a little more time, and the counselor part is a constant learning process that takes a great deal of time and patience to develop.

Once school administrators in my school district observed how well we could assist students in crisis, the demand for our services increased. Parents began to reach out to us for assistance. We were able to refer them to local resources and more importantly, assist the student, school, and family with the continued support that they so desperately needed. Without the CIT and CIC programs, this would not have happened.

SROs need training in many areas. The National Association of School Resource Officers (NASRO) offers some of the best SRO training in the world. CIT and CIC programs should be a requirement for any law enforcement agency that has officers assigned to the schools. After all, what more important service can we give to our citizens?

To learn more about CIT and CIC training for SROs, please contact Sergeant Jon VanZandt at 1 (720) 322-1115 or at jvanzandt@co.adams.co.us.

Editor's Note: Sergeant Jon R. VanZandt is a 22-year veteran of the Adams County Sheriff's Office in Colorado. He is a veteran instructor for NASRO and instructs SRO classes across the United States. He is the CIT Coordinator and the SWAT Hostage Negotiation Team Leader for the Sheriff's Office. 

ADHD Medication Treatment Associated with Higher Academic Performance in Elementary School

Children with Attention Deficit/ Hyperactivity Disorder (ADHD) who take medication to treat the condition tend to do better in math and reading compared to their peers who also have ADHD but do not take medication, according to data from a national survey. The study, funded by the National Institute of Mental Health (NIMH), was recently published in the May 2009 issue of *Pediatrics*.

Background

ADHD, which is characterized by poor concentration, distractibility, hyperactivity, impulsivity, and other symptoms, can adversely affect a child's academic performance. Compared to their peers without the disorder, children with ADHD tend to have lower grades, lower math and reading scores, and are more likely to repeat a year or drop out of school.

Richard Scheffler, Ph.D., University of California Berkeley, and colleagues analyzed a sample of 594 children diagnosed with ADHD who were part of the nationally representative Early Childhood Longitudinal Study—Kindergarten Class of 1998 to 1999, a U.S. Department of Education survey. The children were surveyed for various issues five times between kindergarten and fifth grade. The researchers focused on the children's math and reading scores to determine if medication use for ADHD was associated with academic achievement during elementary school.

Results of the Study

The study found that students with ADHD who took medication had math scores that were on average 2.9 points higher and reading scores on average 5.4 points higher than their un-medicated peers with ADHD. This equated to gains that were equivalent to the progress typically made in one-fifth of a

school year in math, and one-third of a school year in reading. Improvements in reading, however, were seen only in students who had been taking medication for at least two rounds of the survey. The authors suggest that the different findings between math and reading scores may point to underlying differences in the process of learning.

Significance


The findings echo previous studies that have found that use of ADHD medication can improve children's attention and memory skills, which can help them do better in school. In addition, the improvement is notable because early academic success often predicts later school progress, said the researchers. However, they caution that the gains are not enough to eliminate the achievement gap typically seen between children with ADHD and those without the disorder.

What is Next

The findings support the need for long-term studies designed to better understand the relationship between medication use and academic achievement in children with ADHD. The authors also conclude by noting that more research is needed on combining medication with behavioral interventions to improve the school performance of children with ADHD.

Editor's Note: This article is reprinted from the National Institute of Mental Health Web site accessed at www.nimh.nih.gov.

Reference

Scheffler RM, Brown TT, Fulton BD, Hinshaw SP, Levine P, Stone S. Positive association between attention deficit/hyperactivity disorder medication use and academic achievement during elementary school. *Pediatrics*. 2009 May. 123(5): 1273-1279. 

Our Journey

by Angie Thiel, Parent, Nebraska

Alex is a wonderfully witty and caring teenage boy who lives life every day with a mental illness.

As early as 18 months, I noticed some behavioral troubles with Alex. His meltdowns were not tantrums and a timeout was impossible for him to grasp. As his mom, his only advocate, I was fortunate because our community had early intervention services for Alex. Call it mother's intuition, but I knew we needed those services and fast.

