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FALL 2010 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 12 NO. 4

Mental Health Services for Children and Adolescents

By The National Institute of Mental Health (NIMH)

Research shows that half of all lifetime cases of mental illness begin by age 14.[1] Scientists are discovering that changes in the body leading to mental illness may start much earlier, before any symptoms appear.

Through greater understanding of when and how fast specific areas of children's brains develop, we are learning more about the early stages of a wide range of mental illnesses that appear later in life. Helping young children and their parents manage difficulties early in life may prevent the development of disorders. Once mental illness develops, it becomes a regular part of your child's behavior and more difficult to treat. Even though we know how to treat (though not yet cure) many disorders, many children with mental illnesses are not getting treatment.

This fact sheet addresses common questions about diagnosis and treatment options for children with mental illnesses. Disorders affecting children may include anxiety disorders, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, bipolar disorder, depression, eating disorders, and schizophrenia.

Q. What should I do if I am concerned about mental, behavioral, or emotional symptoms in my child?

A. Talk to your child's doctor or health care provider. Ask questions and learn everything you can about the behavior or symptoms that worry you. If your child is in school ask the teacher if your child has been showing worrisome changes in behavior. Share this with your child's doctor or health care provider. Keep in mind that every child is different. Even normal development, such as when children develop language, motor, and social skills, varies from child to child. Ask if your child needs further evaluation by a specialist with experience in child behavioral problems. Specialists may include psychiatrists, psychologists, social workers, psychiatric nurses, and behavioral therapists. Educators may also help evaluate your child.

If you take your child to a specialist, ask, "Do you have experience treating the problems I see in my child?" Don't be afraid to interview more than one specialist to find the right fit. Continue to learn everything you can about the problem or diagnosis. The more you learn, the better you can work with your child's doctor and make decisions that feel right for you, your child, and your family.

Q. How do I know if my child's problems are serious?

A. Not every problem is serious. In fact, many everyday stresses can cause changes

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Kids Do Get Better: Values Driven Inpatient Care

By Joseph Commisso, PhD and David Woodlock, MS Four Winds Hospital - Saratoga

In New York State, and across the country, the story of how mental health care began begins with inpatient care provided in large institutions located in a bucolic rural environment. This "humane treatment," in its day, was considered a progressive avant-garde form of care. For decades this form of inpatient care was virtually the only option for those with more serious illnesses. While well intended, these environments were not without their darker sides as reflected in Ken Kesey's "One Flew over the Cuckoo's Nest."

In the more modern era, inpatient care has often come to be thought of in a very negative light. Born of historic overuse, and too often abuse, the need for inpatient care became reflective of inadequate (either poor quality or not enough) community based care. The cost of inpatient care has also been seen as a limiting factor in the development of community based alternatives.

The truth is that the inpatient level of care has evolved just as mental health care in general has. During the current emphasis in policy circles on Evidenced-Based Practices, it is often said that there is no evidence that inpatient care is effective. "Inpatient" is a place and the term says little or nothing about what occurs there or what kinds of treatments or supports are offered. At Four Winds Saratoga we have a great deal of empirical evidence that brief inpatient treatment can be extremely effective in stabilizing acute symptoms, interrupting negative spiraling of behavior and helping adolescents and their families get "back on track."

For those experiencing and those witnessing the deterioration in a young person's functioning, it can be disconcerting and in many cases, terrifying. As a parent, one wonders what has gone wrong. You may suspect illicit drug use, or even some type of abuse or trauma. Children who are admitted to the hospital present with a variety of symptoms and issues. Particularly during adolescence, it is important to identify and clarify symptoms. For instance, an increase in aggressive acts, volatility in your child's mood, a noteworthy change in his or her fearfulness, withdrawal and isolation, feelings of sadness and hopelessness, or a significant focus on body image and weight issues are all worthy of attention, assessment, and often, some type of intervention. A parent may obtain this information from their own experience or by speaking with their child's teacher, therapist, daycare provider, coach, troop leader or any individual who has regular contact with their child and may recognize changes in functioning. Problem solving between the parent and child may suffice or initiating outpatient counseling may be enough to help resolve these issues. In many cases, these "symptoms" will be attributed to "hormones" (i.e., How do I know what is teenage behavior and what is a mental health problem?). Or, "she's hanging with a different crowd" or "the media puts a lot of pressure on kids these days." It is when the aforementioned symptoms dramatically impede functioning or become dangerous or when other interventions have proved ineffective, that inpatient care may be necessary.

