The Ups and Downs of Serving Students with Bipolar Disorder

PRESENTED BY:
Diana Browning Wright, M.S., L.E.P.
dianawright@earthlink.net

Areas We’ll Cover

1. Is there a true increase now?
2. Is it real? What is it? Is it different from adult Bipolar? Is the criteria changing?
3. Does this all equal “eligibility” and an IEP?
   (a) “Child Find” obligation?
   (b) What disabilities?
   (c) If eligible, eligible for what “specialized instruction”? And then what -- supplementary aids and supports? Related services?

Areas We’ll Cover (cont.)

4. What about Sec. 504 for a Bipolar Disorder?
5. What if they already have eligibility (504 or IEP)? Should we add something to the IEP services for co-morbidity?
6. Research and websites for families and educators
7. Determining IEP components, if needed

History of BP

• See History, Handout 7
  – Highlights:
    • 400 BC mania and melancholia described as separate illnesses by Hippocratic physicians
    • 150 AD first written account of JBPD
    • 1949 benefits of lithium described to treat mania
    • 1969 children as young as 6 treated with lithium in Sweden
    • Late 1990s multi-site treatment and longitudinal studies funded by NIMH. More psychiatrists dx and rx for JBPD

Is There a True Increase Now?

• Yes—Increased incidence since 1940s
  • People are more mobile, making inter-marriage of two Bipolar adults more likely.
  • High co-morbidity rate with alcoholism; women did not go to bars for drinking or finding mates until 1940s.
  • Gene Penetrance increases inheritability when both parents have the disorder.
Triggers for Onset

OFTEN APPEARS WITH NO IDENTIFIABLE CAUSE, HOWEVER:

– Puberty is a time of higher risk for males and females.
– Treatment with stimulants or antidepressants can trigger onset.
– Meth is a stimulant-some evidence of trigger effects reported
– Traumatic event or loss may trigger first episode of depression or mania.

What is it and how is the childhood version different from the adult version?

Four Versions of Typical Bipolar, a Mood Disorder from DSM IV-TR
(only seen in 10% of non-adolescent children with dx of “Bipolar”)

1. Bipolar 1 Disorder
2. Bipolar 2 Disorder
3. Cyclothymia
4. Bipolar Disorder-Not Otherwise Specified (NOS)

• Review of Dx and Research Slides adapted from Ron Russell, Ph.D., Ca. Dept. of Ed.-Diagnostic Center-South, with permission, 2008

Adult/adolescent Type 1 of 4. Bipolar 1
• Manic Focus
  History of one or more Manic Episodes or Mixed Episodes
  – Mixed Episode: Mania and Major Depression nearly every day, with moods rapidly alternating between sadness, irritability, euphoria.
  – Core features: elated/euphoric mood and grandiosity with 3 additional symptoms of mania.
  – Alternate: IRRITABILITY instead of euphoric/grandiose mania; 4 additional symptoms of mania are required.
  – Major Depressive Episodes usually accompany mania.

Adult/adolescent Type 2 of 4: Bipolar 2

Major Depressive focus:
History of one or more Major Depressive Episodes with at least one Hypomanic episode.
Hypomanic = a “low grade” Mania that is not as disabling
Variant: heightened anxiety or irritability instead of euphoria.

Adult/adolescent Types 3 and 4

• Cyclothymia:
  Hypomanic periods with symptoms that do not meet criteria for Manic Episode with depressive periods coupled with symptoms that do not meet criteria for a Major Depressive Episode. (Absence of full Manic or Mixed Episodes distinguishes it from Bipolar I Disorder).

Bipolar Disorder-NOS

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Criteria for Episode of Major Depression: What It Looks Like

- Depressed mood nearly every day.
- Crying spells or tearfulness.
- Sleeping too much or inability to sleep during depression (adults more likely; children sleep disturbance during mania likely).
- Withdrawal from previously enjoyed activities.
- Change in concentration, memory, thinking/decisions, word retrieval, verbal fluency
- Pervasive sadness or irritability.

Major Depression (cont.)

- Agitation or excessively quiet.
- Drop in work (or school) performance.
- Thoughts of death and/or suicide.
- Low energy.*
- Increase or decrease in appetite/weight.*
- Feelings of worthlessness or guilt.
  – Children may feel, but don’t have insight to report or discuss worthlessness or guilt
- Slow moving, e.g., difficulty getting out of bed.
  *more likely to occur in adults

Criteria for Manic Episode

(note: mania takes longer to develop in the disorder, children demonstrate depression usually first)

- Euphoric or elevated mood, lasting at least one week.
- Decreased need for sleep w/no daytime fatigue.
- Racing thoughts or flight of ideas.
- Pressured speech; pressure to keep talking.
- Grandiosity or inflated self-esteem.

Grandiose Tales and Plans

- Involvement in pleasurable but risky activities. (KEY SYMPTOM-Geller studies)
  – Hypersexuality: exhibition, kissing, flirting, dirty talk (different from abused children- no anxiety or compulsive qualities noted during talk)
- Distracted by irrelevant details.
  – but not agitated as in depression
- Distinct increase in bizarre, disorganized goal-directed activities.
- Impairs social and/or occupational functioning; may require hospitalization if harm is present.
  Note: Psychosis, may occur with mania; but is not a diagnostic criterion.

Criteria for Manic Episode (cont.)

- Less severe symptoms of Mania that do not impair social or occupational functioning or require hospital.
- Increase in multiple goal-directed activities, but organized and not bizarre.
- Unlike Mania, no psychosis.

Criteria for HYPOMANIC Episode

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Children Are Not Miniature Adults

- Adults, adolescents and a minority of children (10%) present the distinct episodes of mania, depression, and hypomania just described, and meet duration criteria;
- The majority of children with JBPD present chronic irritability instead of distinct episodes.

Onset and Features

Bipolar adults report first manic episode occurred before age of 21, with 20% occurring in childhood.
- Childhood onset (<13 years) usually begins with Major Depression (crankiness, sadness, loss of interest in play).
- Adolescent onset (13-17 years) more likely to begin with Manic Episode.

Recently

- Recent research is finding evidence that when onset is in childhood, the disorder becomes a more severe form of adult Bipolar Disorder.
- However, findings are inconclusive about what percentage of JBPD evolves into adult Bipolar Disorder.

CLUE: CHILDREN EXPERIENCE MANIA DIFFERENTLY

Adults typically enjoy Mania, or at least Hypomania, while children experience it as negative (irritable response?).
High arousal (mood) is the core, subjective response can be either an emotional + or emotional -.

Critically Different Observable Behaviors

Adults and adolescents typically experience euphoric mania (elation- yee haw!). Children’s mania, however, can appear as
1. chronic irritability if negative response to arousal.
2. giddy/goofy/silly if positive response to arousal.
What Does NIMH Roundtable Propose About Types of Childhood Bipolar Disorder?

- **Narrow**: The minority who meet BP-1 or BP-2
  - Clear episodes elevated mood or grandiosity of 7+ days for Mania or 4+ for hypomania, clear switches from other moods; irritability excluded
- **Intermediate**: Like Narrow, but includes irritable mania or hypomania with shorter duration of episodes

An Alternate: Papulos’ Proposed “Core” Phenotype

- **Episodic, abrupt transitions in mood states accompanied by rapid alteration in levels of arousal, emotional excitability, sensory sensitivity, and motor activity.** Variable mood states of mania/hypomania and depression meet DSM4 symptom criteria, but not duration criteria, Mania/hypomania/or mixed state(required):
  - mirthful, silly, goofy or giddy; elated, euphoric, or overly optimistic, and self-aggrandizing, grandiose or difficulty regulating self-esteem.
  - Depression: withdrawn; bored or anhedonic; sad or dysphoric; overly pessimistic and self-critical.

An Alternate: Papulos’ Proposed “Core” Phenotype

PLUS Poor modulation of at least one of four drives that is excessive for age and/or context:

1. **Aggressive** (fight/flight*),
   - critical, sarcastic, demanding, oppositional, overbearing “bossiness,” easily enraged, prone to violent outbursts, and/or self-directed aggression (head-banging, skin-picking, cutting, suicide attempt),
2. **Sexual, Appetitive** (cravings) developmentally premature and intense sexual feelings and behaviors
3. **Acquisition** (have to have wanted item NOW).
   - Appetite dysregulation (binge eating, purging, anorexia) and poor control over acquisitive impulses (buying excessively, hoarding).

Papolos’ Proposed “Core” Phenotype

4. **Sleep/wake disturbances:**
   - Sleep discontinuity: Initial insomnia, middle insomnia, early morning awakening, hypersomnia.
   - Sleep arousal disorders: REM dysregulation, night terrors/nightmares (often containing images of gore and mutilation, and themes of pursuit, bodily threat and parental abandonment), bruxism, sleep walking, enuresis, confusional arousal.
   - Sleep/wake reversals: Tendency toward periodic lengthening or shortening of sleep duration associated with day-for-night reversals, often dependent of circannual changes in zeitgebers (external time cues), including light/dark duration, changes in temperature, and social zeitgebers (established routines, work shifts, etc.).
   - Executive function deficits.
   - Deficient habituation to sensory and environmental stimuli.
Of Interest: Non-specific Features
Parents Report (not DSM4 Criteria)

- Irritability – Chronic for many children, a cardinal feature that causes others to “walk on eggshells” around them.
- Defiance of authority (typically related to grandiose delusion of believing they are right).
- Easily overwhelmed by emotions.
- Explosive reactions, often lengthy, with slow recovery, and often destructive. Can be triggered by “no.”
- Strong and frequent cravings, often for carbohydrates and/or sweets.
- Self-regulation difficulties (different from Tourette’s dysregulation).