He began *Head Start* at age three. The program provided Alex with a structured setting where he would not be kicked out because of his behavior. The program was staffed so that he got one-on-one assistance. However, even with that, his behaviors were uncontrollable. Alex would physically manifest his rage by hitting, biting, running, cussing, and causing pure chaos in his classes. At age five, before kindergarten, I tried in vain to get him qualified for special education. Unfortunately, our school system did not believe his testing and psychological observations warranted accommodations. And that is when Alex's involvement with the juvenile justice system began.

Each day Alex shared his desire to go to school and be "normal." That "normal" phrase made my stomach turn because it was such a challenge for him. After a brief honeymoon period in the beginning of each school term, he would become uncontrollable, aggressive, and violent. He was suspended numerous times beginning in kindergarten. My parental frustrations were not only over my fear and desire to get him services he needed, but that the learned behaviors of being sent home became another hurdle for us to overcome. When school sent him home, he went to his Grandma's house. He was not comfortable in school and going to Grandma's house was a safe zone. In retrospect, the funny part is that I too often wished that I could go to Grandma's house because it was a



Angie Thiel and Alex

place to cuddle up and be shielded from the pain.

As his years in school progressed, Alex became much more acquainted with the local police department. It was not that the school overly relied on them, but even with all the training the school staff had and continued to try to use with Alex, he was sometimes still overpowering, assaultive, and harmful to himself and others. Most times our interactions with law enforcement involved trying to calm Alex down and assess the situation. The police department proved to be supportive at critical and high stress times.

As Alex got older, and his behaviors crossed the line into punishable crimes, I began to feel like I was losing control. Fortunately, I got support for our family through NAMI education programs. These programs allowed me to learn more about mental illness and to talk with other families impacted by mental illness. All the while though there was still this looming fear of the juvenile justice system.

Our most serious interaction with law enforcement came in September 2008. By this time Alex was 12 years old and bigger than I was. He had started 7th grade on a positive note. On one crisp Tuesday morning, we said our goodbyes and I love yous as I left for work and he left for school. The school called about an hour after I got to work and said I needed to get there as soon as possible. I was out the door. When I

arrived at school, Alex was standing outside the building with three school staff and a police officer. He was manic, belligerent, and handcuffed. Alex was charged with disturbing the peace during a wild hour of behaviors that included running off campus, destroying property, and assaulting others. The officer told me his charges and that the department would not allow an officer to transport him to juvenile hall, an acute psychiatric hospital, or even to our home. It was my responsibility. At that point, she walked him to my car, placed him in my front seat, removed the handcuffs, and shut the door. Alex continued to assault me that day, which allowed me to call law enforcement to our home and they transported him to a local mental health center for medical observation. It was the 26th time we had been there in his short 12 years of life.

That day in September 2008 led to some positive changes. Our local Chief of Police implemented a new rule within the department that if this happened again at the local schools, then law enforcement officers should call an ambulance to transport the student. Clearly, this is far better for our kids than either being transported in a patrol car or by parents while the crisis is ongoing. A mental health crisis should be treated like an asthma attack, seizure, or heart attack, with medical care rather than a ride in a police car.

I have fought hard and loud to get Alex the help he needs. Because of this advocacy, he is getting the medical, social, educational, and family therapies he needs to do well. He is living life without a judge, court system, or criminal charges. The charges filed against Alex were dismissed because the county attorney took time to understand his diagnoses, treatment plan, and level of care. It is wonderful that Alex was given a second chance. We are on this journey together as a family. His actions that day in September, and at other times in his life, were wrong and he needed help. However, without criminal charges and court involvement, he has a much more promising future. **B**

A New Beginning for Kenny

by **Tricia Baker**, Kenny's Mom, New Jersey

Kenneth Silas Baker, my son, was sweet, funny and loved by all. Adults always commented to me that he was such a polite and kind teen. He got along so well with his younger sister, Katelyn, that I used to brag to my friends about how my children rarely argued. There was no one who did not like Kenny Baker.

It was a train that ended Kenny's life early Tuesday morning, May 19, 2009, but what really killed him was his illness. It was debilitating and, for him, as fatal as an illness like cancer or heart disease.

Kenny could always make others laugh despite the deep sadness within him. A good friend of his stated, "...being around him always meant a fun time. He was bound to do something spontaneous and silly that brightened my day. He was the life of the party, and lit up the room with his smiles."