For the vast majority of those admitted to the hospital, the safety of the child or those around him has been compromised. For those not posing an imminent safety risk the impact on functioning is so profound that it affects not only the child, but family functioning as well. For instance, parents may not be able to maintain a steady work schedule due to the need for multiple appointments. Or their child's problems in school such as poor attendance related to behavioral problems, anxiety, school phobia, or depression have

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Mental Health News Education, Inc.
16 Cascade Drive
Effort, PA 18330

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Mental Health News™

Is a Publication of Mental Health News Education, Inc, A Nonprofit Organization.
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Regarding Divorced People with Mental Illness and the Expression "Being on the Dole" - Two Issues that Warrant Our Attention

By Ira H. Minot, LMSW
Founder and Executive Director
Mental Health News Education, Inc.

This issue of *Mental Health News* examines the topic "Mental Health Services for Children and Adolescents." As children are our future, there can be no more important area of vital concern than providing for their mental health. Our topic could fill volumes, yet in the short span of this issue we have compiled several excellent articles that I believe you will find very interesting.

In this column I would like to address two issues that have concerned me for some time. One is, "Why doesn't the mental healthcare system address the needs of divorced people with mental illness that have children in the same way they do for married people with mental illness?" The other issue concerns the use of the term "being on the dole" to describe someone who is receiving government entitlements or disability benefits when they are in need of them.

As many of you who have followed my writings know, I often draw upon my own experience as a survivor of a horrible 10-year battle with depression. My analysis of the aforementioned issues is not done with any specific research other than a thorough search of the internet and my own opinion gathered through real-life experience.

Ira H. Minot, LMSW

Helping Divorced Parents with Mental Illness Stay Close to Their Children

I was in my mid 30s when I became ill, a short time after several deep personal losses I had experienced within my family. One of these losses was the physical and psychological separation from my then five year old son following the breakup of my marriage. The other was the loss of my mother following her hard fought battle with cancer. Unbeknownst to me was that I was not prepared to cope with such losses. It was a perfect psychological storm that was about to hit me like a hurricane whose path I could not avoid. The worst did happen and I was thrown into a black hole that became a serious depressive illness.

Being the father of a young child and missing the closeness of living with him, combined with the heartless cruelty being dealt to me in the form of the pain of my deepening depression only made matters worse. But I was in treatment. Shouldn't the mental health professionals that were caring for me have been able to also help me address the pain I felt from being separated from my son, and help me and my son better cope with my illness? The answer was NO. It wasn't even on their agenda.

I found that over the many years I struggled with my illness, I was seen more as a single adult than as a divorced parent with a young son. Thankfully, my son was in counseling to help him adjust to his parent's divorce, and I imagine that in these sessions he was also able to get support for the additional burden placed on him by my illness. However, he and I were never invited into any counseling sessions together—a monumental oversight by my team of treatment professionals. Looking back, I firmly believe that this was because of the fact that I was divorced.

A search of the internet on the subject of "When a parent has a mental illness" reveals a wealth of information about the problems that children encounter and how to help them cope when one of their parents has a mental illness. However when you search for "When a *divorced parent* has a mental illness," nothing related to that specific situation comes up at all. I find that incredibly hard to believe.