Non-Specific Features (cont.)

- Clingy/separation anxiety-extraordinarily so.
- Difficulty settling for sleep; sleep may be erratic.
- Poor school attendance.
- Anxiety and physical complaints.

Additional Facts & Features

- Adolescents and adults may experience periods of complete wellness/recovery between episodes or cycles; children are not as likely to do so, especially when there are no distinct episodes.
- Geller’s longitudinal study of 6-17 year olds with JBPD: 58/89 (65%) recovered (8 consecutive weeks without mania or hypomania).
- But then, the relapse (2 consecutive weeks of mania after a period of recovery) occurred for 32/58 (55%) approx. 29 weeks post recovery on average.

Kindling Effect

- Once the illness emerges, episodes tend to recur and increase in severity, especially without treatment. Referred to as kindling effect.

Treatment Response

- Responds quickly to mood stabilizers, but this does not solve the problem.
- Mood and behavioral dysregulation, like a seizure, is the outward, observable manifestation of internal Central Nervous System pathology.
- Bipolar is not a simple mood disorder, it is a complex neurological condition with labile mood a prominent, but not only feature that handicaps.

Geller’s 2005 Longitudinal Study

- Children with JBPD are twice as likely to recover when living in context of intact, nuclear family;
- Four times as likely to relapse in the context of low maternal warmth; these children demonstrate significant levels of low mother-child warmth, high mother-child tension, high father-child tension, and peer problems.
Additional Facts & Features (cont.)

- Co-occurring ADHD and Bipolar appears to be a genetically transmitted form associated with earlier onset and more severe features.
- Regular “social rhythms” and routines (esp. sleep/wake) may reduce risk.
- Much higher probability when one or both parents have BPD.
- Recovery more likely in context of nuclear family; and with “warmth” and reduced levels of tension in parent-child interactions.

Addition Facts & Features (cont.)

- Incidence rate is 3-6% equally distributed across both genders.
- Many teens with untreated Bipolar Disorder abuse alcohol and drugs
  - Adolescents who appear normal until puberty, then experience sudden onset are thought to be especially vulnerable to substance abuse.
- Children with hypomania are very likely to develop mania; but are also likely to recover.
- Creativity and humor are common features.

Borderline Adolescents

1. Psychotic-like behaviors (drug-induced psychosis, quasi-delusional statements).
2. Unstable moods (anxiety, inability to be alone, anger, depression and suicidal behavior).
4. Unstable relationships (idealization and devaluation, splitting, manipulativeness).
5. Identity problems (uncertainty about self, feel like different persons; problems with gender identity, values, loyalty, career goals; sense of emptiness and unreality).

Medication Side Effects

Medications for treating JBPD may cause further complications, report if observed
- Impaired memory
- Reduced organizational skills
- Altered concentration

Complications—physician will monitor:
- Nausea, diabetes, weight gain, liver toxicity, poly-cystic ovary disease

Importance of Early & Accurate Diagnosis

- Prevent “kindling effect.”
- Prevent suicide and substance abuse.
  - 33% attempt suicide within the first 6 years after onset; 15-19% succeed.
  - 1% of youth attempt suicide by age 18, 22% with major depression and 44% with JBPD
- With co-morbid PDD, can prevent further impairment of functioning caused by JBPD.
Characteristics of Suicide Attempts

DATA ON SUICIDE - - JBPD CAN BE LEthal:
• 33% attempt suicide (across all ages).
• Older children more vulnerable, and especially as depressive episodes subside.
• 11% had most extreme degree of intent, while 16% had moderate-to-high probability.

PREDICTORS OF SUICIDE ATTEMPTS
• Mixed Episodes.
• Psychosis.
• Physical/Sexual Abuse.
• History of Psychiatric Hospitalization.
• Substance Use Disorder.
• Co-morbid Panic Disorder.

Less likely if child/adolescent has ADHD and SIBs.

Features That Impact School Performance
• Difficulties recognizing facial expressions of emotions.
• Easily overwhelmed by emotions.
• Impulse control difficulties and poor judgment result in risky behaviors.
• Can appear defiant.

Implications for School (cont.)
• Impose rules on peers that they may have difficulty following.
• Difficulties with concentration and sustained attention.
• Disorganization; reduced task completion.
• Handwriting difficulties.
• Psychotic delusions.

Verbal Memory Impairment
Verbal memory impairment found with Bipolar Disorder:
• Recall impaired (high “forgetting” rates).
• Recognition impaired due to poor encoding rather than rapid forgetting.
• May contribute to impaired daily functioning.

Reported in Psych Res 2006; 142: 139-150
Co-morbid Conditions

More Common: ADHD (60-80%); ODD (70-75%); Substance Abuse (40-50%); Anxiety (35-40%); OCD.

Less Common But Significant: PDD/ASD (21% meet criteria for JBPD); Tourette’s.

Co-occurring ADHD and Bipolar in childhood appears to be a genetically transmitted form with earlier onset and more severe features.

Differentiating ADHD from JBPD

SIMILARITIES: Talkative, Distractible, Overly Active

KEY DIFFERENCES: [delineated in Handout 1]

Very common for co-occurring conditions to be diagnosed first, causing long latencies between emergence of JBPD symptoms and a clinical diagnosis.

Co-morbid PDD

• Children with PDDs are 2 to 6 times more likely to develop co-morbid psychiatric condition.
• Possible genetic link between Bipolar and PDD.
• Mood disorders can further impair PDD.
• More mood disorders in children with NVLD, which is similar to Asperger’s.

Co-morbid PDD (cont.)

Persons with MR and DD have different clinical presentations of mood disorder due to:

• Intellectual distortion
• Psychosocial masking
• Cognitive disintegration
• Baseline exaggeration

Better Indicators of Mood Disorder for MR/DD Students

Depression: Increased self-injurious behaviors, apathy, loss of adaptive skills (e.g., onset of urinary incontinence).

Mania: Increased verbalization (rate or frequency), overactivity, distractibility, noncompliance.

If We Suspect Bipolar?

• Conundrum: Refer to physician “for diagnostic purposes”?
  — And/or
• Provide data to assist diagnoses.
• NIMH publishes screening instruments for symptoms of Bipolar Disorder, which are available at: www.nimh.nih.gov/publicat/manic.cfm.
• Structured Interview for Childhood Affective Disorders (Kiddie SADS) available at: www.wpic.pitt.edu/ksads/default.htm.
• Papalos has published a screening instrument, the Child Bipolar Questionnaire (CBQ), as well as a follow-up diagnostic interview protocol; both are available at: www.jbrf.org/library.
False + and False - ? YES
Co-morbidity Possible? YES
• Post Traumatic Stress Disorder
• Reactive Attachment Disorder
• Intermittent Rage Disorder

Literature describes several examples, false +, -
• Autism Spectrum Disorders
• AD/HD
• Psychotic Episode

Literature describes False + and false -, Co-morbidity

### Should Children Be Taking Mood Stabilizing Drugs?

• Bipolar medications reduce brain injury from the disorder

**HYPERCORTISOLEMIA—damages the brain**

• With Major Depression and Bipolar, increased levels of Cortisol (Hyper-cortisolemia) cause damage to various areas of the brain. For example, it causes structural damage to the hippocampus, which results in poor regulation of emotions as well as learning disabilities. Some medications reduce Cortisol toxicity by turning on a naturally occurring protective protein, Brain-derived Neurotropic Factor (BDNF), which helps repair nerve cells. BDNF latches onto Cortisol molecules, rendering them less toxic.

### But Do They All Need IEPs?

• Core question:
  – Do the symptoms come under control and remain under control with medical intervention?

  • Yes? Eligibility would then be in question, effective differentiated instruction in the least restrictive environment may suffice.
Do They All Need IEPs?

Two-prong eligibility determination applies

1. “Child Find” for Handicapping Condition
   - LD or, ED or, OHI?
   - TBI (co morbidity? head injury occurred during dangerous behaviors?)

2. If criterion is met, does the student need “specialized instruction” due to the unique nature of the disability?
   - Yes? IEP description of specialized instruction

Famous People Reported to Have Bipolar Disorder:

- Winston Churchill
- Abraham Lincoln
- Theodore Roosevelt
- Virginia Woolf
- Ernest Hemingway
- Tolstoy
- Schumann
- Goethe
- Handel
- Patty Duke

LD: Suggestions for Validity

- Assess the processing areas most commonly reported for JBPD.
- Do NOT assess cognitive or adaptive functioning when in a depressed state; be cautious when in a manic state.
- Carefully assess academics, use short sessions, structured with “winning” prizes.

Neuropsychological Impairments Persist After Mood Is Stabilized:

- May be a “processing disorder” in LD determination
  - Verbal and visual memory
  - Visual-motor skills for writing
  - Planning and problem-solving
  - Attention & Executive functions
  - Misinterpretation of facial expressions (often result in attribution errors-hostile intent from neutral stimuli)

Neuropsychological Impairments Persist After Mood Is Stabilized:

Executive functioning deficits demonstrated in assessment

- Difficulty inhibiting previously learned or “intuitive” responses when a new rule is introduced (pre-potent responses).
- Decreased ability to adapt to changing rules or contingencies, ability to switch between multiple sources in problem solving (cognitive flexibility deficits).
- Planning and problem-solving (Examine project time line skills, word problems in math, etc.)

ED Eligibility? Suggestions

- ...a condition (BP) exhibiting one or more of the following characteristics over a long period of time (6 months or more?) and to a marked degree (well beyond typical children) that adversely affects a child’s educational performance (look at class performance, achievement of educational and social/emotional milestones that has not responded to RtI: including well designed behavior and accommodation plans, implemented with fidelity)

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ED, A through E, Requires One or More

A. An inability to learn that cannot be explained by intellectual, sensory or health factors. (manic/depressed states?)
B. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (chronic irritability?)
C. Inappropriate types of behavior or feelings under normal circumstances. (fears? High anxiety? Attribution theory deficits-hostile intentions from neutral stimuli?)