At the age of 15, Kenny's world began to crumble. He was hospitalized for the first time with depression, later he was diagnosed with anxiety and depression. From that time on, his life was a continuous struggle.

If he had been diagnosed with cancer or heart disease, there would have been an outpouring of support from the community. Instead, the stigma attached to mental illness forced Kenny to hide his illness from the world. As his mom, I could not be forthcoming as we privately struggled to get him the medical help he needed.

And how we did struggle. In my mind, I cannot help but run through the "what ifs," the "should haves," and the "might have beens." There is a sense that the "system" failed my son.

After a hospitalization in 2006, Kenny was recommended to the Value Options Care Management Organization (CMO), the highest level of care offered by the county. However, due to lack of funding, he was passed

down to the lower level of care, and within a few months, his case was closed and we were left on our own. By the time his condition was critical, he finally came under the care of the CMO; however, because he had turned 18 years of age, there were absolutely no programs for someone his age.

The case manager sat in my living room, only a week before Kenny's death and shrugged her shoulders. She could offer no help for our case. She shared with me, "if only Kenny had come to the CMO sooner, we could have helped him."

*Kenny could always
make others laugh
despite the deep
sadness within him.*

The public high school continually let Kenny down. It is shocking how professional educators, within one of the best school systems in the state, have little understanding of and sensitivity toward those suffering from mental illness. It was easier for the school to label Kenny as lazy, and me as a "helicopter mom," than to recognize his illness. The final irony is that the public high school principal wanted to cover over pictures of Kenny in the yearbook with stickers. While the principal said that he would do this only out of concern for us, as his parents, we believe that he wanted to erase all memories of Kenny because of how he died. The stickers would erase not only Kenny, but the reminder that mental illness is everywhere, even in



Kenny Baker

his Blue Ribbon high school.

Kenny was my son, my inspiration, and my teacher. For the last three years, I watched him suffer from day-to-day, and admired him for his strength. Even though I cannot fully comprehend the emotional and physical pain he experienced daily, I got glimpses of how much it truly hurt and how he stayed as

long as he could because he knew he was loved. His strength is now my inspiration giving me strength to go on. Kenny reminded me that life is fleeting, a gift given to us just for a short time. Kenny also taught me not to be quick to judge others, because we never know the path they walk on.

I believe that Kenny's passing has already had a positive impact on lives left behind. I heard the high school, so closed-minded to Kenny's situation, helped bring a struggling teen to the hospital the week after Kenny's death. A good friend's child who has been hospitalized several times in the past two months shared, "how many lives Kenny's death has affected has taught me to see how many people care for me, it has influenced me to get better."

We hope that sharing Kenny's story and being open about his struggles, will bring about acceptance and the elimination of stigma. Mental illness is an illness. A disease that needs a cure. It is not to be ignored or spoken of in hushed tones.

I believe that Kenny is finally at peace, happy, and living in God's care. He loved his family so much that he dealt with unbearable pain and stayed with us for as long as he could. Kenny's time on earth was too short, but he cast a bright, beautiful light that touched so many lives. Everybody loved Kenny and we will love him forever. **FB**



Kenny and Katelyn Baker

My Beloved

by Katelyn Baker, Age 15

*My soul longs to be near you,
It is something I can not fight,
but no matter how far I climb
No matter how many times I cry,
You are still just out of reach.
Your presence gives me strength,
in the weakest of times.
Just please come out tonight,
And all my pain will leave me,
Forever.
My beloved brother moon.*

Comfort

by Anna LeProvost, Age 17

*Everything was scattered
nothing was clear
and there was a
never ending darkness.*

*Out of nowhere
light cascaded in
from every which way.
At first it was blinding.
It seemed almost to hurt.
It became the warmth,
the comfort that was never there.
Slowly becoming more
and more
accustomed to it.*

*A love that comes
once a lifetime.
The support of a soulmate
the comfort of a partner
always by your side.*



Kenny Baker and Anna LeProvost

I'll Never Understand

by Pamela Goldberg, Age 16

*I will never understand why
No matter how hard I try
It hurts me so
To see you go*

*I can not believe that you have moved on
But I know that you have gone
Up to a better place
Although it is hard to face*

*I realize that you could not stay
That is why G-d took you away
You are now an angel way up in the sky
But in our hearts you will always be nigh*

Rest in peace, Kenneth Baker. You are greatly missed. We love you.



