

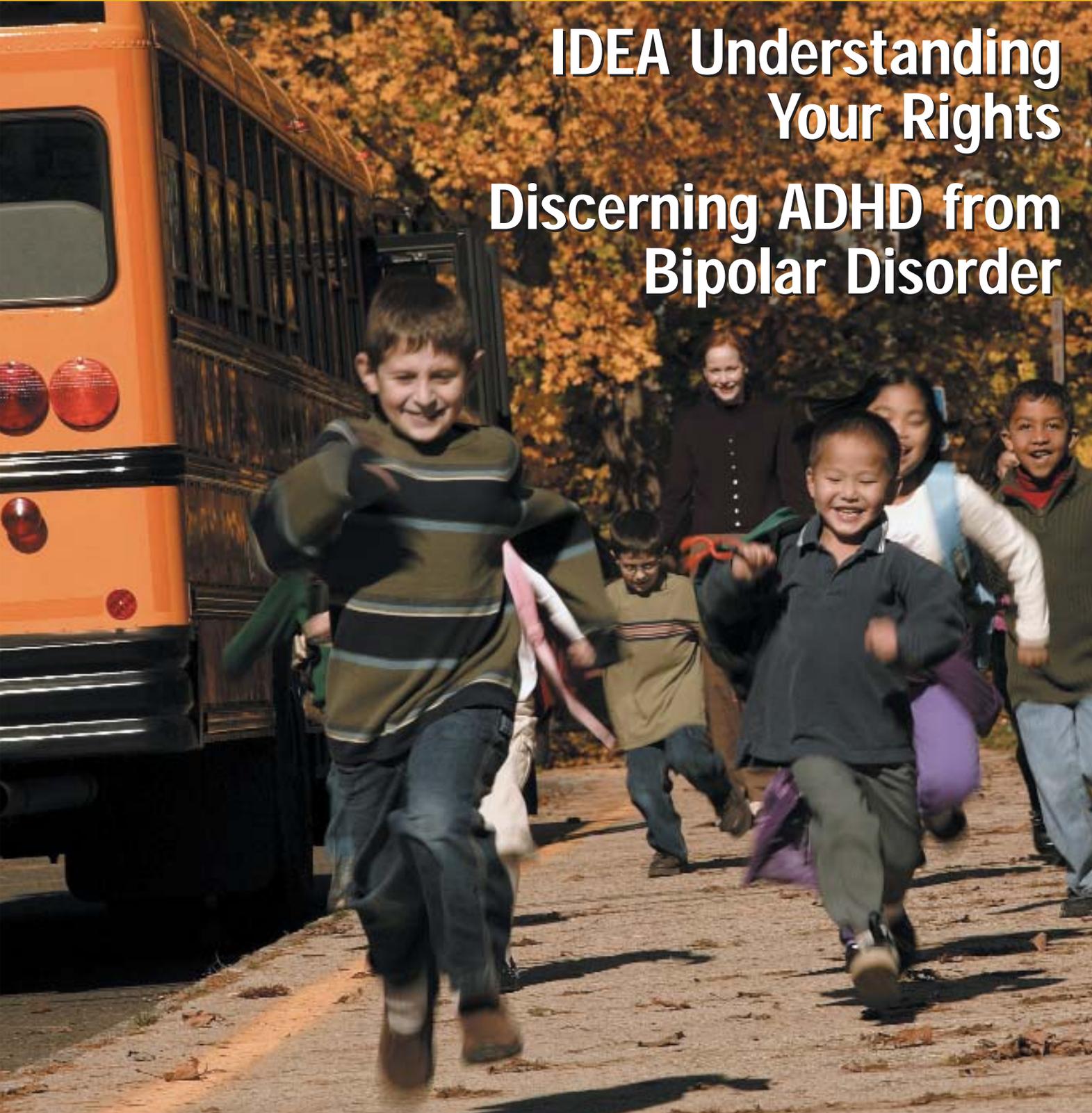


nami *Beginnings*

Summer 2004 ★ Issue Five

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

IDEA Understanding Your Rights Discerning ADHD from Bipolar Disorder



The Youth Voice ★ State and Affiliate News ★ Book Review

C O N T E N T S

2 POLICY ALERTS
Capitol Hill Watch

3 Helping Parents Understand Their Rights in Special Education

8 The Special Education Process

9 ASK THE DOCTOR

11 FAMILY VOICE

12 THE YOUTH VOICE

13 STATE NEWS

14 AFFILIATE NEWS

16 BOOK REVIEWS



Capitol Hill Watch

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

The Individuals with Disabilities Education Act (IDEA)

The Senate passed legislation to reauthorize IDEA (S. 1248) on May 6, 2004. The final bill included the following four amendments:

- **Full Funding** – Senators Harkin (D-IA) and Hagel (R-NE) sponsored an amendment, strongly supported by NAMI, that would have required Congress to live up to its promise to fund special education at 40 percent (Congress currently funds it at around 18 percent). Unfortunately, the amendment failed. The Senate passed a competing amendment that provides annual authorized funding levels that essentially maintain funding at its current level.
- **Attorney's Fees** – Senator Gregg (R-NH) offered an amendment that the Senate approved that allows courts to award attorney's fees to state or local education agencies when it determines that the case is frivolous and without foundation.
- **National Children's Study** – Senator Clinton (D-NY) offered an amendment, which was approved, that adds the Department of Education as a partner in the National Children's Study. The study will examine the effects of environmental influences on the health and development of children in the U.S.
- **Homeless and Foster Care Children with Disabilities** – this amendment, which passed the Senate, is designed to ensure that IDEA better addresses the educational needs of children who are homeless or in foster care.
- **Medication Use** - this amendment calls for a study to determine the extent to which schools pressure parents to use medication for their child to treat ADHD. This study should shed light on whether this issue warrants further federal action.

Now that bills have passed in both the House and Senate, a conference committee will be appointed to work through the vast differences in the bills. NAMI is opposed to the House bill to reauthorize IDEA (H.R. 1350) that passed in April 2003. It may be difficult for Congress to complete its work on IDEA during this legislative session because of the shortened session and the current political climate.

Take Action - please contact your senators and representatives and ask for them to ask House and Senate leaders to reauthorize IDEA this year. Also, ask for their support of the senate IDEA reauthorization bill (S. 1248) and to oppose the house bill (H.R. 1350) that threatens to deny students with disabilities their fundamental right to receive a free and appropriate education. Please visit the NAMI Web site for periodic updates on IDEA.

NAMI is also working on the following youth-focused legislation:

- Keeping Families Together Act (S. 1704/H.R. 3243);
- Family Opportunity Act (S. 622 passed the Senate, H.R. 1811)
- Healthcare Crisis Relief Act (S. 1223/H.R. 1359);
- Youth Suicide Early Intervention and Prevention Expansion Act of 2004 (S. 2175); and
- Child Medication Safety Act (S. 1390/H.R. 1170).

To learn more about this legislation, please visit the Child and Adolescent section of the NAMI Web site at www.nami.org. 

NAMI *Beginnings* is published quarterly by NAMI, Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201-3042. Ph: 703.524.7600 Fax: 703.524.9094

Michael Fitzpatrick,
Acting Executive Director
Darcy E. Gruttadaro, J.D., *Editor-in-Chief*
Maria Belen Assusa, *Managing Editor*
Joe Barsin, *Art Director*
Jennifer Nevins, *Copy Editor*

Guest Contributors:
Matthew D. Cohen, J.D.,
Ken Duckworth, M.D.,
Linda Champion, Carol Howe,
Kristen Putignano, and Karen Szybalski.