ED, A thru E (cont.)

D. A general pervasive mood of unhappiness or depression (check period of time?)
E. A tendency to develop physical symptoms or fears associated with personal or school problems (state fluctuation anxieties and fears; psychosomatic complaints; on going separation anxiety?)

ED Additional Criteria

• ii. The term includes schizophrenia. (Psychosis sometimes associated?) The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance. (Consider group affiliations, but assess for all items above to rule out ED eligibility. It is possible to be gang affiliated AND BP !)

OHI or ED?

• OHI limits strength, vitality, energy, and cognitive functions, impacting alertness to instruction.
• Some claim EBD programs worsen JBPD. Biased view?
• EBD Quality Program Components are appropriate.

Understanding the Effects of Misinterpretation of Facial Expressions

• Students with bipolar disorder tend to misinterpret neutral facial expressions as hostile.
• Over-identification of anger on neutral faces can stimulate aggression and irritability, which impacts social interactions.

Reported in an advance online publication by the Proceedings of the National Academy of Sciences
Proc Natl Acad Sci 2006; 103: Advance online publication

EBD Quality Program Indicators

(see article at ccbd.net/beyondbehavior Spring 2003)

• Environmental Management
• Affective Education
• Behavior Management
• Internalize Affective Education
• Engaging, Quality Instruction
• Connect Instruction to Adult Living

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EBD Quality Program Indicators

**Strongly recommended additions:**
- CONSTANT SUPERVISION while symptomatic, especially when prone to destructive rage.
- Avoid struggles for control.
- Collaboration with prescribing physician.
- Appropriate accommodations.

OHI vs. ED

- Limited strength, vitality or alertness, including altered responses to environmental stimuli, that impacts alertness to instruction.
- Energy levels AND other cognitive functions are impacted by JBPD, BUT …
  - … JBPD primarily impacts mood and behavior.
- JBPD is a mental illness.
- Services and Placement are the real issues, not category.

504?

- A condition.
- Substantially affecting a major life activity.
  - Learning
- Results in a need for accommodations.
- If “specialized instruction” and related services are required, special education will be delivered under an IEP (funding).

Case Management for Bipolar Disorder

- Share strategies that work, and don’t work with all teachers and staff
- Make safety a top priority.
- Assure consistent accommodations across all settings (document and share).
- Collaborate with home and physician on response to medication changes.

IEP Content

- Academic goals aligned to state standards.
- Determine any Supplementary Aids and Supports.
  - 1. “Special Factors” consideration.
    - Does behavior “Impede Learning of Student or Peers?”
      - Positive Behavior Supports
      - Can include a function-based behavior plan
  - 2. Accommodation Plan and Behavior Plan to Maintain LRE.
- Determine any Related Services to benefit from special education.

Rage Is Cardinal Feature

- Stories abound: Stab, bite others, usually mother.
- Parents become fearful of them; younger siblings at risk of harm.
- Parents lock doors to prevent raging child eloping and doing harm; keep child away from knives, sharp objects, even pencils.
- Sometimes triggered by antidepressants or stimulants.
- Child FEARFUL OF HIS/HER RAGE.
Reacting to Challenging Behaviors

- Help student channel manic energy productively.
- Use non-violent crisis prevention **verbal de-escalation** techniques.
- In handling defiance, recognize it is often rooted in manic grandiosity, which can be delusional.

Accommodations

- Easy access to nurse, counselor, etc.
- Cues and prompts
- Organization strategies
- Consistent schedule
- Visual checklists
- Flexible grading
- Safe haven

Accommodations (cont.)

- Extra time or individual assistance
- Modify demands that elicit anxiety
- Modify P.E. instruction
- Carefully select courses
- Schedule challenging tasks during times student performs optimally

Behavior Supports

- Individual, classroom and school wide systems that teach and encourage appropriate behaviors.
- Individual interventions to monitor antecedents of escalation to rage.

Related Services as Needed to Benefit from Special Education

- Consider “Related Services” to benefit from the special education
  - Cognitive Behavior Therapy to address
    - Internalizing behavior
    - Externalizing behavior

Evidence-based Psychotherapy Approaches

(Consider for Related Services)

- Cognitive Behavioral Therapy
- Affective Education
  - Disability awareness and social skills training
- Social Rhythm Therapy-- Frank (2005)
  - Lack of stable sleep patterns increased social problems
- Family Therapy

See Handouts for description
See websites
See: Empirically-Supported Interventions in School Mental Health
Parent Support

- Behaviors at home are often more intense and problematic than at school.
- Parents are likely to have Bipolar Disorder, given strong inheritability, and this can complicate grieving “loss of healthy child.”
- Recovery more likely in an intact nuclear family; additional factors of parental warmth, low tension between parent and child, and flexibility also affect outcome.

Dx: Take-home Messages

- Juvenile BP dx is on the rise.
- Criterion is in flux.
- Adult and Juvenile phenotype differ depending on emotional response to heightened arousal changed by the disorder.
- BP is not simply a mood disorder.

Dx: Take-home Messages

- There are false positive and false negative dx.
- Research is demonstrating BP is one of the most heritable of psychiatric disorders.
- Comorbity can occur with other disorders compounding the service needs.
- Medication does not fully address the problem.

Eligibility: Take-home Messages

- BP dx triggers a “child find” obligation-service needs will vary.
  - Most with BP will require accommodations for mood effects on learning.
  - Many with BP will require behavior support.
- Many with BP will require IEP or 504.
- Some with BP will require no “specialized instruction” and therefore, no IEP.
- Some with BP will require neither IEP nor 504.

Services: Take-home Message

- All require adult understanding, supervision and a disability perspective.
- Most require accommodation plans.
- Many to most require behavior plans.
- Most with special education eligibility benefit from related services.
- For All--Safety is a primary concern.
  - Beware increased probability of risky behavior, including suicide risk.

Online Resources

Bipolar and Juvenile BiPolar Disorder:
- www.bpkids.org
- www.bipolarchild.com
- www.bpchildren.com
- www.jbrf.org
- www.bpinfo.net

MENTAL HEALTH IN SCHOOLS: see handouts
- www.dmh.ca.gov/mhsa
JBPD Summary--HANDLE WITH CARE

A.R.M.S.

ASSESS- needs

REFER-therapy & information sources

SUPPORT- behavior & accommodations

MONITOR- Safety

THANK YOU For Your Time Today!
**DIFFERENTIATING ADHD FROM JBPD**

**SIMILARITIES:** Talkative, distractible, and overly active.

**KEY DIFFERENCES ASSOCIATED WITH JBPD:** Daily transitions in mood and diurnal cycling that is ultra-rapid; grandiosity; elated mood (co-occurs with irritable mood 87% of the time); hyper-sexuality; flight of ideas or racing thoughts; decreased need for sleep; “mission mode” in which there is a relentless pursuit of needs; and family history of Mood Disorders (including Bipolar) and alcoholism.

<table>
<thead>
<tr>
<th>ADHD</th>
<th>JBPD</th>
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<tbody>
<tr>
<td>Inadvertently engage in risky behaviors.</td>
<td>Intentionally seek out hedonistic and/or dare-devil activities; hypersexuality is in this category.</td>
</tr>
<tr>
<td>Possible difficulty falling asleep. Typically, no difficulty with morning arousal and hyperactivity predictably occurs upon awakening.</td>
<td>Decreased need for sleep rather than insomnia; and difficulty staying asleep, typically due to night terrors. Sleep inertia (difficulty with morning arousal) with bursts of energy from late afternoon to very early morning. With decreased need for sleep, typically engage in goal directed activities during typical hours of sleep.</td>
</tr>
<tr>
<td>OCCASIONAL IRRITABILITY OR AGGRESSION. Usually triggered by sensory or affective over-stimulation; do no cause severe regressions; recovery occurs within 20-30 minutes. Occasional unintentional destruction of things; stumbles into fights.</td>
<td>SEVERE, UNCONTROLLABLE AGGRESSION. Often triggered by limit-setting, and may last several hours. Intentional destruction of things (destructive rage); instigates fights.</td>
</tr>
<tr>
<td>Interview tolerant: pleasant upon first meeting.</td>
<td>Interview intolerant: may be dysphoric and rejecting.</td>
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<tr>
<td>Natural course is chronic and continuous, with trend toward improvement.</td>
<td>More severe or dramatic symptoms over the lifespan during symptomatic periods, especially without medical treatment.</td>
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<td>Similar behavioral difficulties at home and school.</td>
<td>Behavioral difficulties likely to be worse at home than school or during difficult time of day for the student (due to irregular circadian rhythms).</td>
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<tr>
<td>No loss of reality testing expected.</td>
<td>Psychosis (loss of reality testing) with Bipolar-One and Bipolar-Two. More likely to occur for adolescents than children.</td>
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<td>20% meet criteria for JBPD.</td>
<td>93% meet criteria for ADHD.</td>
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<tr>
<td>Onset is at birth, although symptoms typically appear by age 2, and diagnosis is usually by age 4.</td>
<td>Onset “rarely” occurs before age 6.</td>
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Handout 2

Summary of
A Controversial Diagnosis: Juvenile Bipolar Disorder

Because of the following issues, many have questioned the validity of a Juvenile diagnosis of Bipolar Disorder:

- DSM-4 criteria for Mania were developed for persons 18 and older (although no youngest age was identified).
- Mania & Depression are addressed as separate, distinct phenomena in DSM4, but are often combined in children as chronic irritability, which is considered by many to be a non-specific feature.
- Irritability is an acceptable alternative to mania according to DSM4 criteria for mania.
- It was not until relatively recently that chronic irritability was recognized as a possible alternative to the hallmark criteria of euphoric mood and grandiosity for children.
- In addition to a debate over presence or absence of episodes, the type of rapid cycling seen in children is far more rapid than the type that meets the Rapid Cycling criteria in DSM4.