Pamela Goldberg

Editor's Note: On May 19, 2009, Kenny Baker lost his life to suicide. NAMI greatly appreciates the poems shared by Katelyn Baker (Kenny's sister), Pamela Goldberg (Kenny's friend), and Anna LeProvost (Kenny's girlfriend). They are a warm and loving tribute to his life.

Assuring Your Child Receives Support for Positive Behavior in the Classroom

by **Mark D. Weist, Ph.D.**, Professor and Director, Center for School Mental Health, University of Maryland School of Medicine

Background: School Mental Health

Students who struggle with more significant emotional and behavioral issues often benefit from a range of supportive strategies and interventions in the classroom. These strategies should help your child feel more comfortable in the classroom and reduce the likelihood that emotional and behavioral problems will act as barriers to learning.

While schools have been providing services to promote positive student behavior and mental health for a long time, in recent years there has been a move to expand these services to reflect a full continuum for improving environments; broadly promoting student wellness, positive behavior, and mental health; and implementing prevention, early intervention, and treatment programs and services for students in general and special education.¹ A key value for these school mental health programs and services is that they reflect a shared agenda involving school-family-community system partnerships in all aspects of program development, guidance, and ongoing improvement.

Positive Behavior Support

Efforts to promote student positive behavior and mental health should ideally proceed from a platform of broad strategies related to enhancement of the school environment toward a nurturing, consistent, and positive climate that includes clear and frequently reinforced positive expectations for student behavior. In this realm there are a number of strategies that are very helpful; including programs involving *Positive Behavior Support* (PBS). The federal

Office of Special Education Programs (OSEP) supports a technical assistance center for PBS (www.pbis.org) that includes guidance for the promotion of positive behavior in the classroom. Positive behavior support strategies are described as moving away from aversive and punishment-based interventions toward preventive and positive strategies, with key guiding principles that include the following:²

- Involve systemic and individualized strategies;
- Work for all students;
- Provide common expectations regarding positive behavior;
- Focus on procedures and systems that are evidence-based, or have a science base of support, and that can be efficiently delivered;
- Focus on learning and behavior together; and
- Focus on climate in schools and classrooms and teamwork and collaboration with all staff learning and reinforcing skills.

Teachers and Strategies for the Classroom

Teachers obviously play a critical role in assuring positive classroom environments, with many skills involved, including the following:³

- The way students are grouped or assigned seating (e.g., not having disruptive students sitting close to one another or in the back of the room);
- How tasks are scheduled (e.g., completing less preferred tasks before students can engage in more preferred ones);
- The use of stimulating materials and activities; and

- Matching communication and direction to students in light of their presenting behavior.

The last point is a particularly important theme for effective classroom management and the promotion of positive classroom behavior. That is, the ideal is for teachers to be proactively scanning the environment, noticing how students are doing, praising them for positive behavior, using humor and maintaining a lively and fun environment, and proactively and with empathy addressing behavioral issues in students very early on. In this regard, most students will show that they are beginning to have trouble, for example, by shifting in their seat or showing discomfort. An empathic and supportive response provided to the student one-on-one by walking over to them can often disrupt the development of negative behavioral chains.

Research has demonstrated that teacher and student behavior are inter-related and dependent. For example, teacher behavior affects student behavior, which affects teacher behavior. In general, classrooms function better when teachers engage in a “high approval” style, involving positive and constructive feedback, than a “high disapproval” style, which is more negative and consequence driven.⁴

Other critical skills for educators to promote positive classroom behavior include the following:^{5,6}

- Implementing classroom rules that are behaviorally specific and easy to follow (versus subjective and hard to understand and enforce) and fostering student ownership of the rules;

¹ Weist, M.D., Evans, S.W., & Lever, N. (2003). *Handbook of school mental health: Advancing practice and research*. New York, NY: Springer.

² Sugai, G., Horner, R.H., Sailor, W., Dunlap, G., Eber, L., Lewis, T., Kinciad, D., Scott, T., Barrett, S., Algozzine, R., Putnam, R., Massanari, C., & Nelson, M. (2005). School-wide positive behavior support: Implementers' blueprint and self-assessment. Eugene, OR: University of Oregon.