Staff Contributors:
Darcy Gruttadaro, Maria Belen Assusa,
Jennifer Nevins and Joe Harris.

NAMI is a grassroots, family and consumer, self-help, support, education, and advocacy organization dedicated to improving the lives of children and adults living with severe mental illnesses. Severe mental illnesses are biologically based brain disorders that can profoundly disrupt a person's ability to think, feel, and relate to their environment and others.

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

Helping Parents Understand Their Rights in Special Education —

An Interview with a Legal Expert

Darcy Gruttadaro, Director of the NAMI National Child & Adolescent Action Center, recently interviewed Matthew D. Cohen on issues related to The Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act.

Mr. Cohen is a founding partner of Monahan and Cohen, a Chicago law firm specializing in special education, disability rights and human service law. Mr. Cohen has represented thousands of children with disabilities, lectures frequently on special education law around the country, and has written numerous articles on special education issues. He is an adjunct faculty member at the Loyola Law School. He is also a past president of Children and Adults with Attention Deficit Hyperactivity Disorders (CHADD), and helped organize the Children's Behavioral Alliance (CBA). The CBA issued a briefing paper, "In the Best Interests of All," which addressed the educational and mental health needs of children with social, emotional and behavioral challenges. NAMI was a member of the CBA.

Darcy Gruttadaro (DG): Please briefly describe the eligibility criteria under both IDEA and Section 504 – and specifically as it relates to students with mental illnesses.

Matthew Cohen (MC): IDEA and Section 504 have very different criteria for eligibility and it is important to understand the general differences in these federal laws to understand how they relate to students with mental illnesses. IDEA requires that a student meet the eligibility criteria in one of the thirteen categories of disability. Emotional disturbance (ED) is one of

the thirteen categories, and includes children with mental illnesses and behavioral disorders, if the problems are severe and adversely effect school functioning.

Section 504 does not use categories of disabilities and does not specifically identify any disability as being covered or not covered. Instead, Section 504 refers to any physical or mental impairment. Therefore, at the outset, both laws provide for the potential protection of students with mental illness but do so in very different ways.

The second thing that differentiates IDEA from Section 504 is that IDEA requires a showing that a student's disability has an adverse effect on their school performance as a result of the disability. By contrast, under Section 504, there is a requirement that the identified physical or mental impairment substantially limits a major life activity. Both learning and thinking are considered major life activities. Therefore, the language of the two laws is very different in how they describe disability and how the disability impacts functioning. Section 504 is much broader in the range of functioning that it covers.

The third area of difference between IDEA and Section 504 is that the criteria for eligibility under IDEA require that once you have met one of the thirteen categories and there has been some indication of an adverse effect on educational performance, the student still has to demonstrate that he or she requires special education. By contrast, under Section 504, once it is determined that the student has a physical or mental impairment and that it sub-

stantially limits a major life activity, the student qualifies for protection under the law if they need special education,

related services, or accommodations. The critical difference here is that to be eligible for special education, the student must need special education instruction. To qualify for 504 protection, a student may be in need of related services or accommodations without special education instruction. Typically, that protection under Section 504 is understood to include

social services, counseling, occupational therapy, speech or physical therapy or may include accommodations for timing in testing or preferential seating. It may also include specialized instruction, if that is necessary to address the impact of the disability. Thus, there are some situations where the student is eligible for Section 504 but not eligible under IDEA.

What is interesting about the ED category under IDEA is that it is not based on a diagnosis of mental illness, although the law does reference schizophrenia. Rather eligibility is based on the presence of behavior that fits into several prescribed categories. Therefore, a student's eligibility relates more to what people observe in the behavior of the student than it is based on a determination of a mental health professional that the student has a mental illness. The behavioral characteristics that are used under the ED category in IDEA include inappropriate behavior or feelings under normal circumstances, inappropriate relationships or difficulty developing relationships with peers or adults, indicators that suggest the child has a school related



Matthew D. Cohen, J.D.

phobia, and others.

Because the IDEA eligibility criteria for the ED category is behavior-based, there is a frequent disconnect between how the parents and private evaluators view the child's needs and how the child is viewed by providers and school professionals. This is one of the sources of disputes between parents and schools because the existence of a clinical diagnosis of mental illness does not by itself determine whether a child is eligible under either IDEA or Section 504. Instead, schools focus on behavior and particularly on behavior that is exhibited in the school.

IDEA and Section 504 not only work differently for eligibility, but they also have different implications for

“It is important to note that the purpose of both of these laws (IDEA and 504) is not to ensure that the students have a positive school experience.”

schools. IDEA is a funding statute. If a student is eligible for IDEA services, the school then qualifies for reimbursement from the state and federal government for a portion of the services that they provide. However, in return for that funding, the school district is expected to follow detailed procedures in evaluating the student, developing an IEP, reporting to and involving parents, following the child's progress and addressing the student's behavioral needs. By contrast, Section 504 is not a funding statute. It is a civil rights statute and provides no funding for Section 504 services. As a result, schools are often more willing to use Section 504 when a student does not require a lot of services because Section 504 does not have the same level of regulatory requirements. When a student requires more expensive and extensive services, then the school may be more motivated to provide IDEA services because the school is more likely to qualify for reimbursement.

DG: Parents often express concern that schools tell them that their child with a mental illness is not eligible

for special education services under IDEA because the child is doing well academically. However, the child is clearly struggling in school in other areas. What can parents do?

MC: Many schools assume that a student's eligibility under IDEA exists only if the student's disability results in a measurable impact on the child's academic performance. The schools often take this a step further and evaluate educational performance based on whether the student receives passing grades and makes progress on school-wide achievement tests. While passing grades and achievement test scores are relevant in assessing whether a child is making adequate progress in school,

they should never be the only factors in determining whether a student may be experiencing an adverse effect on their performance as a result of their mental illness under IDEA or a substantial limitation in their academic performance in school under section 504.

Both laws require that the school district evaluate the child's performance holistically on the following factors:

- The child's functioning in school, including an assessment of the child's behavior;
- The child's social relationships;
- The child's ability to participate successfully in class;
- The ability to complete work and perform acceptably on tests;
- The child's ability to conform to school rules and classroom expectations; and
- The child's ability to access education in a way that is productive given their capabilities.

Schools also need to measure the child's communication ability, self-help ability to develop vocational skills,

development of motor skills and more. There are a wide range of different skills that impact a child's ability to participate in and benefit from education that need to be assessed in determining a child's need for special education services under IDEA or Section 504 protection.

It is important to note that the purpose of both of these laws (IDEA and 504) is not to ensure that the students have a positive school experience. The purpose is to assist students in developing skills that will promote their ability to be independent functioning citizens in adulthood. If the only measures for IDEA or 504 eligibility were higher test score, then these laws would fail to address many of the skill areas that the laws recognize as necessary to accomplish the goal of promoting independence and self sufficiency in adulthood.

Schools often fail to recognize the significance of these other life domains in determining whether a child with a disability is eligible under IDEA or 504. It is entirely possible that a child with a mental illness could receive passing grades and even high test scores while spending most of their time in a disciplinary status in the principal's office or withdrawn with no meaningful participation in class with peers. Those are examples of situations in which schools might fail to appropriately apply the eligibility criteria for IDEA and 504 by focusing solely on grades and achievement test scores, and deciding that the child is not eligible for services on that basis alone, despite the fact that the child's behavior in school shows clear evidence of the child's overall struggle in functioning.