My son and I fortunately had a happy ending. When I finally received the treatment that broke the chains of my illness, my son and I were able to begin rebuilding the many years of lost time, terrible hurt, and misunderstanding about my illness that had taken place. When I began to get my life back and started this newspaper, my son was finally able to understand that my illness was not his fault or my fault, and was a medical condition. It is regrettable that the mental healthcare delivery system failed to bring my son and I together into counseling where these hurts and misunderstandings could have been addressed while they were happening. A great deal of pain and suffering could have been avoided for both of us.

I believe there have been a few programs over the years that have tried to address the importance of helping parents with mental illness stay close with their children. There was one a few years ago in Ohio that I read about on the internet called Bart's Place (http://psychservices.psychiatryonline.org/cgi/content/full/52/1/107). It was a program located at a psychiatric hospital that united and counseled young children and their hospitalized parent while they were inpatients. A little thing they did was to take photos of the parent with their child that the child could take home and the parent could keep by their bedside while in the psychiatric hospital. This is the best medicine that could be given. Unfortunately, I don't believe Bart's Place is still in operation today. If it or any similar programs like it do exist today, I would like to hear from these programs and feature them in *Mental Health News*.

The mental health care system must address the needs of divorced parents with mental illness in the same manner that they help married couples when one has or falls ill to a mental illness. Mental health reimbursement allowances must also be made by insurance companies to provide family counseling for children and their divorced parent as they do for married couples with children. This is especially needed today with the thousands of soldiers returning from the Middle East with PTSD and other serious mental health problems. Divorce rates for these brave veterans are high. There needs to be a new mindset within the mental health system that puts counseling between divorced individuals and their children high on the list of required steps in the treatment process.

The Expression "Being on the Dole" Is Hurtful and Stigmatizing

According to my search of the internet, the first use of the expression "being on the dole" began around 1919 following World War I and referred to the "doling out" or "handing out" of charitable gifts of food or money. During those times the expression certainly was meant to have a humanitarian and life-saving meaning during the horrors of that war. Today however, whenever I hear someone say, "He's on the dole," or "When are these people going to get off the dole," I get a sickening feeling in my stomach because I know that today's use of this expression is meant to stigmatize and cast the person who is receiving financial assistance in a totally negative fashion. I am especially sensitive to the use of this expression when referring to someone with a medical condition, be it physical or mental.

When I had my first bout of depression in my mid 30's, (which I often refer to as my first breakdown), I was convinced that it was merely a normal short-term reaction to the losses I had experienced within my family. I guessed that it would pass in a few days, and at worse I would be prescribed a medication that would calm my nerves and allow me to go about my life as if nothing major had happened. Up until that point in my life, I had rarely missed a day of work, and was climbing the ladder within my career as a social worker and fundraiser for non-profit organizations. My first thoughts were that I had no time for these inconvenient feelings of depression and that I had to get back to my job in a few days. Little did I know that this first breakdown was to be the first of many that would hurl me into a life and death battle that I would endure for over 10 years and would end up destroying my life as I had once known it.

My plunge into the darkest days of my illness followed soon after my first breakdown and I quickly reached a state where I had to be hospitalized. Following my discharge from the hospital, I bravely tried to go back to work, but it was obvious by my behavior that I was not the same eager, bright, and confident man. My employer wished me well and I was soon let go from my job. Losing my job in that way was a horrible experience and over the next few years I managed to survive on my savings. I clung to the notion that getting back to work was the one thing that validated my worth as a human being—otherwise I didn't deserve to live. In addition my depression and inability to support myself convinced me that I was a "bad parent," which added to the pain I felt as a divorced father.