³ Gettinger, M., Stoiber, K.C. (2006). Functional assessment, collaboration, and evidence-based treatment: Analysis of a team approach for addressing challenging behaviors in young children. *Journal of School Psychology, 44*, 231-252.

⁴ Polirstok, S., Gottlieb, J. (2006). The impact of positive behavior intervention training for teachers on referral rates for misbehavior, special education evaluations and student reading achievement in elementary grades. *International Journal of Behavioral Consultation and Therapy, 2*, 354-361.

⁵ Lloyd, J.W., Forness, S.R., & Kavale, K.A. (1998). Some methods are more effective than others. *Intervention in School and Clinic, 33*, 195-200.

⁶ Gottlieb, J. & Polirstok, S.R. (2005). A school-wide professional development program to reduce behavioral infractions and referrals to special education in three inner-city elementary schools. *Children and Schools, 27*(1), 53-57.

- Having teachers self-monitor their use of language and striving to use positive and encouraging words or phrases versus negative or critical ones;
- Increasing positive statements and praise to individual students, groups of students, and the whole class; and
- Implementing simple systems for rewarding students for positive behavior (e.g., end class a little early and allow talking time).

A critical skill for teachers is to make requests of students in a way that promotes their compliance with these requests. If this is handled well, positive behavior is promoted, but if handled poorly, behavior by students can quickly get out of control. For example, if a student does not comply with a request and a teacher yells, the student may be rewarded by this yelling (by attention on him or laughter by his classmates), and may act out more in response. Instead, teachers should strive for a calm and business-like manner in making requests of students, involving the following steps:⁷

- Present the request in clear behavioral terms for one action at a time;
- State the time limit for starting to respond to the request;
- Provide contingent praise and positive attention to students who comply with a request on time;
- Withhold praise and attention if there is no compliance with a request within the specified time;
- Provide gentle prompting and guidance, without praise or comment, for compliance following the time limit; and
- Calmly implement disciplinary consequences if there is still no compliance.

Resources and Relevant Initiatives

All of the above represents general strategies that should be implemented to promote positive behavior by all students in classrooms. Students who present more significant emotional and behavioral challenges should also receive tailored support and interven-

tion to assist them in addressing these challenges and to promote their positive performance in school. Under the federal Individuals with Disabilities Education Improvement Act (IDEA, most recently reauthorized in 2004), these services may be provided through the school system through placement in special education and receipt of services under an Individualized Education Plan (IEP), or through the receipt of special services as provided through 504 plans.

If your child does not have an IEP or 504 plan, and is experiencing emotional and/or behavioral concerns that you believe are impacting his or her ability to succeed in the classroom, communicate with your child's teachers and grade-level special education case managers regarding their behavior in the classroom and possible strategies and interventions. To learn more about possible resources for your child related to emotional or behavioral disabilities that impair learning, see the Regional Resource and Federal Centers Network of the Office of Special Education Programs (OSEP) at www.rrfcnetwork.org (click on *Technical Assistance and Dissemination Network*).

Also, as reflected in the introduction to this article, schools are increasingly partnering with families and community mental health systems to expand the range of mental health promotion and intervention services available to students and their families. There are numerous on-line resources, including those from:


- The Center for School Mental Health (CSMH) at the University of Maryland at csmh.umaryland.edu and www.schoolmentalhealth.org;
- The Center for Mental Health in Schools at the University of California, Los Angeles at www.schoolmentalhealth.org;
- The Center for the Advancement of Mental Health Practices in Schools at the University of Missouri at www.education.missouri.edu/orgs/camhps; and
- The Center for School-Based Mental Health Programs at Miami

University of Ohio at www.units.muohio.edu/csmbhp.

Further, the University of Maryland CSMH, in collaboration with the IDEA Partnership, funded by OSEP and housed at the National Association of State Directors of Special Education (www.nasdse.org), is building a *National Community of Practice on Collaborative School Behavioral Health*. This community is promoting dialogue and collaboration on multiple dimensions of learning support and school mental health, and includes 12 states pursuing systematic school mental health initiatives and 12 practice groups pursuing the advancement of training, practice, research, and policy in key theme areas in the field. The Community meets annually (with the next meeting in Minneapolis, Nov. 2-4, 2009), with ongoing learning and collaborative work occurring through an interactive Web site at www.sharedwork.org.