One of the useful pieces of data that parents should review in preparing for the evaluation for special education services or Section 504 protection, is report cards and progress reports for their child. Most schools' report cards include not only grades for academic performance but a rating system or comment section for behavior. It is often the case that the student may be receiving passing grades but the comment section for behavior lists a variety

of problematic behaviors. Clearly, this type of information documents the school's recognition that the student is experiencing social or behavioral problems.

The most important data that parents can use to establish the basis for their child's eligibility for special education is information from the child's educational record, although sometimes a parent may need outside clinical evaluation data. It is important that parents keep all records that they get from the schools, including report cards, progress reports, notes from teachers, informal reports, disciplinary reports, and others. The school district often has information in a student's record that shows ongoing social or behavioral concerns about the child, but which has not lead to either a decline in achievement scores or poor grades.

DG: What do you recommend that parents do to prepare for the initial evaluation for special education services and during the evaluation process? If their child is found ineligible, what should parents do if they believe that their child is eligible for special education services?

MC: Parents need to keep all records for their child including school records, report cards, progress reports, notes from teachers, informal reports, disciplinary reports, and other related documents.

One of the disabilities that is frequently misunderstood and at times addressed incorrectly by schools is attention deficit/hyperactivity disorder (ADHD). Many children with ADHD do not require special education services or even the protection of Section 504. But for children with ADHD who do require special education services, the IDEA regulations provide that the child may be covered under the category called Other Health Impairment, if they meet the criteria for that category. If a child's ADHD results in the student having a limited ability to attend to educational tasks by virtue of their being excessively occupied with or

attentive to other things in the environment, then the child qualifies for special education services. Students with AD/HD may also be covered under Section 504, particularly if they only need accommodations or related services, such as nursing service to administer medication.

Under the law, a student's needs are supposed to be met regardless of which labels that the child is given. However, in some situations the label drives the service rather than getting services to meet the needs of the child. Consequently, there may be circumstances where an educational label the school is choosing to categorize the child may not be the most appropriate or desirable label for the child. It is important for parents to be aware of the impact of these labels and to make informed choices about which label they believe will most appropriately address the needs of the child.

If a child is already involved with a private mental health professional, it is important for parents to obtain information from that mental health professional (preferably in writing) indicating the professional's assessment of how the student's emotional condition is affecting their functioning in school. It is equally important that parents obtain from that professional any recommendations about the types of interventions, support, or services that the child needs in school to address the emotional disorder and its resulting symptoms. It is particularly useful for the outside professional to be specific about the type and amount of services, any things that should be avoided, and the type of positive behavioral interventions the child would benefit from.

DG: What do you recommend that parents do to best prepare for the Individualized Education Program (IEP) meeting and how do they ensure that their child has the most appropriate IEP to meet his or her needs?

MC: The single most important step for parents preparing for the IEP meeting is to have as much information

Online Resources on IDEA and Special Education

- Council for Exceptional Children – www.cec.sped.org.



- NICHCY – National Dissemination Center for Children with Disabilities – www.nichcy.org.

- Technical Assistance Alliance for Parent Centers – www.taalliance.org.



- Department of Education – Office of Special Education Programs – www.ed.gov (click on “About Ed” and “Offices” and “Office of Special Education and Rehabilitative Services”).
- National Association of State Directors of Special Education – www.nasdse.org.
- Wright's Law on Special Education – www.wrightslaw.com.

as possible about their child's needs, about their child's functioning at school, and about solutions that they think will be helpful for the child to function successfully at school.

Parents need to arrive at the IEP meeting as informed consumers with the necessary information to advocate for their child's needs. They also need to assess whether the proposals offered by the school are adequate and responsive to the child's needs. There also may be options available within the school system that the particular team is either unaware of or disinclined to offer and unless the parent has information about what is available, it will be harder to access those services.

Although the IEP process is intended to develop a program in response to a child's individual needs, it is always easier to obtain services that are already available than to have the school provide new services that it has not previously offered. In addition, it is important for parents to focus on services that are necessary for the child as opposed to services that are ideal or optimal because schools are only required to provide those services that are necessary to ensure that a child receives an appropriate education.

It is also important for parents to think about the type of communication that will be necessary for them to understand how their child is progressing on the IEP plan and to be adequately informed about whether the plan is working. In some instances the child may have a mental illness that is unfamiliar to the school staff and in these cases parents should share information with the school about the child's disorder and how it affects the child's functioning in school. Mental illnesses are sometimes hidden disorders and the symptoms of these disorders do not manifest themselves in the same way throughout the school day or the school term. School staff that do not understand these disorders may misinterpret the variability of the symptoms as misbehavior or a lack of motivation rather than understanding that the behavior is a symptom of the illness. Parents need to explain to the school staff why the behaviors or

symptoms may vary to help them take seriously the impact of the illness. Parents should also be familiar with the school's disciplinary guidelines and the classroom's disciplinary standards to determine whether there may be any modifications necessary for their child.

Parents should also be aware that their child's IEP should include goals to address areas of need, which may include academic or behavioral needs. The law requires schools to address not only the direct consequences of the child's disability but also any collateral effects. As a result children with mental illness may need support not only for the behaviors or symptoms associated with the illness, but may also need goals that address their academic functioning because of any adverse effects that their illness may have on their actual academic performance.

DG: Parents frequently express concern that they have worked with the school to develop an appropriate IEP for their child, however the school is not following the IEP. What can parents do in these circumstances to ensure compliance with the IEP?

MC: The first step in addressing a failure to properly implement the IEP is for the parents to ensure they have adequate documentation of what the school is or is not doing that is required in the IEP. Parents often respond to implementation problems with anecdotal reports that become battles of each party denying the position of the other without evidence. Behavioral reports, phone calls, communication, progress sheets, reports of meetings and other documentation are all important to establish patterns of the failure to properly implement the IEP. In the case of a school failing to implement the IEP, parents should carefully move up the hierarchy of authority within the school district, starting with the individuals who are supposed to be implementing the IEP but are not doing so.

When a school fails to properly implement the IEP, it creates an impossible dilemma for many parents in which their complaints of non-compli-

ance lead to deterioration in their relationship with the school staff. As much as possible, parents should try to solve the problem within the school before moving up to complain to the school district. However, there are a number of vehicles available to parents if they have been unsuccessful in attempting to resolve the IEP non-compliance issue. These include—complaints to the Director of Special Education, the Superintendent and the School Board. Parents may also decide to file a complaint with the State Education Agency, or to submit a complaint to the Office of Civil Rights within the US Department of Education. Parents may also request a due process hearing under either IDEA or Section 504. In addition, parents may request mediation either before requesting a due process hearing or as a first step after requesting the due process hearing. However, it is always preferable to resolve disputes with the school district in a voluntary and cooperative manner rather than through the adversarial process.

DG: Can schools use the argument that they lack the funding necessary to provide services to ensure that the child eligible for services under IDEA receives an appropriate education?