Nine years had passed after my first breakdown and my illness had exhausted my savings, left me homeless and I was still caught in the grip of depression. It was at that point that I was fortunate to be admitted to a psychiatric teaching hospital in New York. It wasn't fortunate, however, that I was brought in on a stretcher following my third suicide attempt. It was at this hospital where I agreed to undergo a full course of ECT, commonly known as "shock treatments." It would be the magic bullet that brought me back to life and which I credit for saving my life. It was like being revived from being in a coma for almost 10 years. The first thing I said to my doctors when I began to come around was "I've got to get back to work." "No," they said, "You have to spend time healing before you can do that." I realized they were right, and further realized that my resume had been left in tatters anyway, showing a 10-year lapse in employment. At the doctor's insistence, I was told to forget about going back to the high-stress world of fundraising as a career choice. I had to start all over again and had no clue what new career I could find to support myself. It was there at that hospital that the case-management staff arranged for me to be put on Social Security Disability (SSD) and arranged for me to be placed in a supportive housing apartment. This became the safety-net which allowed me to begin the healing process I so desperately needed to succeed in my recovery—a process that the doctor's believed would take me a number of years.

The support I received from those entitlement programs saved my life. I never wanted a hand-out from anyone, but without the aid I received I never would have made it. I remember friends and family referring to my being on this assistance as "being on the dole," and I found this very hurtful. Having a mental illness was stigmatizing enough. Having others refer to my receiving life-saving SSD and supportive housing as "being on the dole" just added to the hurt and shame I already felt. Let us remove this expression from our vocabulary and treat people who are bravely recovering from their illnesses with the respect they deserve. I have always thought that people who casually use stigmatizing language like this were simply ignorant and uneducated. I invite them to walk a mile in *our* shoes. This would surely enlighten them.

Good Luck in Your Recovery
Have a Wonderful Fall Season!

— Point of View —
Mental Health Needs in Kinship

Michael B. Friedman, LMSW

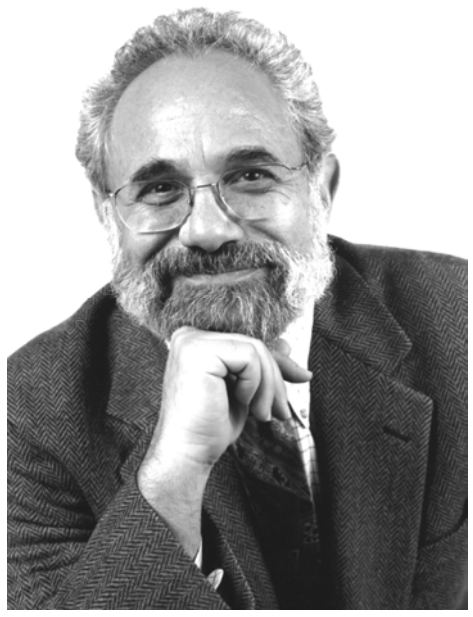
There are 350-400,000 children and adolescents in New York State that are in kinship care. I.e., they are raised by relatives other than their biological parents. Although there is some evidence that these children do better psychologically than those who are in foster care with strangers, there are serious mental health challenges for these kids, for their kin caregivers, and for their biological parents. New York State can and should do more to address these challenges.

This was the overarching conclusion of a workgroup on mental health that AARP and the NYS Kin Caregiver Coalition convened to identify key mental health issues in kincare and to develop recommendations regarding how to address them.

Kin caregivers include grandparents raising grandchildren, aunts and uncles who fill in for their siblings, older brothers and sisters, who are often kids themselves, and other family and friends who are willing to take on parental responsibilities despite the burden it creates in their lives.

Sometimes kin caregivers step in because of the death of the children's parents, but more often it is because the biological parents are unable to provide basic care for their children. For example, military service members who are deployed away from home may have to turn to their parents or others to raise their children while they are away. Similarly, some parents have non-military work assignments that take them away for long periods of time. Other parents are away from home not because they are serving their country or working to earn a living but because they have been incarcerated for crimes. Others have physical, mental, or substance use disorders that impede caregiving. In many cases the children have been victims of abuse and/or neglect at the hands of their parent(s) or step parents and may, therefore, have been removed from their homes by the child welfare system for their own protection. When this happens, relatives may become "formal" kin caregivers and get financial support and oversight like unrelated foster parents. But far more often, families make arrangements on their own ("informal" kincare) with limited, or no, assistance from the child welfare system.