- In addition to a debate over presence or absence of episodes that define JBPD, there are variations of the cycling that define it:
  - Complex Cycling - short cycles embedded within a more prolonged cycle or episode.
  - Ultrarapid: 5 to 364 cycles per year.
  - Ultradian: 365+ cycles per year (or, at least 1/day) with mania duration of 4+ hours per day.

- According to DSM4, an ultradian cycle is not considered an episode or a cycle of mania, hypomania or depression; thus, no criteria corresponding to this type of cycling seen in children.

- Some have suggested that children have ultra-ultra-rapid cycling.

- Symptoms of mania are not yet in the behavioral repertoire of young children. (e.g., disinhibition manifested by immodest attire or excessive spending are precluded by parental control.)
- Labile moods are common in young children.
- Labile moods (shifts from elevated to depressed states) are common in young children.
- DSM4 describes Mania and Depression Episodes separately, while the majority of children with JBPD present chronic irritability or “affective storms” instead of distinct episodes of mania and depression.
- Mania experienced differently by children: adults enjoy mania (at least hypomania) while many children experience it as negative and agitating.
• Some of the symptoms of mania are not yet in the behavioral repertoire of young children and are colored by developmental stage of the child (e.g., disinhibition manifested by immodest attire or excessive spending would be precluded by parent control over dress and money management.

• Symptoms often do not meet 4 to 7 days duration criterion; therefore, diagnosis of BPD-NOS is commonly given.

• Symptoms of JBPD significantly overlap those of other childhood disorders, including ADHD, Autism Spectrum Disorders, Anxiety Disorders, OCD, and Disruptive Behavior Disorders.

• There have been no objective measures to substantiate clinical impressions, which may be influenced by idiosyncratic experiences of the clinician, with cases in which certain symptoms are pronounced.

• Some researchers emphasize centrality of irritability, even in absence of elation, grandiosity, and episodicity.

• Others consider irritability a core symptom only if it co-occurs with elated mood or grandiosity.

• Grandiosity alone is not adequate for a diagnosis.

• At the outset, I mentioned JBPD may be a controversial diagnosis because clinicians are diagnosing children with criteria that were established primarily for adults and adolescents.

• It is also possible that Bipolar Disorder simply looks different in children, i.e., there are no distinct “polar” episodes of mania, then depression, then mania......and so on; rather, mania and depression are fused, causing severe mood and behavioral dysregulation.

• We will review the features of a “core phenotype,” or diagnostic model, at the end of the training, as a review.

**Conclusion:** Despite controversy, the consensus of NIMH Roundtable group is that there is a spectrum of JBPD phenotypes, ranging from “Narrow” (meets extant DSM4 criteria) to “Broad” (includes features established since publication of DSM4 in 1996.) New diagnostic guidelines are being developed by several research bodies and the next DSM manual will likely provide further clarification.
Accommodations and Behavior Support Plans for JBPD

- **An Accommodation** supports LRE and provides default positive environmental changes to ameliorate the characteristics of JBPD; it does not alter state standards.
- **A Behavior Support Strategy** deals with a specific behavior that has not been successfully addressed through default accommodations that is “impeding the learning of the student or peers”.

Generic possible accommodations (depends on individual needs)

- Assist family and school in providing flexible, low-stress home environments.
- Modify or eliminate homework if it is creating extreme stress.
- Consider home instruction when symptoms preclude attending.
- Consider a later start time when sleep is disordered.
- Provide access to water and restroom (dehydration and frequent urination are side effects of mood stabilizers).
- Provide streamlined access to nurse for medication and to deal with medication side effects.
- Supervise and support organization strategies for remembering assignments, such as agenda and second set of books for home.
- Use cues and prompts to assist concentration, retrieval, memory.
- Provide a visual checklist of required steps for problem solving.
- Consistent schedule; prior notice of changes or transitions.
- Flexible grading, expectations, and possibly assignment reduction when energy levels fluctuate.
- Assure a safe haven when emotions are overwhelming; e.g., access to counselor.
- Give extra time or individual assistance when concentration and organization are reduced or unreliable.
- Modify demands that elicit anxiety.
- Alter P.E. instruction or excuse absence when energy level takes downturn. Most students will NOT require APE; so alter this in an accommodation portion of the IEP.
- Remember the sleep disorder aspect of JBPD: Carefully schedule tasks and courses so they occur during periods in the diurnal cycle when student is typically most alert and compliant.
- Consider accommodations for sensory differences (reduce or eliminate irritating input; provide sensory diet of soothing input).

Supporting Positive Behavior, and Managing Challenging Behavior

A function based behavior support plan is recommended for students whose strong “rejection” behaviors require careful staff attention. See: [www.pent.ca.gov/forms](http://www.pent.ca.gov/forms) for forms that embody the key concepts in behavior analysis. All strategies will depend on the function of the behavior and the current environmental structures that are present or absent to support behavior.
Generic Effective Behavioral PREVENTATIVE Strategies (depends on individual needs)

- Provide teacher and staff models of interactions that easily convey to the student unconditional positive regard and obvious affection. **This is the primary preventative component!**
- Be proactive with environmental supports that reduce the likelihood of defiance and other problem behaviors (see BSP Desk Reference at: www.pent.ca.gov).
- Provide ample praise, contingent access to desired activities and other reinforcers for compliance. Remember to “shape” behavior, reinforce closer and closer approximations to the desired behavior.
- Use task pacing aids (e.g., when 4 items are checked off on your list, then you earn a break!).
- Provide adult supports to “reality check” if hostile intention is attributed to neutral stimuli.
- Allow and even prompt a “Time Away” brief break from tasks self-initiated by the student (see: BSP Desk Reference, chapter 13 at: www.pent.ca.gov).
- Teach peers to check the student’s attribution to their actions.
- Teach adults to understand the source of problem behavior.
- Teach the student disability Awareness and Self-Advocacy Training that includes a relapse prevention plan.

**Generic Effective Behavioral REACTIVE Strategies**

1. **Prompt to an agreed upon alternate strategy or redirect**
   - In handling defiance, recognize it is often rooted in manic grandiosity, which can be delusional.
   - Redirect to an activity known to be soothing, using the strong developed relationship.

2. **Manage the Problem Safely**
   - Use non-violent crisis prevention programs with *verbal de-escalation* techniques (NCPI: PROACT).
   - Avoid struggles for control, especially when it is evident refusals or opposition is due to grandiosity.
   - Fear of harm to self or other is a feature of aggression associated with JBPD that causes dangerous behaviors. Maintain relationship, use calm voice, with decreasing volume, spaces between words to bring the situation under control.

3. **Debrief following episode**
   - Student is likely to be fearful of his/her rage. Be reassuring and perform a “social autopsy” on how WE can handle a frustration TOGETHER in the future.
   - Watch for signs student plans to harm self. Suicide risk is increased with this ACCURATE diagnosis (false positives and negatives abound).

4. **Consequence if necessary**

   RAGE IS A CARDINAL FEATURE that requires interventions or accommodations or both; and threat assessment when threats are made to determine whether the student is on a path toward violence. Sometimes rage can be triggered by antidepressants or stimulants. Report to physician unusual episodes of moderate to severe rage. Conduct a threat assessment to determine if the student is on a path toward violence. See: www.pent.ca.gov for threat assessment information.
Handout 4

Final Comments JBPD:
Accommodations, Behavior Plans & Related Services

What if the family of the student with Bipolar Disorder asks for accommodations, related services or a behavior intervention plan, and school personnel do not believe it is appropriate?

- Do not respond with:
  - “We can’t provide those in this setting” (FACT: Accommodations and BIPs are necessary in any setting prior to consideration of a more restrictive placement change; related services can be provided on site, through transportation elsewhere, or through funding other options on site. All students, with & without IEPs need individualization of supports to meet state standards)
  - “We can’t afford that” (FACT: students with IEPs receive an education without regard or consideration of affordability.)
  - “That wouldn’t be fair to the other students” (FACT: Fair is not everyone getting the same thing, fair is everyone getting what they need -- a free appropriate public education in the least restrictive environment, with all necessary supplementary aids to support the LRE, and all related services to benefit from the special education)

- Respond with:
  - First, think carefully before you respond. Be sure the request is not appropriate; be open to the complex support needs of these students. Ask questions and build bridges
  - If you believe the requested intervention is not appropriate: “Let me show you the facts and data that support our conclusion that the intervention you request would not be appropriate for your son or daughter.” And, “Let me explain our training, expertise and background in serving students with Juvenile Bipolar Disorder that is at the basis of our conclusion. Let us describe interventions that are supported by research.” Reach consensus. If not, remember parent rights for mediating differences if the student has an IEP.

Eligibility Issues

- Not all students with a Juvenile Bipolar Disorder diagnosis will be eligible for special education services. Report of a JBPD dx should trigger a “child find” for possible eligibility. JBPD is a mental health disorder.
- Those that are eligible, likely qualify as emotionally disturbed, but consider all other possibilities as well, including other health impaired.
  - They will require specialized instruction due to the unique nature of that disability, and
  - supports to maintain least restrictive environment, and
  - commonly, related services to benefit from their special education.
- Some students with Juvenile Bipolar Disorder have other diagnoses that qualified them for special education. They may require multiple supports for both the other diagnoses and for bipolar disorder.
Handout 5

Evidenced-Based Psychotherapy/Counseling Services

Cognitive Behavioral Therapy (CBT): Focuses on cognitive distortions that affect mood and challenges them. Manualized programs of CBT are more standardized and have stronger evidence of benefit.