MC: No. Neither IDEA nor Section 504 allows cost to be the determining factor in whether a service is provided to students with disabilities. While cost may be considered as one of many factors, it may not be the sole or controlling factor. It is important for parents to recognize that under IDEA the school district receives substantial financial support from the state so that the cost of any service is not paid exclusively by the school district. It is also important for the parents and school to recognize that the failure to provide needed services may well lead to the need for more expensive services at a later time. However it is equally important that the parents be reasonable in their requests and strategic about asking the schools for things that are essential as opposed to seeking from the school district any possible service that could

be documented regardless of whether it is critical to the student's ability to function and learn at school. In addition, it should be recognized that if a school truly does not have the resources, they may reject the request even though they recognize the necessity. While the parent may ultimately prevail in a due process hearing against the school district, it will be less expensive for a parent to obtain a particular service on their own than it would be for them to enter into a legal battle with the school district over it.

DG: What has your experience been with securing “related services” outside of the school building (e.g. home and community-based services) for children with mental illnesses?

MC: School districts generally do not have well developed cooperative relationships with community mental health providers, although IDEA calls for the existence of interagency relationships that will provide coordinated

services. Parents may request outside services at the district's expense if the school district is unable to provide a service that is demonstrated to be necessary within the schools. However, schools are reluctant to agree to pay for private services even when they do not have the specific service available within the system because of the potential for escalating costs.

The parents will need to justify or probe the need for an outside service by documenting both that the service is essential to the child's ability to be successfully educated and that the service is unavailable within the public school system. Parents should be careful in requesting outside services because of its impact on school finances but should recognize that school districts have an obligation to provide all services that are necessary to meet the child's needs other than medical services.

Schools may sometimes refer a child to an outside mental health professional for evaluation. If this is being done in order to determine eligibility for

special education or Section 504 protection, it is supposed to be done at no cost to the parents.

DG: Recognizing that it is crucial that parents develop an “individualized” plan for their child, do you have any specific recommendations about what parents may wish to consider requesting in their child's IEP given that their child has a mental illness?

MC: Mental illnesses are highly variable in their impact on each child, as are the interventions that are appropriate to address them. However, parents can seek a number of interventions to address their child's needs. Since some schools are unaware of these mental illnesses and their impact on children, parents can request that information about their child's illness be shared with school staff. This is critical to promote sensitivity and appropriate judgment on the part of schools in working with the child. When schools lack staff

continued on page 15

NAMI's Child & Adolescent Action Center Participates in Duke University's CAPTN

Darcy Gruttadaro, the Director of NAMI's Child & Adolescent Action Center, has been selected to serve as a Steering Committee member for the Child and Adolescent Psychiatry Trials Network (CAPTN), a collaborative effort of the Duke Clinical Research Institute and the American Academy of Child and Adolescent Psychiatry (AACAP).

CAPTN is designed to conduct large, simple, practical trials that provide answers to important clinical questions in child psychiatry. As many families know, the current research base in child psychiatry is inadequate. Many of the psychiatric treatments that are used for children have been studied in adults, but not thoroughly studied in children. The overall goal of CAPTN is to evaluate the effectiveness and safety of treatments delivered by child and adoles-

cent psychiatrists under usual clinical conditions (in their community practice settings) to children and adolescents with mental illnesses. CAPTN holds real promise in helping to promote evidence-based medicine (EBM – the idea of EBM is that physicians have systematic research available to help guide their decisions about the treatment provided) in child psychiatry and in markedly increasing the research capacity in this area.

Here's how it works: CAPTN is currently recruiting child and adolescent psychiatrists to participate in practical clinical trials. This research will be done in clinician's offices rather than in controlled academic settings, so the findings are likely to have much broader application. Child and adolescent psychiatrists who join the CAPTN network benefit

by learning more about existing treatment and clinical research, by improving the care of youth they see in their practice, by receiving recognition in peer-reviewed journals, and by receiving clinical research and human subjects protection training.

Please consider asking your child's psychiatrist to participate in CAPTN. Both you and your child's psychiatrist can learn more about CAPTN by visiting their Web site at www.captn.org. The NAMI Child and Adolescent Action Center will continue to send updates about CAPTN through our e-mail group. If you would like to be added to our e-mail group, please e-mail Belen Assusa at belen@nami.org. We will also post updates about CAPTN on the child and adolescent section of the NAMI Web site, www.nami.org.

The Special Education Process

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

It is now well documented that most states fail to comply with the Individuals with Disabilities Education Act (IDEA), our nation's special education law. This article is designed to help families understand some of their rights under IDEA.

Step One — The Evaluation

IDEA requires that a child receive an evaluation to determine eligibility for special education or related services before these services are provided. The request for an evaluation can come from a parent¹, the school district, or others. The parent must consent to the evaluation in writing before it takes place.

Once the school district receives the request, it must complete a full and individual evaluation. If it refuses to conduct the evaluation, then it must give appropriate notice to the parents with an explanation of their rights.

The initial evaluation is designed to decide two things—first, whether the child has a disability that fits within one of IDEA's 13 disability categories, and second, whether that disability affects how the child performs in school. The evaluation must meet several requirements: it must be done by trained and knowledgeable personnel; it must not be discriminatory on a racial or cultural basis; it must be administered in the child's native language (unless it is clearly not feasible to do so); and it must assess the child in all areas of the suspected disability.

Those typically involved in an evaluation include the parent, one or more of the child's general education teachers, a special education teacher or service provider, a school administrator, a person to interpret the evaluation,

other individuals invited either by the parent or the school with knowledge or special expertise about the child, the child (when appropriate), and other qualified professionals.

Step Two — Evaluation Completed ~ Eligibility Decision

The determination of whether a child is eligible for special education services is made after the evaluation by a team of qualified professionals and the parent of the child. The law requires that a copy of the evaluation report and the documentation that was used to determine eligibility be given to the parent. If a child is found not to be eligible for special education or related services, then the school must notify the parent in writing along with an explanation of what the parent can do to challenge the finding.

What happens when a school decides that a child is not eligible and the parent disagrees with that finding? Parents have a right to an Individual Educational Evaluation (IEE), which must be completed by someone who does not work for the school district. The school district must pay for the IEE or must take the matter to a due process hearing and show at that hearing that its evaluation is appropriate.

Step Three — Eligible for Services ~ Develop an IEP and Placement Determination

After eligibility is established, a meeting must be held within 30 days to develop the child's individualized education program (IEP). The IEP should include three general components: (i) information about the child's current levels of educational performance and how the disability affects progress; (ii) a statement of the meas-

urable annual goals, including short-term objectives or individual steps and major milestones that must be taken to meet the child's educational needs; and (iii) information about the services that the school district must provide to help the child meet the goals included in the IEP.

The IEP should also include timelines defining when services will begin and when they will be provided, along with the location of the services (IDEA requires that services be provided in the least restrictive environment appropriate to the child's needs). The IEP should also address transition needs and state how the school will measure the child's progress. It is best to ensure that progress will be measured by an objective rather than a subjective evaluation process. This can include looking at standardized test scores, the child's percentile ranks, and other measures. The same individuals who work on the IDEA evaluation and eligibility team typically develop the student's IEP.

What if you disagree with the IEP or the proposed placement for your child? Parents should first attempt to work out their difference with the IEP team and reach an agreement. However, if that fails, then parents may ask for an impartial due process hearing or mediation to resolve the dispute. This option may not be feasible because it requires hiring a lawyer and can be costly.

Step Four — Annual IEP Meeting ~ Reevaluation

The IEP team meets at least once per year to discuss the child's progress toward meeting the goals included in the IEP and to determine whether any changes need to be made. Parents of students receiving special education

¹This article uses the term "parent," which applies to both parents and caregivers.

services must also be informed regularly about their child's progress or at least as often as parents of children without disabilities.