What You Can Do

A critical theme associated with the quality and effectiveness of school mental health programs and services is active family involvement in all aspects—from being a collaborator with mental health providers and your child in his or her mental health care to helping to guide school mental health programs and services at school, community, state, and national levels. The family voice should be heard. If you sense obstacles to such involvement or that your voice is not being heard, express your concerns to the school principal and to leaders of your community's child and adolescent mental health system. As you are able to, get involved in program and policy-focused meetings pertaining to school and child and adolescent mental health.

Author's Note: Appreciation is extended to Christianna Andrews and Matthew Page of the CSMH for their help in conducting background research for this article. 

⁷ Cipani, E. (1993). *Non-compliance: Four strategies that work*. Washington, D.C.: The Council for Exceptional Children.

It Takes a Village...and Police Who Care Youth Focused Crisis Intervention Team Training

by Louise Pyers, M.S., Criminal Justice Project Director, NAMI Connecticut

Families often do not know where to turn when their child is exhibiting signs of mental illness. Many children end up in the “school to prison pipeline” due to symptoms of their mental illness. Too often, schools use police as a tool to handle behavioral situations that they do not understand. Law enforcement *Crisis Intervention Team* (CIT) training focused on youth can give police the knowledge they need to divert children from the juvenile justice system to the help they need. The Memphis Model of CIT brings together all the necessary components to accomplish that goal. First, however, it is important to understand what CIT is and how it works.

What Are the Goals of CIT?

The developers of the CIT model, Major Sam Cochran, retired, Memphis Police Department, and Dr. Randolph Dupont of the University of Memphis have outlined the following goals:

- To improve safety of officers and persons with mental illness.
- To redirect individuals with mental illness from the judicial system to the health care system.¹

Core Elements of CIT—“More Than Just Training”

Ongoing elements

- Partnerships with police, NAMI members, hospitals, mental health providers, schools, child advocates, systems of care collaboratives, and other key stakeholders.
- Police and their community partners must take ownership and be involved in planning and implementation.



Louise Pyers and police officers who care.

- Policies and procedures must be developed and adopted.

Operational Elements

- CIT officers, dispatchers, and CIT coordinators.
- Curriculum development and training.
- Emergency Service Providers—emergency rooms, mental health facilities and crisis clinicians must be ready to provide a timely response to police referrals.

Sustaining Elements

- Evaluations and Research: educational institutions can be recruited to evaluate the program's effectiveness.
- Refresher courses for CIT officers.

- Events honoring or recognizing exemplary work in CIT—Officers should know that their work does not go unnoticed.
- Outreach and information sharing with other communities.²

For a more detailed explanation of these core elements, please visit the national CIT Web site at www.cit.memphis.edu (click on *CIT Core Elements*).

Does Your Community Have CIT?

Visit the national CIT web site to find out if your community has CIT. Ask the CIT coordinator to join you in efforts to expand CIT to help children in psychiatric crisis.

If your community does not have

¹Dupont, R., Cochran, S., & Pillsbury, S., *Crisis Intervention Team Core Elements*, University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, CIT Center, p. 3

²Dupont, R., Cochran, S., & Pillsbury, S., *Crisis Intervention Team Core Elements*, University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice, CIT Center, p. 3

CIT, you must first convince the police that this program not only helps persons with mental illness, it also increases safety for police. CIT gives them tools to make their difficult jobs a little easier.

Find a Champion—Build Bridges

A high ranking law enforcement officer who is willing to “champion” CIT can help immensely when promoting CIT to police departments. Attend a Citizen’s Police Academy if your police department offers this. It will give you a better idea of police work, and increase your understanding of police culture. Many departments offer ride-alongs with police officers. Take advantage of this and go! Your interest in them and the relationships you form will go a long way toward making CIT happen. A CIT champion might emerge from these efforts.

Make an appointment with the Chief of your police department to


discuss CIT with him or her. NAMI’s web site has a CIT toolkit that can provide you with more information (www.nami.org/cit).