- University of Maryland operates a web site that publishes an inventory of evidence-based psychotherapy approaches according to disorder (depression, anxiety, substance abuse, disruptive behaviors, etc.) and whose effectiveness was established for school-based mental services. U. Maryland Center for School MH: Empirically–Supported Interventions in School Mental Health: http://csmh.umaryland.edu/resources.html/resource_packets/download_files/empirically_supported_2002.pdf

Affective Education: Also known as Patient Education (Medical/Psychiatric Model); includes disability awareness, especially implications for social interactions and the types of explicit social skills training (explicit instruction in how to handle social interactions) that are appropriate. One effective approach, especially with younger students, is the use of social stories to teach them the features of the disorder, how to advocate for their exceptional needs, and how to more effectively handle interpersonal problems.

- A resource for social stories: www.bpinfo.net/children.htm (books available include Storm in My Brain, Anger Mountain, My Bipolar Rollercoaster, and Brandon and the Bipolar Bear).
- My School Day with and without Accommodations (Help) is available at www.bpkids.org.

Adult Guided Practice to Help Internalize Affective Education.

Interpersonal and Social Rhythm Therapy: Strategies to regularize daily routines and sleep schedules, which can stabilize mood; and strategies to stabilize interpersonal relationships, such as relationship maintenance/repair. Based on the work of Frank (2005), who found two factors that impact the course of Bipolar Illness:

- Supports for maintaining consistent daily routines, especially sleep-wake cycles.* Sleep is critical for the production of neurotransmitters that help regulate mood.
- Supports for maintaining social relationships.

*Compromised Circadian Rhythm Integrity, especially alterations of the sleep/wake cycle, has negative impact. Loss of deeper stages of sleep can trigger mania. One intervention for this is the reduction of caffeine intake to less than 250 mg, as it impairs quality of sleep, especially stages 3 and 4 (deep sleep when neurotransmitters are produced by the brain), and thereby can trigger mania.

Family Therapy: Emphasis on training the family in relapse prevention (e.g., systems for monitoring child for early warning signs; establishing a relapse response drill/scripts). Also emphasizes reducing the tremendous level of stress caused by the illness; and grieving or mourning the loss of the healthy child (more common in families who have experience with the disorder). Note that:

- Behaviors at home are often more intense and problematic than at school, because affect and associated behaviors are more intense in close interpersonal relationships.
- Parents are likely to have Bipolar Disorder, given strong inheritability; while “inside knowledge” of this disorder may be helpful, it also increases awareness of disabling implications, and this can result in earlier and more intense grieving.
- Recovery more likely in an intact nuclear family; additional factors of parental warmth, low tension between parent and child, and flexibility also affect outcome.

CAUTION: Forcing a child into therapy will negatively impact outcome future receptivity to treatment.
Web-based Resources

BIPOLAR AND JBPD:
- www.bpkids.org (Local Resources Categorized by State; Social Story for Disability Awareness & Self-Advocacy Training).
- www.jbrf.org (click LIBRARY; first document is Final Diagnostic Manual that includes Child Bipolar Questionnaire).
- www.bpinfo.net (several social stories books).

MENTAL HEALTH IN SCHOOLS:
- www.dmh.ca.gov/mhsa California Department of Mental Health School Mental Health Project

PENT WEBSITE FOR downloading powerpoints, and other materials: www.pent.ca.gov.
Empirically Validated Information:
BIPOLAR MEDICATIONS REDUCE BRAIN INJURY

HYPERCORTISOLEMIA
With Major Depression and Bipolar, increased levels of Cortisol (Hyper-cortisolemia) cause damage to various areas of the brain. For example, it causes structural damage to the hippocampus, which results in poor regulation of emotions as well as learning disabilities. Some medications reduce Cortisol toxicity by turning on a naturally occurring protective protein, Brain-derived Neurotropic Factor (BDNF), which helps repair nerve cells. BDNF latches onto Cortisol molecules, rendering them less toxic. The gene that turns on BDNF naturally becomes disabled when an individual has Bipolar or Major Depression. Lithium and antidepressants are able to turn on BDNF, reducing the likelihood of brain injury caused by Cortisol.

UNREGULATED APOPTOSIS
Lithium also prevents unregulated Apoptosis (neural pruning). This is a naturally occurring type of “neural pruning” is turned on genetically at specific stages of development to optimize neural functioning. Bipolar affects the gene that switches it off, resulting in unregulated pruning or loss of neural cells.

MEDICATIONS FOR BIPOLAR DISORDER YOUR STUDENT MAY TAKE
Many medications prescribed for children with Bipolar Disorder are used “off label,” i.e., for purposes or populations other than those in drug studies of efficacy and safety. For example, Risperdal has been in use with children for at least several years, but was only recently approved by the FDA for treating children; and the evidence pertains only to children with Autism. Prescribing medication is more complex for children. This is due in part to the fact that students may require more medications:
- Twenty percent of children with Bipolar respond to monotherapy (a single medication).
- Eighty percent require four medications, whereas most adults require three.

Obtaining accurate reports about therapeutic effects and side effects is also more difficult, as the information is obtained second hand through parents (mostly). The algorithm involves targeting a symptom, treating it with a medication; monitoring the effects and altering dose or adding a medication; and proceeding in this fashion, one medication at a time, trying to maximize the dose before discontinuing a drug of little apparent benefit. Conclusion: SCHOOL COMMUNICATION TO AUGMENT PARENT REPORTS IS CRITICAL

Mood Stabilizers
Lithium Depakote (Divalproex) Lamictal (Lamotrogine)Tegretol (Carbamazepine) Trileptal (Oxcarbazepine)Topamax (Topiramate)
[Most are also Anti-Epilepsy or Seizure Medications. By definition, mood stabilizers prevent depression and mania, but Lithium is the only one that does both. For example, Depakote appears to have more anti-mania effects, while Lamictal has more anti-depressant effects.]

Second Generation Antipsychotics (SGAs)
Risperdal (Risperidone), Geodon (Ziprasidone) Zyprexa (Olanzapine), Seroquel (Quetiapine Fumarate), Abilify (Aripiprazole)

Antidepressants
SSRIs (Serotonin Re-uptake Inhibitors), MAOIs (Monoamine Oxidase Inhibitors), TCAs (Tricyclic Antidepressants)
The Evolution of Bipolar Diagnosis and Treatment

400 B.C. - Mania and melancholia described as separate illnesses by Hippocratic physicians.
150 AD. - First written account of bipolar disorder in adolescence
1817 - Lithium discovered in a Swedish iron mine.

Late 1800s - British physician Sir Alfred Garrod describes lithium as therapeutic for mood disorders.
1913 - Kraepelin establishes modern concept of manic-depressive illness as separate from schizophrenia.
1930s - Freud states that a classical depressive syndrome could not occur in children before puberty.
1849 - Australian researcher John Cade reports the benefits of lithium to treat 10 patients with mania.
1952 - The American Psychiatric Association publishes the first Diagnostic and Statistical Manual (DSM), includes the diagnosis "manic-depressive reaction." J.D. Campbell reports 18 cases of pediatric onset of psychotic mania with strong family history of affective disorders in Journal of Nervous and Mental Disorders.
1969 - Swedish psychiatrist Dr. Anna-Lise Linell successfully treated manic-depression in children as young as 6 using lithium.
1960s - A handful of articles in the medical literature observe that many adult bipolar patients have been ill since adolescence. Leading psychiatrists insist that to diagnose manic-depression in children, they must meet adult criteria.
1970 - Lithium is approved by the FDA to treat mania; doctors in U.S. and Sweden begin using lithium to treat children as young as age 5 with good results.
1973 - First use of anticonvulsants in treatment of bipolar disorder.
1980 - Bipolar disorder replaces manic-depressive disorder as a diagnostic term in the DSM-III.
1980s - Researchers establish differences between adult and early-onset bipolar disorder, but most psychiatrists continue to maintain that pre-pubertal children cannot have the disorder.
1986 - National Depressive and Manic-Depressive Association (National DMDA) founded.
1997 - The Journal of the American Academy of Child & Adolescent Psychiatry publishes "Child and Adolescent Bipolar Disorder: A Review of the Past 10 Years" by Barbara Geller, M.D. and Joan Luby, M.D., and "Practice Parameters for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder" by Jon McClellan, M.D., and John Werry, M.D.
1999 - Parents of children with JBPDis swell support groups on the Internet and flood the telephone lines of national mental health organizations; they established The Child & Adolescent Bipolar Foundation.
1999 - Bipolar Disorders medical journal founded; International Society for Bipolar Disorders begun.

Late 1990s - Multi-site treatment studies and longitudinal studies following early-onset children are funded by the National Institute of Mental Health and the Stanley Foundation. More psychiatrists begin to diagnose and treat the disorder successfully in children.
2000 - The Bipolar Child by Demitri Papulos M.D. and Janice Papulos is published; ABC News airs a segment of 20/20 on early-onset bipolar disorder; and The Child & Adolescent Bipolar Foundation interactive web site (www.bpkids.org) is launched.

2005 - Treatment Guidelines for Children and Adolescents with Bipolar Disorder published (written by a consensus conference of experts convened by CABF
**Handout 8**

**Bipolar Disorder:**
Accommodations, Behavior Intervention Plan Components and Related Services

www.dianabrowningwright.com

**Disclaimer:** The following components are commonly recommended to address educational support needs for students with Juvenile Bipolar Disorder and are described throughout books, manuals and on-line resources. (See: Juvenile Bipolar Research Foundation and others in references.) Remember, all interventions must be individualized; this table provides beginning points for IEP team discussion in providing interventions for any specific student. **Definitions:**

1. **An accommodation is a supplementary aid to maintain the least restrictive environment.** It attempts to remove behavioral barriers to educational success by addressing student characteristics that impede that success, while continuing to teach to the curriculum standards.