Parents may disagree with any proposed changes to the IEP raised at the annual meeting. They should always document their disagreement in writing and keep organized copies of all documents that are either sent to the school or received from the school by the parent. When a parent disagrees

with proposed changes, the child will continue to receive the services included in the IEP until the parent and school reach an agreement. If they cannot reach an agreement, then the parent can ask for an Independent Educational Evaluation or can resolve the dispute in a due process hearing or through mediation.

Students who have an IEP will be re-evaluated at least every three years to determine whether they continue to

be eligible for special education and related services. 

Resources:

National Dissemination Center for Children with Disabilities, Basics for Parents: Your Child's Evaluation, 1999 (accessed at www.nichcy.org). Technical Assistance Alliance for Parent Centers, Understanding the Special Education Process, 2001 (accessed at www.taalliance.org).

ASK THE DOCTOR

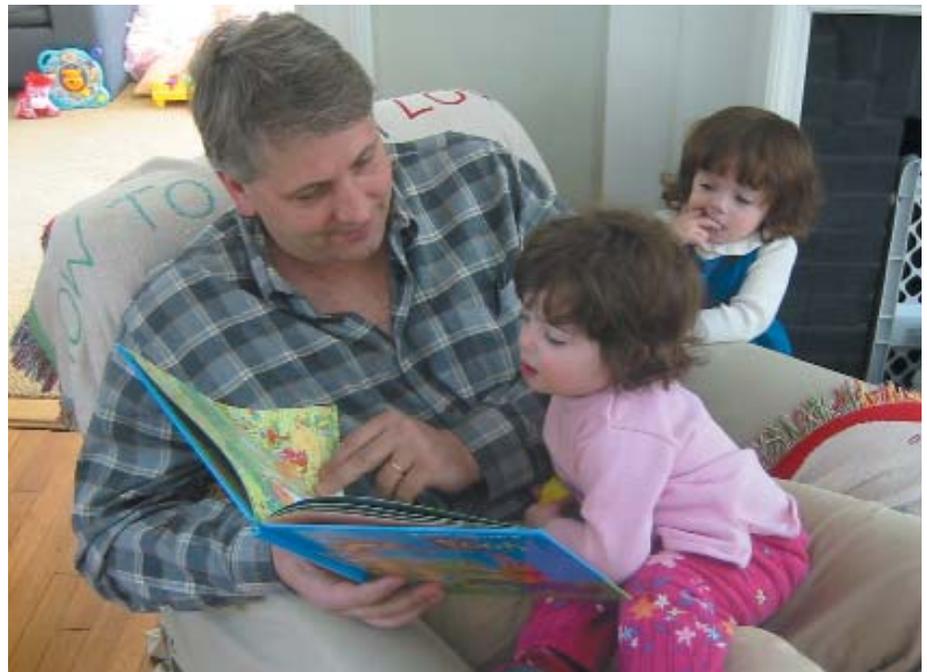
Under-charted Waters: Discerning ADHD from Bipolar Disorder in Children and Adolescents

By Kenneth Duckworth, M.D., NAMI Medical Consultant

Many people ask me about the relationship between attention-deficit/hyperactivity disorder (ADHD) and bipolar disorder, and how to differentiate the two. Let me explain how I understand the travels through these under-charted waters.

We Are All New Here

First, remember that bipolar disorder in children is a relatively new conceptual framework. When I was trained in child psychiatry at Harvard in the early 1990s, I was taught that bipolar disorder occurred in one's twenties or thirties. But recall that in the 1960s, clinicians did not conceptualize depression in kids—it didn't fit the model. The conceptual framework taught us that depression was a byproduct of our critical conscience—called the superego—and kids were not developed in that area yet, so they were thought to be unable to experience depression. Then researchers decided to actually interview kids, and found that some were persistently sad, had no sense of future,



Dr. Duckworth and friends

had thoughts of self-harm, and were having sleep and energy problems. Although bipolar disorder, unlike depression, had no clear-cut psychological model, clinicians also just assumed

that it didn't occur early. As we look back, that seems unusual, as schizophrenia and depression can present early.

In 1995, Harvard researchers led by

Janet Wozniak, M.D., described the phenomenon by assessing kids and noting that some kids with ADHD were having multiple symptoms that were not easy to explain by ADHD alone. The consensus is now that this was a major step forward, but the margins or outside elements of the condition are controversial. ADHD is thought to be much more common, but that condition also does not have diagnostic precision. Impulsiveness and hyperactivity go with both diagnoses, so you can't stop there.

Watch the Movie, Not the Trailer

Diagnosis is longitudinal, not a one-time thing. The course and impact of a person's symptoms are of paramount importance in making a diagnosis. This means seeing the child over time, reviewing records, and talking with parents about the temperament of the child as an infant. In my practice, I do not make a diagnosis quickly; I identify a lead diagnosis and stay open to the fact that new information will allow revision.

Seeing symptoms in a context over time is crucial for adult diagnosis as well. A single interview should not a diagnosis make. For instance, bipolar disorder in kids is more episodic, and ADHD is more consistent. A child presenting with severe depression has to be seen over time to see if a manic episode follows.

Show More than Tell

Children may present distress with physical symptoms rather than with words. "Frequent Flyers" in school nurses' offices are sometimes expressing emotional distress. Kids are also not thought to be good at self-reporting things like sleep patterns, the disturbance of which is consistent with bipolar disorder. Some kids, however, can easily discuss their emotional state.

In older kids, I watch for how they are doing with their peers; as the job of adolescents is to develop a separate identity and transition out of the home, they may not turn to their parents. But if they do not turn to their friends, I know there is some distress there. Distress is not a diagnosis, however.

Respect the Elders

Family history is a key clue, and one that is underutilized in sorting out clinical puzzles. ADHD and bipolar disorder both have strong family inheritance, and ADHD has one of the strongest familial linkages in the field of psychiatry. Bipolar disorder in family members should be a clue, but is not a lynchpin. Alcoholism and completed suicide in grandparents do not necessarily indicate a family history of bipolar disorder, but they suggest that mood symptoms may have been self-medicated with alcohol. Ninety percent of suicides are associated with a psychiatric diagnosis, often mood disorder.

Both adults and children who take antidepressants should have a handle on their family risk, as manic symptoms can be precipitated by antidepressants if not planned for. I just saw an adolescent today who had manic symptoms that were uncovered by antidepressants. In talking with the family, I learned that manic symptoms were many. It is clear that this was an unnecessary risk for the young man, and a better history would have shown that.

Both Conditions Have Concerns with Common Theme: Quest for Self-Regulation

Strategies that teach self-regulation are useful for many conditions. Occupational therapists talk of a "sensory diet," which is a useful framework for our efforts. Teaching people to modulate their inputs and their responses is a key life skill, but one I was not taught. Parents often intuit this with an ADHD child—you can't do three things in one day and expect that they can filter out all the stimuli. Family psychoeducation approaches can help to give people this language and framework. Classrooms that have a lone desk aside the teachers can be a tool for awareness. If it is a desk any child can use, the child is learning to notice his or her own state and develop a strategy (going to a quieter spot). This is preferable to one desk being assigned to a single child, as that strategy does not teach the child how to reflect on his or her own sensory state.

I also like martial arts, as it is all

about developing control over one's impulses and body. Exercise is also good—kids notice they feel more relaxed afterwards—and it taps into emerging research that shows that the cerebellum, a part of the brain responsible for balance and some movement coordination, may have a useful role in improving executive functions.