NAMI Basics and Parents and Teachers as Allies

These programs can raise awareness about the need for CIT. *NAMI Basics* can provide information about CIT to parents and caregivers. *Parents and Teachers as Allies* can also inform teachers about CIT and how they can work with families, police, and mental health providers to improve the mental health system while making their classrooms ideal learning environments for children. Information on these programs can be found on the NAMI web site.

In Connecticut, the CT Alliance to Benefit Law Enforcement (CABLE), the providers of statewide CIT training, are currently working with school resource officers and others to fine tune and

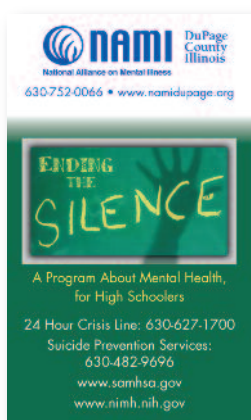
expand CIT training on children’s mental health. Training segments include: early-onset mental illness, the biological basis of mental illness and other brain disorders, brain development in children and teens, stigma, family concerns, strategies to calm youth in psychiatric crisis, signs of trauma, assisting traumatized children, and resources for families and police. It continues to be a work in progress.

For more information on CIT promotion and outreach, contact Louise Pyers at criminaljustice@namict.org or lcp@cableweb.org. For more information on the planning, implementation, and CIT curriculum development for youth, contact Lieutenant Jeffry Murphy or Officer Kurt Gawrisch of the Chicago Police Department at 1 (312) 337-2853 or 1 (312) 337-2856 or jeffry.murphy@chicagopolice.org or kurt.gawrisch@chicagopolice.org. 

AFFILIATE NEWS

Ending the Silence—A NAMI DuPage Signature Program

by Brenda Hilligoss, School Outreach Coordinator, NAMI DuPage, Illinois



The business-sized resource card handed out to students during Ending the Silence presentations.

NAMI DuPage is proud to introduce *Ending the Silence*, a program designed for high school audiences and typically presented in freshman or sophomore health classes during the mental health portion of the curriculum. The interactive program teaches the basic signs and symptoms of mental illness in adolescents, presents personal stories to reduce stigma, and provides resource materials for students.

At the beginning of the class period, students are asked to address a postcard that is sent home to their parents to provide a full disclosure and outreach to family members. Next, an informational and interactive PowerPoint presentation is presented,

along with the personal story of a young consumer. The last few minutes of the class are devoted to completing evaluations and Q&A. “Mood Pencils,” which have our contact information imprinted on them and change color in the holder’s hand are used as an incentive for students to ask questions. They are a huge hit with teenagers! Students are also given a business-size resource card and a brochure from the Substance Abuse and Mental Health Services Administration (SAMHSA) called “What a Difference a Friend Makes.”

One indicator of the success of the program is that in less than two years, we are more than halfway to our goal of educating students in every school in our county. Several school districts have been so impressed with *Ending the*




Brenda Hilligoss, Matt McNichols, Consumer Presenter, and Jim Bondi, Health Educator, after an *Ending the Silence* presentation at Hinsdale South High School in Darien, Illinois.

Silence that they have provided financial support for the program. We have also developed a strong and positive relationship over the years with our Regional Office of Education, which supports all of our programs, including *Parents and Teachers as Allies* (PTasA). Just as PTasA is the perfect educational tool for school professionals, *Ending the Silence* is a proven way to meet students' needs to be educated on mental illness.

Another way we know our program is successful is the enthusiastic responses we get from the students. Some have directed their parents to NAMI DuPage's *Parent Support Group* and *Parent Education Class*. We also consistently receive overwhelmingly positive student evaluations.

After one of our presentations, we received a handwritten letter from a high school student that illustrated the impact that *Ending the Silence* can have. The student wrote, "I would like to thank you for coming in and talking to my school. Your program helped better educate me and it gave me the courage to talk to my parents about my brother. He has been seeing a 'feelings doctor' and he is ten. I sadly do not think it is working, so I sat my Mom down and talked to her...She is going to take him to the doctor. Thank you for better educating me and giving me the courage to speak up." That says it all!