The mental health challenges inherent in kincare are numerous. Children who have been separated from their parents almost inevitably experience grief and suffer various forms of trauma that can have a long-lasting impact on their development. Kin caregivers generally experience tremendous stress and are at increased risk for mental and physical disorders, which are often exacerbated because the caregivers do not have the time or resources to address their own needs adequately. The biological parents also often experience grief and trauma, and some have had their children removed because the child protective service believes that they have mental and/or substance abuse disorders and has concluded (not always correctly) that for this reason they are not capable of raising their children.



Michael B. Friedman, LMSW

How can these mental health challenges be better addressed? A group of experts (including kin caregivers themselves) met in December 2009 and another group met in June 2010 to answer this question. Their observations and recommendations were far-reaching and too extensive to report in this column. But here are a few highlights:

• The mental health and substance abuse service systems are often not able to provide adequate services to kids, kin caregivers, and their biological parents because services are in short supply; because they are often difficult to access due to distance, office hours, language barriers, or cost; and because often they are not provided by staff with expertise regarding this population.

• All of the systems that serve this population could do more to promote mental health rather than waiting for a disorder to emerge. This includes primary health care, schools, child welfare services, aging services, the criminal justice system, etc.

• Most service systems have tunnel vision and fail to notice or do anything about the fact that the children they serve may be in kincare or that the adults that they serve are also parents or kin caregivers.

• The fragmentation of the service systems—a problem noted in all discussions of the limitations of service provision in our society—also affects kincare. It is particularly important to improve the integration of physical and behavioral health services because primary health care provides opportunities to promote mental health, identify mental and substance use disorders, and provide treatment. But integration is also important in schools, child welfare programs, aging services, the criminal justice system, employee assistance programs, and the military and veterans' service systems.

• Kin caregivers often do not get physical and mental health care, especially preventive care and regular check-ups, in large part because kin caregivers tend to put their own needs second to those of the kids they are raising. Outreach to encourage them to take care of themselves can be very important to their physical and mental health.

• The needs of biological parents with mental disorders are often neglected. There is great controversy and confusion about when parents' with mental disorders are incapable of providing adequate care for their children, when they need support, and when they can be good parents on their own despite the fact that they have a mental disorder. In addition, psychiatric rehabilitation, which could help parents with serious mental illnesses develop the child-rearing skills they need, generally does not focus on this as a major life goal, despite the fact that for many parents with mental disorders raising their own children is their highest personal priority.

Needless to say, addressing these issues is exceedingly difficult—especially during a period of history when the economy makes service expansion largely politically impossible in New York State. Nevertheless, the workgroup identified steps that are possible now that could be extremely valuable later. These include:

1. Make Kinship Care A Policy Priority:

• Multiple state and local agencies touch on the lives of people involved in kincare, including mental health, substance abuse, health, education, aging, corrections, and more. Each should include kincare among its priorities.

• Planning processes related to children, health and mental health, aging and more are constantly underway in New York State at both the state and local levels. Few of these address kinship care at all, let alone the mental health challenges of kinship care. But they should.

• In addition, a number of inter-agency groups have been convened at the state and local level to develop coordinated approaches to address health, behavioral health, and human service needs. All of these planning and advisory groups should include kinship care among their major priorities.

2. Improve The Mental Health and Substance Abuse Systems: Issues of access, outreach, engagement, and quality all need to be addressed by the mental health system not just in general but specifically with regard to the hundreds of thousands of kids in kinship care. Immediately this could include:

• Establishing a workgroup to review and make recommendations to improve OMH's clinic standards to assure appropriate attention to the family context and to the challenges involved in reaching and treating family caregivers.