We Need Better Research

Snapshot research does not get us where we need to go. We need to better understand how interventions play out in different kids over time. This is true for medicines that are not FDA approved for kids, like valproic acid, and also for other interventions, like family psychoeducation. There is no Framingham Heart study of kids with different presentations and symptoms that follows them into adulthood. This is a profound missed opportunity, as we have so many more tools for intervention. We also need to ensure a supply of capable child psychiatrists—I would not want a pediatrician to try to keep up with the emerging literature in child psychiatry. I have not discussed medications in this article because the focus is more on diagnosis. That issue will require a separate article, so please stay tuned. 

CHADD 16th Annual International Conference on AD/HD

Striking the Right Note through Science, Education and Support

The conference will be held on October 28-30, 2004 at the Renaissance Nashville Hotel and Convention Center in Nashville, Tennessee

For the program and more information:

Please contact CHADD at 800-233-4050

Send an email to conference@chadd.org.

You can also learn more about the conference by visiting the CHADD website at www.chadd.org.

I Love You Angry Bear

By Karen Szybalski

My house feels like a cave and Daddy acts like an angry bear. He growls, "I love you, Carl." Then he sleeps, all day long.

Every morning I would hear WHIZZZZZ. Daddy is shaving! Together we brushed our teeth and talked silly, mouths full of toothpaste.

It was snowing the day the WHIZZZZZ never came. He didn't brush his teeth.

"What happened to Daddy?" I ask.

Mama says, "He's still in bed!"

Daddy has a crooked beard and mud puddle eyes. They make me cry. Mama hugs me.

I make a mess in the kitchen and Daddy roars like an angry bear. I dash to my room.

Mama and I make a tent with her fuzzy blanket. She asks, "Are you scared?" Yes, I nod.

Mama hugs me. She says, "Daddy's upset but he'd never want to hurt you!" I ask, "Why's he acting like an angry bear?"

"Daddy's depressed. His brain isn't working right. His feelings are stuck in a traffic jam of sad, mad and upset. Pain is all he can find."

Then Mama kisses me with words. "I love you! We're in this together!" I lie in the snow and ask the giant oak tree, "Why?"

Daddy moves his books and clothes into the empty bedroom. I hear snoring and sound from the TV.

Mama says, "The doctor is giving Daddy lots of tests. He wants to find out what's making Daddy depressed."

Daddy is sent to a special doctor. His name is Dr. Matthew. He is called a psychiatrist. He helps people who are depressed and acting like angry bears. Dr. Matthew gives Daddy medicine to help his brain work better. Dr. Matthew also helps Daddy listen to his mad, sad and upset places. He helps Daddy hug his feelings.

I still go to school, visit friends, attend parties and see Grandpa. Mama and I plant new flowers in the garden.

At home, I bang on Daddy's door. "Play with me!" I shout. No answer. I stick 10 fingers under his door, wiggling a hello. No answer.

I drive tiny cars under his door one after another. No answer. I fall asleep on the floor. Still no answer.

Mama says, "Daddy's depression is not my fault. It is not



Peter and 7 year old Bryan - Karen appears in the small photo

Daddy's fault. It is nobody's fault. It is just the way things are right now!"

I visit Dr. Matthew. He helps families who live with angry bears. He plays with me and says, "I will tell you about depression, then it won't seem so scary. I will help you say how you feel. Then we can hug your feelings."

Summer comes. I go camping, swimming at Grandpa's, eat pizza with my friends, Daddy misses everything!

Mama and I meet other families living with angry bears. Their hugs and kisses make me warm inside. Mama says this will keep us from becoming angry bears too.

At home, I hurl my blocks into Daddy's door. I crash my wooden truck on the floor. I empty my toy box next to his door.

I scream, "Daddy! Don't you love me anymore!"

Daddy roars, "Leave me alone!" I cry.

Mama gives me a bath with lavender blossoms. I calm down.

Mama burns dinner and throws it in the trash. She isn't upset. "Nothing matters, except to love each other through this!"

Mama and I paint a box for Daddy. I cover it with glitter and buttons. I put in pictures from school, stones from the garden, a blue bird feather, an acorn and a penny. I will give this to Daddy when he feels better.

Mama says it's listening time. She asks, "How are you feeling?"

My tummy feels like it has baby frogs jumping inside. "I miss Daddy, I'm sad he's sick! I'm mad at him! Did I do

something wrong? Doesn't he want to be my daddy?"

Mama whispers, "It's easy to feel all of those things when Daddy isn't acting like himself. Even though Daddy can't show it right now, he still loves you and you haven't done anything wrong. Let's give those hurting places inside of you a big hug."

Daddy takes a bath. I sit on the floor and help Mama scrub his back. He is not better. I hug Daddy on the bed. "I am sorry!" he whispers. He is not better. Mama and I go to church. We visit the minister. We pray for Daddy. He is not better.

Missing Daddy makes me tired. Mama and I take walks, afternoon naps, and try to eat healthier. I find fall leaves for Daddy and put them in his room. Mama and I make up poo poo haiku and laugh till our bellies hurt.

Dr. Matthew says, "You are waiting. Waiting can be hard. If Daddy reaches out, talk to him, tell him you miss him. Give him a hug."

Mama screams at Daddy, "Don't give up! Please! We love

you depression or not!" I hug her as she cries.

In the morning Mama doesn't do the dishes or comb her hair.

"Are you an angry bear too?" I ask.

"No honey, I need some rest today. I'll feel better tomorrow."

It begins to snow. Winter is here. I hear WHIZZING in the bathroom. I peek around the corner. Daddy is shaving!

Daddy comes to eat breakfast with us. His beard is gone. He sits at the table, talking. I tell him, "I love you Daddy, I am sorry you don't feel well! I feel bad sometimes too!" We hug for a long time.

Daddy feels a little better each day.

Everyday he says, "I love you!"

Everyday I say, "I love you!" back.

Mama and I know what to do if this happens again. We are not alone. 

THE YOUTH VOICE

My Favorite Teacher

By Kristen Putignano

I would like to share a story about a teacher that changed my life forever. In sixth grade,

I had my first male teacher. Frankly, I did not really know what to expect from this experience. That was the year before I got sick. His name was Mr. Minarovich (Mr. M). He was nice. It was also his first year of teaching. Our class always had fun in his classroom. I often stayed after school for extra help, or just to play a game of mancala with Mr. M. I thought it was cool to learn that teachers are real people too! When I was younger, I always thought they were aliens or some other unusual creature. The year was going well. It was not easy for our class or Mr. M to get accustomed to each other. We were always ready for one of his "serious talks." We often laughed because Mr. M liked to talk about problems in the class, especially if we were being disre-



Kristen

spectful toward him. My parents met Mr. Minarovich at parent-teacher conferences. They also liked him. The year ended, and I was sad to go on to a new school, because I felt like I was losing a friend. I told him that and he reassured me that I could come back and visit him anytime. I did visit Mr. M often. As the year went on,

fewer and fewer people went back to visit Mr. M, but I would never miss a game of mancala.

Then I got sick. I was embarrassed that I had to go to a psychiatric hospital for depression and self harm. My mom told me that Mr. M found out that I was in the hospital and wanted to come to visit me. I was embarrassed at first, but then I looked forward to his visit. He came one day, and brought me an article about a friend of his that had committed suicide. He told me how that had affected him, and that he would be very upset if that same thing

happened to me because he cared about me. I was astonished and amazed when I saw in his face how much he really meant it. Just that talk with Mr. M changed my outlook on taking my life because I realized I had people other than my family that cared about what happened to me.