Ending the Silence is available through NAMI DuPage for a small fee. To learn more about the program, visit www.endingthesilence.org. 

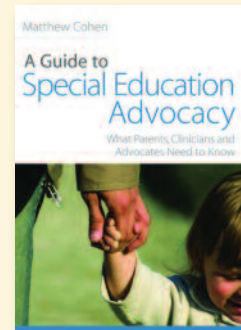
A Guide to Special Education Advocacy ~ What Parents, Clinicians and Advocates Need to Know

by Matt Cohen, Esq.

List Price: \$24.95
Soft Cover: 302 pages (2009)


It is fitting during baseball season to say that Matt Cohen has hit it out of the park with this guide. It takes a truly gifted writer to translate the often complex special education laws and regulations into practical information that families can easily digest and use.

This guide focuses on special education topics for all students with disabilities, however includes much content specific to students with mental health needs. The guide quite effectively covers those issues that matter most to parents, including special education eligibility, the evaluation process, the IEP, special education and related services, the least restrictive environment, behavior management and discipline, transition and graduation, IDEA vs. 504, understanding the politics



behind special education, and much more.

Each chapter includes a summary of the federal law and regulations on a variety of special education topics, and then translates it into practical terms on what it means for students with disabilities. Matt Cohen includes advocacy strategies in each chapter of the book. These strategies speak directly to families with practical step-by-step approaches on how to effectively advocate for appropriate services. This is exactly what families need most to help secure the right services for their child.


This book is a must read for families and advocacy leaders. Matt Cohen hits a homerun with this guide and clearly establishes why he has become a highly regarded national authority on special education law, advocacy strategies, and special education policy. 

Reinvesting in the Community: A Family Guide to Expanding Home and Community-Based Mental Health Services and Supports

NAMI recently released a publication titled, *Reinvesting in the Community: A Family Guide to Expanding Home and Community-Based Mental Services and Supports*, to inform families about the importance of expanding the array of home and community-based services and supports available to children and youth with mental illness and their families.

NAMI's new family guide provides families with a list of home and community-based services and supports and discusses model states and communities that have embraced these interventions as alternatives to

out-of-home placement. The guide outlines how litigation, a desire to achieve better treatment outcomes, Medicaid expansion, and strong leadership have all played a role in the successful expansion of home and community-based services.

To download a copy of the family guide, please visit NAMI's Child and Adolescent Action Center's Web site at www.nami.org/caac. Sections of the guide are also available in Spanish. To order hard copies of the family guide, please contact Bianca Ruffin, Program Assistant, at biancar@nami.org or 1 (703) 516-0698. 

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NAMI Releases Guide to Crisis Intervention Programs for Youth

NAMI has published a guide titled, *Supporting Schools and Communities in Breaking the Prison Pipeline: A Guide to Emerging and Promising Crisis Intervention Programs for Youth*, to help inform advocates about existing crisis intervention programs for youth and how they can promote and implement such programs in their states and communities.

The guide responds to concerns about the alarming number of youth with mental health treatment needs who continue to enter the juvenile justice system. Schools in particular have been a pipeline into the juvenile justice system for many youth in America. Crisis intervention programs for youth promise to support schools and communities in helping to break this prison pipeline.

The guide highlights three communities that have adapted the adult Crisis Intervention Team (CIT) model to develop crisis intervention programs for youth that can be used in school and community settings. It provides an overview of the CIT

model and discusses the key components, benefits, and costs associated with crisis intervention programs for youth. It also details the action steps that children's mental health advocates can take to effectively promote and implement these programs for youth in their states and communities.

CIT is a dynamic collaboration of law enforcement, community agencies and organizations committed to ensuring that individuals with mental illness are referred to appropriate mental health services and supports rather than thrust into the criminal justice system.

To download a copy of the guide, please visit NAMI's Child and Adolescent Action Center (CAAC) at www.nami.org/caac or NAMI's CIT Resource Center at www.nami.org/cit. Advocacy fact sheets are also available with the guide.

For more information about NAMI's work on crisis intervention programs for youth, please contact Dana Markey, Program Coordinator, CAAC, at

danac@nami.org, or Laura Usher, CIT Coordinator, at laurau@nami.org. 