2. **A behavior intervention plan is also a supplementary aid to maintain least restrictive environment.** It specifies the precise interventions to a specific problem behavior serving a function, or specific function for the student. The BIP is based on an antecedent-behavior-consequence analysis and includes environmental alterations and the teaching of alternative replacement behaviors, reinforcement for these competing behaviors and reactive strategies to use if the behavior occurs again, as well as a specific on-going communication system to monitor effectiveness. Frequently Accommodations and BIPs will overlap. (See BSP Desk Reference at www.pent.ca.gov).

3. **Related services are provided so that the student can benefit from his special education.** In general, cognitive behavioral therapy has been found effective to address some of the complex needs of individuals with juvenile bipolar disorder. These services are typically provided by school psychologists or social workers, though the IEP team can select any person whose training prepares them to serve that role.

<table>
<thead>
<tr>
<th>Symptoms Commonly Reported for Bipolar Disorder in Children</th>
<th>Possible Accommodations (ACC); Behavior Intervention Plan Components (BIP-c); and Possible Related Services (RS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Irritability</td>
<td>ACC/BIP-c: Offer a “time away,” a private place the student can go to calm down when overwhelmed; ACC/BIP-c: Offer a staff person the student can go to non-punitively to “cool down” when agitated.</td>
</tr>
<tr>
<td></td>
<td>Further Assess/BIP-c: Conduct an FBA to identify triggers that cause the student to lose control. ACC/BIP: Alter the environment to minimize the impact of those triggers. ACC/BIPc: Assign an aide to the classroom teacher with the goal of preventing situations that may cause the student to lose control. Consider RS: Cognitive behavior therapy, to teach the student self-calming and anger management techniques.</td>
</tr>
<tr>
<td>• Explosive “rage” behavior</td>
<td>ACC: Reduce writing assignments by allowing student to use a computer so the page appears neat.</td>
</tr>
<tr>
<td>• Perfectionism</td>
<td></td>
</tr>
<tr>
<td>Difficulty making transitions due to a “drive to completion” or “resistance to change”</td>
<td><strong>ACC:</strong> Reduce the length of an assignment; break up assignments into parts; allow the student to finish the task before moving on. Have all teachers cue the student as to transitions and the time they will occur.</td>
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<tr>
<td>Cognitive dulling or lack of endurance as a result of depression or medication</td>
<td><strong>ACC:</strong> Schedule frequent breaks; <strong>ACC:</strong> Provide extra time for work completion, allow “skill fluency practice” through oral means rather than constant written work.</td>
</tr>
<tr>
<td>Difficulty during transitions due to poor peer interaction skills</td>
<td><strong>ACC:</strong> Assign student to transition before the rest of the class; assign an aide to follow at a short distance as a “trouble shooter;” provide an aide who will give direct verbal support and cueing during non-supervised periods of the school day (lunch, recess, escort to and from the bus waiting area, etc)</td>
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<tr>
<td>Difficulty with test taking</td>
<td><strong>ACC:</strong> Allow extra time during lows; provide reinforcers for maintaining attention to task during test taking during all states; allow the student to take important tests later in the day if focus is better then.</td>
</tr>
<tr>
<td>Reversal in sleep/wake cycle present; extremely difficult for the student to get to sleep at night and to wake up early in the morning</td>
<td><strong>ACC:</strong> Schedule academic classes later in the day when the student is more alert and emotionally available for learning’</td>
</tr>
<tr>
<td>Daily and seasonal fluctuations in mood and energy; student is more attentive to class work at certain times and less attentive at others.</td>
<td><strong>BIP-c:</strong> Create formal contingency plans when the student is unstable and is experiencing periods of withdrawal or fatigue (a symptom of the illness and often a side effect of the medications).</td>
</tr>
<tr>
<td>Excessive thirst, a frequent need to urinate, or bouts of diarrhea occurring as a result of some of the medications (especially in the early stages of treatment)</td>
<td><strong>ACC:</strong> Allow continuous access to a water bottle or to have unlimited access to (non-caffeinated) fluids and unlimited access to the bathroom following private teacher/student signals.</td>
</tr>
<tr>
<td>Student reports “bullying”</td>
<td><strong>ACC/BIP-c:</strong> Aide in the classroom monitors social interactions and reports incidents of social conflict. <strong>RC/BIP-c:</strong> Aide reports conflicts and related service provider helps interpret and explain errors in attribution, if present, i.e., student interprets neutral stimuli as negative, should they occur. Episodes of bullying are reported to administration for anti-bullying school services.</td>
</tr>
<tr>
<td>Issue</td>
<td>ACC/BIP-c</td>
</tr>
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<td>---------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td>Student has difficulty with peers; ignores group consensus; may be bossy, misperceive the behaviors and intentions of others, and be socially inappropriate at times.</td>
<td>ACC/BIP-c: Assign a safe place and person where the student can regroup and calm down—preferably someone with whom the student can talk easily; RC: Have the student keep a journal in and record anxiety-producing thoughts and school experiences-share with related service providers. ACC: If the treating psychiatrist recommends the use of a light box, provide this daily during a study period in the resource room.</td>
</tr>
<tr>
<td>Periods of excessive anxiety and sadness.</td>
<td>ACC/BIP-c: Assign a safe place and person where the student can regroup and calm down—preferably someone with whom the student can talk easily; RC: Have the student keep a journal in and record anxiety-producing thoughts and school experiences-share with related service providers. ACC: If the treating psychiatrist recommends the use of a light box, provide this daily during a study period in the resource room.</td>
</tr>
<tr>
<td>Sleeping in class; physician states this is a new medication side effect</td>
<td>ACC: Provide a place for a brief nap so the school day can continue. (Report to physician weekly—Sleepiness usually subsides as the body adjusts to the medication).</td>
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<tr>
<td>Difficulty staying on task and paying attention; student “fidgets.”</td>
<td>ACC: Place student close to teacher where the teacher can sustain student’s attention using “active engagement” techniques; Schedule frequent breaks; offer choices in location to complete work, e.g., study carrel, quiet area, assign a study buddy/study partner during seatwork.</td>
</tr>
<tr>
<td>Disorganized, often misplaces needed books and materials; forgets to bring home assignments and/or fails to turn in work.</td>
<td>ACC: Teach, monitor and reinforce notebook organization with “to do” separated from “completed” in each subject. Provide a planner book and have teacher or study partners check that daily assignments are recorded properly. Use daily report cards, email or fax parents list of assignments and news of upcoming projects or tests. Prompt student about what materials are needed-help develop a strategy sheet and list of materials; teach backpack organization. Provide a second set of texts for home use. Teach a “work plan” through numbering tasks for homework, starting with a short easy section (behavior momentum) but not saving a long, hard section for last. Make a time chart with approximate times-have student check off and record time it took. Teach previewing questions in a chapter prior to reading; Color code texts with work sheets tabs to speed material matching. Teach locker organization-morning materials separated clearly from afternoon and monitor at least weekly.</td>
</tr>
</tbody>
</table>

Ups and Downs of Serving Students with Bipolar Disorder
Diana Browning Wright, 2008 (chart developed from websites & practice)
Notes for Case Development:

Does the student show these symptoms?
   Yes, all  yes, some  No, none

- Which symptoms are observed?:

- Our accommodation plan for inclusion in the IEP will address which of the above symptoms:

- Our behavior support plan will address a specific behavior that has not been effectively addressed in the accommodation plan, and will be based on the following hypothesized function of the behavior (see www.pent.ca.gov for BSP blank forms)

1. This problem behavior allows the student to (get):____________________________

2. This problem behavior allows the student to (reject/protest/avoid):______________

3. Our analysis of the problem behavior suggests the following functionally equivalent replacement behavior:________________________________________________
Bipolar Disorder Case Study: Stephen
A take-home study for school team training purposes

Stephen is currently a seventh-grader who has been diagnosed with Bipolar II Disorder, attention deficit hyperactivity disorder, and conduct disorder and an educational eligibility of emotional disturbance. His placement changed frequently as he moved through several of the district's programs for the emotionally disturbed. His family is now requesting an IEP to develop an accommodation plan, behavior intervention plan and placement in a non-public school. In the last five years he has been suspended 29 times, with six manifestation determination meetings and 30 other disciplinary actions at school. There is no dispute the student is identified as disabled with a primary disability of emotional disturbance (ED) and therefore eligible to receive specialized instruction and services pursuant to the Individuals with Disabilities Education Act (IDEA) 20 USC 1401 et seq.

Stephen presents with multiple behavioral components which are very difficult for the school staff to manage. The evaluation states his behaviors can differ between the school environment and the home environment. His behavior at home is worse. A psychiatrist notes that Stephen’s symptoms significantly interfere with his learning due to disorganization of thinking, mood intensity and distractibility, which are always present but can become worse with mood exacerbation.