Since then, I have had three surgeries on my shoulder, and have been hospitalized in a psychiatric hospital quite a lot. Mr. M has been there for me every single time, through the bad and good. I know that he is a shoulder to lean and cry on. I also know that he is my friend. I would not be where I am today without Mr. M. He has had an enormous impact on my life. I do not see Mr. M as much these days as I used to because I am out of school. However, we always keep in touch and I would never miss a few mancala games with him now and again. I now realize that both of us learned a lot during his first year of teaching. I also know now that I have made a friend for life. 

Embracing Families: Improving Children's Mental Health Services in Alabama

by Linda Champion, NAMI Alabama and Vice President of Alabama Family Ties

On April 19, 2004, Alabama took a giant step forward to begin the process of improving children's mental health services. NAMI Alabama joined forces with Alabama Family Ties and Children's First Foundation to host a daylong event—with three separate and distinct sessions—that focused on children's mental health services. NAMI Alabama brought in Darcy Gruttadaro, Director of the NAMI National Child & Adolescent Action Center, to provide

technical assistance for the day's events. It was the goal of NAMI Alabama, Alabama Family Ties, and Children's First Foundation to reach three key influence groups: the governor's cabinet members (including the commissioners of all child-serving agencies and Medicaid), family members and other child advocacy groups, and Alabama legislators. Our day could not have been more successful.

“From her vantage point on the bench, Judge Cobb has seen firsthand the tragic outcomes from a mental health system in shambles.”

technical assistance for the day's events. It was the goal of NAMI Alabama, Alabama Family Ties, and Children's First Foundation to reach three key influence groups: the governor's cabinet members (including the commissioners of all child-serving agencies and Medicaid), family members and other child advocacy groups, and Alabama legislators. Our day could not have been more successful.

Session I – Our Morning

We started the day with what we thought would be an hour-long meeting between the three lead advocacy groups and the governor's cabinet. Through the tenacious efforts of Judge Sue Bell Cobb—President of Children's First Foundation and a Judge currently sitting on the Alabama Court of Criminal Appeals—we assembled all of the commissioners of Alabama's child-

serving agencies and other high-level state officials and policymakers.

As the invitees filled the room, we could hardly contain our excitement. Judge Cobb had pulled together Governor Bob Riley's chief of staff, as well as commissioners from the Department of Mental Health and Mental Retardation, the Department of Human Resources (child welfare), the Department of Juvenile Justice, the Department of Public Health, and the Department of Education. The meeting also included family court representa-

tives, the immediate past and current president of the Alabama Chapter of the Academy of Pediatrics, and a renowned and well-respected child and adolescent psychiatrist in Alabama. What was billed as an hour-long meeting went on for two hours, with excellent discussion and a commitment to work together.

Darcy Gruttadaro addressed the group on an array of policy issues related to children's mental health, and spoke of the dire impact that spending cuts would have on children, families, and the community. She focused on the “penny-wise, pound-foolish” reality of deep cuts and the fact that the state is actually paying more for these children, just in all the wrong places. Alabama, like nearly every other state, is facing deep budget cuts.

Darcy skillfully guided the group through a discussion on Medicaid

home- and community-based waivers; the need for effective collaboration and blended or shared funding between child-serving agencies; the benefits and efficiencies of early intervention; the critical need for family-driven mental health systems; and the need for greater use of evidence-based practices. Then it was off to Session II.

Session II – Our Afternoon

This session brought together family members and advocacy groups, program managers from child-serving agencies and Medicaid, and representatives from juvenile and family court. Judge Cobb opened the session with a heart-breaking speech about the tragic consequences of failing to intervene with appropriate services when children clearly need them. From her vantage point on the bench, Judge Cobb has seen firsthand the tragic outcomes from a mental health system in shambles. Next, Darcy Gruttadaro outlined the public health crisis in our failure to serve children with mental health needs. Those attending this session quickly realized the barriers that families and children face in attempting to access mental health services. Darcy also presented a plan of action to help reform the broken children's mental health system and received a commitment from many of those in attendance to work to reform the system. Judge Cobb promised the group that a follow-up meeting would be convened after the end of the Alabama legislative session in late May. Then it was on to the evening session.

Session III –Our Evening

This session included a legislative networking event to better inform legisla-

tors, state officials, policymakers, and other stakeholders about a variety of children's mental health issues. Imagine our surprise when the first guest to arrive was the Speaker of the Alabama House of Representatives! More than 50 people attended this legislative

reception. At the end of the day, we could not have asked for a better outcome. We received a commitment from the morning and afternoon attendees to work together on a strategic plan for children and families and helped educate lawmakers about the crisis in children's mental health. Although it

proved to be a long day, our three sessions really paid off. 

Editor's Note: To learn more about this effort, please contact Linda Champion at lchampion@mh.state.al.us or by phone at 334-353-7178.

AFFILIATE NEWS

NAMI Frederick County: Making Sure Schools Are Armed with the Facts

By Carol Howe, NAMI Frederick County, Maryland

Just as the public needs information about serious mental illnesses (neurobiological brain disorders), so do our school systems, despite the enactment of the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973. Teachers must work everyday with kids who have neurobiological brain disorders, yet many teachers have been taught that these children have "behavioral disorders." Many teachers have the Herculean task of teaching children who sometimes make learning difficult for all of the children in the classroom. And yet, teachers must cope with children with varying shades of disability under the expectation that "no child will be left behind." NAMI Frederick County has tried to make things easier for the teachers through our classes for school professionals, monthly education programs, and our "Gifts to the Counselors and Teachers" program.

When our family moved from Washington State to Maryland in late 2000, we became involved in NAMI Frederick County. For Mental Illness Awareness Week (MIAW) in 2002, we visited the supervisor of counseling and student support for the Frederick County public school system and received a warm welcome from her. She accepted the NAMI Children's Resource Guide and our NAMI

brochure and sent each of the 60 schools in Frederick County a copy of the resource list for their counselor offices. Then in August 2003, we received a grant from the Community Foundation of Frederick County to provide educational materials to thousands of families and to the public. We again went to the county's supervisor of counselors with a letter, which she sent to all counselors, telling them about NAMI's Family-to-Family Course and inviting them to attend. She also sent them Family-to-Family brochures and information about our education program that featured Dr. Ellen Liebenluft of NIMH presenting on early onset bipolar disorder.

During MIAW, NAMI again went to the supervisor and presented her with two folders for each of the 60 schools (120 folders in all) that included the following information:

- Several issues of NAMI *Beginnings*;
- The NAMI Child and Adolescent Action Center Internet Resource List;
- "Parents and Teachers As Allies" brochure;
- "Seeking Answers, Getting Help" brochure;
- A fact sheet, "Broken Promises and the Health Care Crisis—Children and Adolescents with Mental Illnesses";

- Our local NAMI of Frederick County brochure; and
- Ten great fact sheets on early onset brain disorders available from the NAMI national Web site.

Each folder also included the following documents from other organizations:

- "A Common Sense 10 Point Plan to Address the Problem of School Violence" from the American Academy of Child and Adolescent Psychiatry;
- "Helping Children and Adolescents Cope with Violence and Disasters" from NIMH;
- "Questions and Answers—Treatment of Children with Mental Disorders" from NIMH; and
- A large poster from NARSAD with a lovely portrait of a child and a dog.