• Establishing a workgroup to recommend ways to include parenting as an important goal of psychiatric rehabilitation. This would include recommendations for OMH's guidelines for "Personalized Recovery Oriented Services" (PROS).

• Developing a training initiative for behavioral health professionals related to the specific emotional needs of kids separated from their biological parents, to the burdens and distress common among kin caregivers, and to the needs of biological parents separated, or facing separation, from their children. This could include a tool kit for mental health and substance abuse services providers: Your Clients May Be Parents or Caregivers.

3. Support Current Efforts to Integrate Physical and Mental Health Services: As noted above, primary health care provides an opportunity to identify and to respond appropriately to behavioral health problems of kids in kincare, their caregivers, and their biological parents. Integrating mental health services into these settings just makes sense. In addition, some biological parents with behavioral health problems may be getting services from specialized mental health or substance abuse programs. In these cases integrating physical health care into behavioral health centers often makes more sense than expecting them to get care from primary health care providers.

4. Focus on Mental Health Promotion rather than just waiting to respond to diagnosable disorders. One way to do this would be to develop and disseminate a toolkit—"Kids in Kincare and their Caregivers: How You Can Help Them Thrive"—in multiple service systems.

5. Confront the Issue of the Relevance of Mental Disorders to Child Protection by:

• Convening a joint behavioral health and child welfare workgroup to develop realistic and unbiased strategies and suggestions regarding removal of the child of a parent with a mental and/or substance abuse disorder for child protective service workers and for the Family Courts.

• Hammering out a position about the state law regarding parental mental illness and terminating parental rights that reflects contemporary knowledge and values.

These recommendations reflect only a portion of the observations and suggestions that came out of the process set in motion by AARP and the NYS Kincare Coalition. A full report will be released later in 2010. It will contain important observations and recommendations about the more than half-million children and kincaregivers in New York State. Hopefully, policy makers and advocates in New York State will realize that services for this population need to improve and should be a priority for a state that prides itself on supporting families.

Michael Friedman served as the facilitator of the Mental Health Kincare Workgroup until he retired at the end of June. He continues to teach at Columbia University's schools of social work and public health. He can be reached at mbfriedman@aol.com.

— The NYSPA Report —
DSM-5: The Future Face of Psychiatry

By Carol A. Bernstein, MD, President
American Psychiatric Association

Most people who walk into a psychiatrist's office have never heard of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and yet it is one of the most important and widely used texts in all of medicine. According to the National Institute of Mental Health, more than 50 million adults in the United States have a diagnosable mental disorder in a given year. All psychiatric disorders recognized by the U.S. healthcare system – from ADHD and Alzheimer's, to Substance Use and Schizophrenia – are included in the DSM, and without the manual, proper detection and treatment of mental illnesses simply could not occur.

The DSM provides a listing of the symptoms and diagnostic criteria that psychiatrists and other mental health and healthcare professionals use to determine whether someone has a psychiatric disorder. It also includes descriptive information to help clinicians arrive at the correct diagnosis, such as text that clarifies how to differentiate a particular disorder from other similar disorders. Furthermore, the manual provides important statistics about mental disorders, such as how common a disorder is and how often it occurs among males and females. While clinicians make up the majority of DSM users, it is an important tool for other professionals, such as researchers, who conduct studies about the occurrence and treatment of psychiatric disorders, health insurance workers, who use DSM to decide whether a treatment is "medically necessary" and reimbursable, as well as U.S. lawmakers and government executives, who refer to DSM in determining insurance coverage in the public healthcare system.

The first edition of the manual, DSM-I, was published in 1952. Since that time, four editions have been produced, with the most current version, DSM-IV, released in 1994. The American Psychiatric Association (APA) is in charge of overseeing the revision and publication of DSM. Why are revisions needed? Simply put, to ensure that patient care keeps pace with science. As advances in research create a clearer picture of factors such as how mental disorders develop; why certain disorders, like depression and anxiety, tend to occur together; and the symptoms that patients experience, we need to refine the diagnostic criteria to make sure that patients are diagnosed correctly. The use of this manual also helps assure that patients receive the appropriate and most effective treatments.