Stephen’s Educational and Behavioral History

- **Preschool:** Assessment was conducted at parent request for dyslexia. No disability found.
- **First grade:** AD/HD was diagnosed, and an IEP for OHI developed. Stephen has difficulty following directions and respecting authority, with significant aggressive behavior during unstructured times and at home. Medication was given for attention, and behaviors did not improve. No behavior supports were given.
- **Second grade:** Stephen demonstrated above average reading with fourth grade skills in evidence. However, on the BASC, the teacher reports significant somatization, risk for aggression, hyperactivity, and depression. The teacher notes that he frequently is disruptive and acts in a socially deviant manner, and expresses feelings of sadness and stress. High irritability is noted as a continuous state. Stephen’s mother reports attention deficit hyperactivity, major depression and overanxious disorder. An IEP for emotional disturbance and a BIP is developed, but 12 disciplinary actions and 4 suspensions occurred. The counselor reports Stephen is confused by his behaviors and feels he can’t control them and is frightened by them. He is placed on homebound for the last 6 months of his second grade year. An FBA is completed twice, following manifestation determination meetings.
- **Third grade:** Stephen receives resource room placement for 40 % of his day, with one hour a week of counseling, places him in a resource room for 26.50 hours per week, with 1.0 hours per week of counseling and 3.75 hours per week in regular education. A behavior goal is listed on his IEP: to follow school rules and discuss feelings that impact his academic and school functioning. His second grade academic is reported to be above grade level. An IEP was convened to transition Stephen to the intermediate self-contained classroom. Multiple suspensions are given. An IEP meeting convened in May to review the XXX General Hospital evaluations of Juvenile Bipolar Disorder, and develop an IEP for the fourth grade. The adopted IEP is essentially the same as the third grade program but it reduces the counseling component by .5 hours per week, even though the psychologist states there are many psychological issues the child needs to process and a need for continued counseling.
- **Fourth grade:** In October, Stephen is suspended for four days for assaulting a teacher. The IEP team determined the his behavior was not a manifestation of his disability! The FBA provides for implementing a point system for behavior modification, on a one-half (1/2) hour basis. The function of the behavior is to be sent to a preferred adult. In one month Stephen is suspended for engaging in a targeted behavior, which Composite case, combining findings and facts for training purposes. Diana Browning Wright, 2008 Handout 11
persisted for an entire day and he receives a two day suspension. The suspension is followed by another IEP meeting. The parent requests a therapeutic day school program. The school team rejects the parent's request and concludes the district program was appropriate and able to meet the child's behavioral and academic needs. Within days Stephen is again suspended. The discipline report states he was extremely agitated and out of control in all areas of behaviors. Stephen was excluded from school for a week and was then transferred to another school within the district. The parent claims the team fails to control the behaviors before they escalate to the level that the child needs to be suspended from school. School staff testified the discipline reports do not state the disciplinary steps taken prior to referral to the administrator in charge of discipline. The discipline reports sent to the parent note the child was agitated all day until a crisis occurs. The team decided to retain a consultant for the child's program for three months for two hours per month. The school team and parent attended training to understand ADHD and bipolar disorder behaviors/symptoms midyear in the fourth grade. At the time of the training the child was consistently working below grade level and had 11 days of suspension. The training was successful. There was improvement overall. Stephen was not suspended and his grades improved dramatically for the balance of the fourth grade year. The parent agreed Stephen was successful in the school environment at the end of fourth grade.

- **Fifth grade:** In the fall of XX, a triennial evaluation was completed. The report overall concludes Stephen has improved dramatically in the second half of the school year. The turn around is dramatic and coincides with the change in placement with the support of the consultant. Behavior assessments completed by teacher and parent are consistent with behaviors in the average range. The plan is for Stephen to spend more time in the mainstream than he has in years; he is to be included in field trips without an aid. Stephen's time in the mainstream increased to 29 hours per week.

The IEP in February is a manifestation determination for a physical assault on a peer. The team determined the behavior was a manifestation of the child's disability. The manifestation review reports Stephen has had a serious decline in the mainstream, showing aggression, both verbal and physical. Stephen's placement is changed to a self-contained special education class, and five hours per week in the general education. Stephen made unsatisfactory progress in his behavior goal during the reporting period beginning two months after the IEP was written. **Stephen's academic reports states his performance is above grade level in all subjects.** Stephen was suspended 11 days in fifth grade, fourth quarter.

- **Sixth grade:** Stephen’s placement was in the middle school, behavior disorder program. Stephen was able to meet his behavior goals for only three of 13 weeks. During general education art class, he is accompanied by an aide. The balance of the day he is in the contained classroom. The child had three major disciplinary events in September and November. **The IEP recommendation on 11/25/XX was to continue with the current program though Stephen is showing a decline in academics. The record notes concern about reading comprehension, writing and math.** The special education supervisor testified the child's school record shows academic progress despite the fact that his current assessment shows fifth-grade reading level, with prior records showing fourth-grade level in first grade with fifth-grade comprehension and sixth-grade level spelling. He had unsatisfactory progress in his behavioral goals which consists of only one goal: To exhibit responsible personal and social behavior by following class rules refraining from using profanity and exhibiting respect for peers and authority. Interestingly, the mainstream teacher's report is instructive. She notes that Stephen is able to perform well in her mainstream class. Stephen has numerous disciplinary referrals and suspensions in sixth grade. Stephen experienced sharp decline for the sixth-grade year. He had 18 suspensions and significantly lower grades. He participates in curriculum below grade level in subjects that were previously relative strengths for him. At an IEP meeting dated March XX, XXXX, **the parent’s medical provider states the staff is treating symptoms of the disorder as behavior problems completely under Stephen's control.** The school team proposed another placement change. The team proposes a therapeutic program which includes counseling. **The psychiatrist states Stephen is displaying mood symptoms of bipolar disorder which can make him appear disrespectful of authority and rules and makes him even threatening to others.**
• **Seventh Grade:** Stephen had nine days of out school suspension by October of seventh grade. The team held a manifestation determination meeting and concluded the behaviors were related to the child's disability. The police were called because Stephen made a verbal threat. An IEP developed 10/5/XX recommends a diagnostic placement in yet another school. The program is a more restrictive, therapeutic setting with full-time special education and related services. 25. The program description provided to the parent defines the program as one designed to meet the needs of serious emotionally disturbed (SED) students. The primary duty of the BDLC is to enable each student to become a responsible member of society by changing behavior in a positive direction. The goal is to maintain students in their district schools and prepare them to return to the mainstream. The behavior techniques are rooted in positive reinforcement. The program claims to provide structure, intended to provide the child with organization and predictability. The overall objective is to have the student internalize environmental cues and controls. Consistency of environmental response is a component of structure. The techniques employed by this program are systematic ignoring, signal interference, proximity and touch control.

7th Grade Hearing for Nonpublic School Placement

• The parent's objection to the placement is the subject of a hearing. The parent is seeking placement in at the XXX Non-public School, which provides comprehensive treatment utilizing an integrated approach. The therapeutic environment encourages the students to perform skills, activities and behaviors necessary to develop and acquire self-control of their behavior. Family participation is an integral aspect of a successful transition to the community. All students participate in milieu therapy, behavioral therapy, socialization skills training, individual and family therapy, group therapy as required, as well as family-oriented Transfer of Treatment Program. The milieu therapy program consists of a token economy and a corrective and disciplined treatment program. There is a motivational management approach designed by a team to assist the child in acquiring social skills, academic achievement, study habits and self-care behavior by developing and modifying the plan to the child's needs. Motivational management is designed to make the child less dependent on tokens and increase reliance on internal control of behavior by gradually phasing out the token system. The environment is designed to be conducive to the child's treatment with clearly defined expectations. The setting provides structure and techniques that will enable the student to develop the skills and behaviors that promote social and emotional development. In addition to the typical corrective discipline techniques, the program provides for role-play of the behavior that resulted in discipline, a training system that instructs the child on appropriate behavior, through rehearsal restitution and reintegration. Reintegration must be implemented effectively to motivate the child to remain in the program rather than the preferred removal from the program.

Sample (composite) Conclusions of Law:

1. There is no dispute that the child is identified as a child with a disability and therefore entitled to receive specialized instruction and services in the provision of a free and appropriate public education pursuant to the IDEA.

2. The parent seeks a day placement in an out-of-district therapeutic school. A dispute arose between the parties when the LEA proposed that the child be moved to another Behavior Disorder Learning Center at the XXX School, a therapeutic placement for the district. The parent claims the LEA's program is inappropriate because it fails to provide the child with a free and appropriate public education.

3. Whether a program is inappropriate is determined by the two-prong test articulated in *The Bd. of Education of the Hendrick Hudson Sch. Dist. v. Rowley*, 553 IDELR 656, 458 U.S. 176 (1982). The first prong requires the LEA to follow the procedural requirements of IDEA. The Supreme Court states, emphasis on the procedural requirements of IDEA reflects a conviction that adequate compliance with the prescribed procedures would in most cases assure much, if not all, of what congress wished in the way of substantive content in an IEP. *Walczak v. Florida Union*
4. The second prong of Rowley requires the IEP offered by the LEA to be reasonably calculated to enable the child to receive an educational benefit. The benefit cannot be trivial, Rowley; Mrs. B. v. Milford Board of Education, 25 IDELR 217, 103 F.3d 1114 (2d Cir. 1997). Subsequent decisions elaborate how much benefit is sufficient to be meaningful. The act requires educational progress rather than a program that is merely of benefit. Polk v. Central Susquehanna Intermediate Unit 16, 441 IDELR 130, 853 F.2d 171 (3rd Cir. 1988), cert. denied 488 U.S. 1030 (1989). IDEA was enacted to assure that all children with disabilities have available to them a free and appropriate public education that emphasizes special education and related services designed to meet their unique needs, supported by such services as are necessary to permit the child to benefit from the instruction, Rowley. The instruction must be at public expense and under public supervision, meet the states education standard, approximate the grade levels used in the state's regular education program and comport with the child's IEP, Rowley. IDEA does not require states to maximize the potential of handicapped children, id. at 197 n. 21, 102 S. Ct. 3034, but must be reasonably calculated to receive educational benefits, M.C. ex rel. Mrs. C. v. Voluntown Bd. of Ed., 33 IDELR 91, 226 F.3d 60, 62 (2d Cir. 2000).