This May, we hope to get the updated NAMI Children's Resource Guide to provide to each school for mental health month. We hope that resources we have provided have "trickled down" to families, teachers, and school counselors. We know that our efforts have resulted in 10 families with children with brain disorders taking the Family-to-Family course. These families have joined our local NAMI.

We surveyed families that graduated from the NAMI Family-to-Family pro-

gram and received the following suggestions: (1) develop a class like Family-to-Family for child-serving professionals like teachers, school nurses, guidance counselors, and others; and (2) develop a class to help parents understand how to work with schools. Classes like NAMI's Family-to-Family help to take away the blame. Our com-

munity also has a very active Mental Health Association with programs for children and parents.

NAMI is ready to help educate school professionals and others in the community about early onset brain disorders. We are armed with fact sheets, videos, resource lists, and brochures, and have great cooperation from

NAMI National and NAMI Maryland. We are moving full steam ahead to help improve the lives of children and families. 

Editor's Note: To learn more about NAMI Frederick County's advocacy work, please contact Carol Howe at carolhowe@adelphia.net.

F E A T U R E

continued from page 7

with adequate training and experience to develop an appropriate IEP, parents can request that the school retain an expert to assist in the development of the IEP. Under some circumstances, a good first step will be for the parents to simply obtain and provide the information to the school themselves. Parents can also request an aide be available to assist the child. For private space for children with behavioral problems, parents can request access to alternative locations in the schools.

The IEP should also include problem solving and crisis plans in case of behavioral crisis. Schools need to keep parents informed about their children's emotional and behavioral functioning and parents should be informed when there is an emotional or behavioral crisis. Schools need to identify mentors or trusted adults for children to consult during the school day. It is also important to establish a cooperative relationship between the schools and outside professionals, that are providing services for the child. Parents should also identify class or school rules which may lead to discipline, such as tardiness, turning work in late, or the like, and build in to the plan, non punitive consequences and/or positive strategies, such as rewards for good behavior, to address the problem.

DG: Do you have other comments or suggestions for parents of students with mental illness that might help them be a more effective advocate for their child in the schools?

MC: For better or worse, much of the child's school experience will be determined by the level of understanding and sensitivity of the school staff and by the quality of the relationship between the staff and the child and the parents. Parents should make aggressive efforts to establish a positive rapport with the school staff and to build informal effective channels of communications. Parents need to communicate to schools their desire to be supportive of the effort of the school and to assist the staff in accomplishing their goals in working with the child. While some schools are resistant to parental involvement, it is critical for parents to develop trusting relationships with as many of the staff involved with the child as possible. Parents should also work hard in trying to share information in a timely fashion. There is generally little value to keeping private testing or recommendations secret to "spring" on the district at some strategic moment. It is far better to communicate openly and to build

a trusting relationship. In instances where the school is unresponsive to the parent's efforts, parents should seek consultation from knowledgeable mental health professionals, advocates and attorneys as quickly as possible.

Parents should also recognize that the creation of an appropriate IEP is only one step in the process of ensuring an appropriate education for the child. Parents need to be involved with their child's education on an ongoing basis, with an emphasis on implementation of the IEP. 

Mr. Cohen can be reached via e-mail at mcohen@monahan-cohen.com or through his website at www.monahan-cohen.com.

The content included in this article is not intended in any manner as legal advice. If parents and caregivers have legal concerns related to either IDEA or Section 504, they should consult with a lawyer.



NAMI would like to invite you to participate in the Multicultural Center's Third Annual Symposium, African Americans: Facing Mental Illness and Experiencing Recovery. This half-day event will bring together leaders from across the country to address the most pressing

September 8, 2004
1:00 p.m. to 6:30 p.m.
Washington Hilton & Towers Hotel
Washington, DC

mental healthcare concerns in the African-American community. Attendees for the event will include NAMI grassroots leaders, African-American community leaders, families, people with mental illnesses, and mental health professionals.

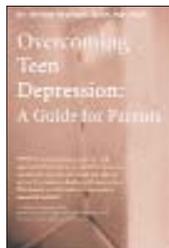
Overcoming Teen Depression: A Guide for Parents

By Miriam Kaufman, BScN, MD, FRCP

List Price: \$16.95

Soft Cover: 262 pages (March 2001)

Publisher: Firefly Books



In *Overcoming Teen Depression*, Dr. Miriam Kaufman has created an easy-to-read guide for parents searching for help for their child. This book is aimed at a general audience, eschewing professional and medical jargon in favor of clear, straightforward language for parents who need quick answers.

The book is divided into chapters that discuss specific issues ranging from diagnosing depression to avenues of therapy to concurrent illnesses that can exacerbate an already serious condition. Each chapter includes case histories that depict specific challenges in the treatment of teen depression. At the end of the book,

there is a question-and-answer section designed to help parents of teens with depression address their own anxieties and fears. The book covers a number of topics, including conventional and alternative treatments for depression, substance abuse, HIV/AIDS, homosexuality, ADHD, and more. Of particular interest is the chapter on adolescent suicide, which helps parents understand when a depressed teen is suicidal and how to prevent a suicide.

The book concludes with a discussion of cultural factors that impact the way depression is viewed in society. In addition to discussing gender, race, sexual orientation, and socio-economic status and their possible links to depression, it covers how to help teens with depression develop resilience, and how to overcome the stressors that can provoke an episode of depression. *Overcoming Teen Depression* is a useful guide for parents who need practical advice on how to help their teen cope with, and ultimately triumph over, depression. Dr. Kaufman's book will also prove helpful to teachers, school counselors, pastors, and other caring professionals who work with teens at risk for depression. **UB**

Editor's Note: A special thanks to our reviewer, Joe Harris, for his valuable contribution in reviewing this book.

The American School Health Association Focuses on Students with Attention-Deficit/Hyperactivity Disorder (ADHD)

Once again, the American School Health Association (ASHA) is focusing on mental disorders in the school community in the April/May 2004 issue of *Health in Action*. This publication is distributed by ASHA to their school professional members across the country.

In December 2002, ASHA focused their *Health in Action* publication on depression and other mood disorders in the school community. NAMI is pleased to see that ASHA is focusing the attention of the school communi-

ty on better understanding the diagnosis and treatment of ADHD, depression, mood disorders, and other mental disorders. Ideally, this will lead to schools better addressing the educational, social, and emotional needs of students with mental illnesses.

In this latest issue of *Health in Action*, Darcy Gruttadaro, the Director of NAMI's Child & Adolescent Action Center, contributed an article on NAMI education programs designed to educate school professionals about mental illnesses in youth. The article features

a description of NAMI Utah's Hope for Tomorrow, NAMI Nassau/Queens' Breaking the Silence, and NAMI National's Parents and Teachers as Allies as an in-service program. There are several excellent articles on ADHD included in the publication.

Please consider recommending ASHA's *Health in Action* to school professionals in your community if they do not already receive this publication. To obtain a copy of this publication, please visit the ASHA Web site, www.ashaweb.org.

This publication is funded by an unrestricted educational grant from McNeil Consumer & Specialty Pharmaceuticals. According to NAMI policy, acceptance of funds does not imply endorsement of any business practice or product.



The National Alliance of the Mentally Ill

Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
703.524.7600 • www.nami.org

Address service requested

Non-Profit Org.
U.S. Postage
PAID
PFCO