5. In order for FAPE to be offered, a school district must show it complied with the statutory elements of an IEP; the goals and objectives in the IEP are reasonable, realistic and attainable, yet more than trivial and de minimus; and the special education and related services must be tailored to reasonably accomplish the goals in the IEP. Board of Education of the County of Kanawha v. Michael M., 32 IDELR 170 (S.D. W.Va. 2000). Meaningful educational benefit for one child may be de minimus benefit for another. Since benefit is a relative term, courts have considered the potential of the student in deciding whether the IEP offered is appropriate, noting that "(w)hen students display considerable potential, IDEA requires 'a great deal more than a negligible benefit, but instead 'significant learning,'" Ridgewood Board of Education v. N.E., 30 IDELR 41 (3d Cir. 1999). The child demonstrated a high level of achievement in the first and second grades; up until the child started middle school, he had above grade level performance. For several years the child had one very broadly stated behavior goal. The goal essentially required the child follow school rules and treat peers and staff with respect. The stated goal did not make it clear to the child, school staff or the family how the behavior goal would be satisfied. The goal may not have been attainable for someone with this disorder. The psychiatrist states in Exhibit P-98, the child is displaying mood symptoms of bipolar disorder which can make him appear disrespectful of authority and rules and makes him even threatening to others. The child requires a program of elaborate, interventions delivered by a tightly coordinated effort of everyone who came in contact with him to meet the behavior goals as they appear in his IEP.

6. The regulations promulgated pursuant to IDEA, 20 USC 1414(a)(4) and 1414(a)(10)(B), provide the LEA, as described in 34 CFR 300.2, shall provide special education and related services. The regulation at 34 CFR 300.342(a)(1) provides that each public agency is responsible for initiating and conducting meetings for the purpose of developing, reviewing and revising the IEP of a child with a disability. Each LEA shall ensure that the IEP team review the child's IEP, no less than annually, to determine whether there is lack of progress towards the annual goals described in Section 300.347(a), and in the general curriculum; or to address the results of reevaluations conducted under [the regulations] and [review] information about the child, provided to or by the parents under Section 300.533(a)(1) or about the child's anticipated needs; or other matters, 34 CFR 300.343(c)(1) and (c)(2)(ii)-(iv). The IEP team members testified the child has made academic progress. The major focus of the numerous IEP meetings convened to plan for the child, however, is to address the latest behavioral crisis. The child's academic progress was lost in the focus to find a classroom or staff member who could handle the child's behavior. The LEA not only failed to provide a program to improve or manage the child's behavior, the team has not provided for a program in which the child makes adequate educational progress. The child's latest triennial evaluation as presented for the hearing record does not include educational or achievement test results. It is not clear these tests were performed even though they are listed in the Consent to Evaluate signed by the parent.

7. The child's record is complicated. The child was suspended from school numerous times as early as the second grade. He was on homebound instruction for the remainder of his second-grade year. The child returned to school Composite case, combining findings and facts for training purposes. Diana Browning Wright, 2008 Handout 11
in the district's behavior disorders class, and was provided with a behavior goal and one hour per week of counseling. The child with average intelligence had above average achievement in his academic subjects. The school therapist record notes the child is confused by his behavior. In December of the third grade the child's placement is changed to the intermediate, self-contained classroom. The child was again experiencing discipline problems and suspended several more times. He was evaluated at XXX general hospital, and identified with early-onset bipolar disorder. The parent and the psychiatrist recommend a therapeutic school specializing in treating bipolar children. The LEA denied the request and reduced the child's counseling to .5 hours per week.

8. In the fourth grade the child is suspended for many days early in the year. At a manifestation determination the team concludes the child's behavior is not a manifestation of his disability; nonetheless, they change his placement to another behavior disorder program within the district. The parent again requests an out-of-district placement. At the new placement the staff is trained to work with bipolar children by an outside consultant. A token reward system is added to the child's program, which includes half-hour monitoring and feedback. The child improved dramatically, and his placement is changed four months later, when the team places the child in a fully mainstreamed program for the fifth grade.

9. In the fall of the fifth grade the child has a triennial evaluation in which the school psychologist cautions that the child's school success may be linked to the structure of support provided in the special education setting. At the IEP, convened to review the triennial results in December of the fifth grade, the team decides to continue the child's placement in the mainstream for 28.7 hours per week. The child's record concludes that the child began having difficulty, receiving unsatisfactory progress reports his behavior goal. The child had been earning above average grades. By May, the child has numerous suspensions for a total of 11 days. At a manifestation determination IEP meeting, the record states the child has been declining for months. The child's placement is changed again to another program within the district, placing him in a self-contained class for 22.5 hour per week.

10. In the sixth grade the child's placement is changed again to the middle school, BDLC. He again has numerous suspensions, his grades decline and teachers express concern for his academic performance in subjects in which his fifth-grade record shows he had above average performance.

11. In the sixth grade the IEP team recommends yet another change in placement as early as October. The parent again requests an out-of-district placement in a therapeutic school. In the IEP minutes, the Director of Special Education states that the child's behavior is beyond the scope of the program. The LEA has pushed for the child to attend their therapeutic program but the parent rejects the program. The IEP minutes reflect the parent's concerns that the school team does not take the actions outlined in the child's IEP.

12. The school team is so focused on the child's behavior that they fail to focus on the child's academic progress. The child is out of school for suspension many days making a consistent behavior plan impossible. The time spent out of class for discipline and suspension must have an impact on the child's academic progress as well. The child's record shows that he makes better academic progress in the mainstream; his program in the contained classroom appears to be a modified curriculum.

13. In the seventh grade the child had 18 days of suspension as early as October 5, 2004. The school team proposes a move to the district behavior therapeutic program. The parent filed for due process when her request for an out-of-district placement is again denied.

14. The child's middle school experience is particularly troubling. Many of the behaviors that resulted in suspension might have been averted by more tightly coordinated staff. The record supports the parent's claim that the team often did not follow prescribed procedures. A Functional Behavior Assessment completed at the time the child was suspended states the child will initiate behaviors that result in suspension to be with a preferred adult. The child's behavior is escalating to the point of police intervention. During the past several years the child's grades have declined and his behaviors are much worse. The school staff has not been able to develop a program that will permit the child to progress in the general curriculum and benefit from his education. The mission...
The LEA's therapeutic program is to enable the students to become responsible members of society by changing behaviors in a positive direction. After many years in the district's programs both the child's academics and behavior have declined.

15. The vice-principal, who serves as the director of the therapeutic program, compared the district's program to the one proposed by the parent. She testified the programs are similar in many ways; they service similar populations using similar techniques. There is a lot of similarity in design and structure. The program has outside behavior consultants. It uses a structured behavioral approach with a token economy. **Overall the child has deteriorated severely both in academic and behavior while attending the LEA's programs. He needs a more consistent comprehensive program to make an improvement. The nexus between home and school is critical if the child is ever to meet the program objective of returning to the mainstream and becoming a responsible member of society. The LEA has not been able to provide FAPE for the child.**

16. The line of cases that provides for public school funding for education in private schools includes *Burlington v. Dept. of Educ.*, 555 IDELR 526, 736 F.2d 773 (1st Cir. 1984), *aff'd* 471 U.S. 359 (1985) and *Florence County Sch. Dist. Four v. Carter*, 20 IDELR 532 (1993). Public school funding of private education requires a finding that the program offered by the LEA does not provide a free and appropriate public education (FAPE). The LEA has the burden of proving by a preponderance of the evidence that the child's program is appropriate, Conn. Agencies Reg. 10-76h-14. In this case the LEA has not established by a preponderance of the evidence that they could provide a free and appropriate public education (FAPE) to the child.

17. Once a determination has been made that the LEA did not offer FAPE, it must be determined whether the private school placement is appropriate. Since the time *Florence* was decided, the reauthorization of IDEA in 1997 confirms that an out-of-district placement does not have to meet the standards of a Least Restrictive Environment (LRE), nor does it necessarily have to have certified instructors in special education, 34 CFR 300.403(c). A case on point that cites various circuit court cases is *Norton School Committee v. Massachusetts Department of Education*, 18 IDELR 186, 768 F. Supp. 900 (D. Mass. 1991). The least restrictive environment guarantee ... cannot be applied to cure an otherwise inappropriate placement.

18. The program description for the parent's proposed placement is outlined in detail the finding of facts. The therapeutic setting provides a nexus between home and school, which is important to transition back to the home and school community. Trained staff implements a program that provides role-play, restitution and reintegration when the child is engaged in behavior that would typically result in suspension in the LEA program. The child will be forced to work through the behavior with the objective to gain internal control. This will be a deliberate process rather than the short-sighted suspension which sends the child home to sit it out until he is allowed to return to school.

How could these findings have been avoided?

- Knowledgeable team, with earlier interventions
- Development of effective classroom organization and structure for EBD
- Development of an Accommodation Plan
- Development of a specific Behavior Plan addressing behaviors through a Functional Approach
- Development of Related Services Plan with goals for Cognitive Behavior Treatment/Therapy

**ACTIVITY:** See Handout 6. Stephen demonstrates all symptoms commonly reported on that handout.

- Read the case. Hypothesize what the courts may decide. Compare your findings.
- Develop an Accommodation Plan in accordance with those demonstrated features.
- Develop a Behavior Plan and Related Services Plan to address rage, periodic sadness and anxiety.

Composite case, combining findings and facts for training purposes. Diana Browning Wright, 2008 **Handout 11**
The Ups and Downs of Serving Students with Bipolar Disorder

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