The process to develop the next edition of DSM – DSM-5 – has been underway for nearly 10 years. Experts hope that potential changes in DSM-5 will bring about improvements in patient care. For instance, we know from research and from working with patients that certain symptoms are very common in most individuals with psychiatric disorders. These symptoms include depressed mood, anxiety, sleep problems, changes in thinking

Carol A. Bernstein, MD

or memory, and several others. However, busy clinicians do not always ask patients about these common problem areas – which means some patients do not always receive the treatment they need. One of the proposed changes for DSM-5 is to include questionnaires that clinicians will use to more thoroughly review these common symptoms. This is similar to the "review of systems" your physician uses when he or she is assessing your general medical health. Given that nearly half of all people who have one mental disorder also meet criteria for two or more mental disorders, DSM-5's "mental review of systems" approach will hopefully aid clinicians in determining whether a patient is experiencing symptoms that need treatment, in addition to identifying any number of psychiatric diagnoses that he or she might also have.

Other proposed changes to DSM-5 are more specific to actual diagnoses, such as changing the wording of diagnostic criteria to more accurately describe patients' symptoms. These also include proposing new psychiatric disorders that are not currently a part of DSM-IV, as well as suggesting that some disorders be included in existing disorders or are removed from the manual altogether.

The process for determining whether a change should occur is lengthy and complex but is designed to produce revisions that are based on science and intended for the betterment of patients. There are 13 DSM-5 Work Groups, each representing expertise in a specific area of psychiatry, such as mood disorders, anxiety disorders, eating disorders, etc. Since the groups were officially appointed in 2007, they have been reviewing published research studies, examining data from previous studies, and conferencing with colleagues and with each other to draft their proposed revisions for each disorder. No decision will be made without careful and thoughtful consideration of the evidence, and whether a given change is truly necessary. In every case, the impact on patient care will be of utmost importance.

As work group members are completing their draft criteria, DSM-5 developers are now preparing to enter the next major stage of the revision process: field testing. Proposals that involve significant changes (e.g., new disorders) will be tested in a series of small studies that allow DSM-5 developers to "evaluate" the potential impact of new criteria in real-world settings. This includes academic institutions and large hospitals, as well as private practitioners and smaller clinical offices. The field trials will allow the work group members to determine whether their proposals are helpful for patients, useful to clinicians, and can be reliably used by different healthcare professionals across different systems of care. After these field trials are complete, work group members will make additional modification to proposed revisions, and there may be a second round of field tests to further evaluate proposed changes. The APA will begin drafting the text for DSM-5 within the next two years, and the final version of DSM-5 will be published and released at the APA's Annual Meeting in San Francisco, Ca., in May 2013.

As part of DSM-5 development, in February of 2010, the APA developed a web site www.dsm5.org, where all of the diagnostic criteria and proposed changes for DSM-5 are listed. A two-month period of public comment followed, with work groups using the online feedback as part of subsequent deliberations on potential changes to criteria. Although no longer open to submissions from the public, I would encourage you to visit the site to learn more about how this process is proceeding. The public will have another opportunity to provide commentary through DSM-5.org in the summer of 2011, after initial field tests are complete and further revisions to the draft criteria are posted online.

Proper diagnosis and treatment are vital to reducing the burden caused by psychiatric diagnoses. The impact of mental illness can be felt in nearly every aspect of society, from healthcare and legislation, to education and the economy. Continued revisions and improvements to the DSM are critical to assuring that those suffering from psychiatric disorders receive the most scientifically based and clinically beneficial treatment possible.

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The Economics of Recovery: When Worlds Collide

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

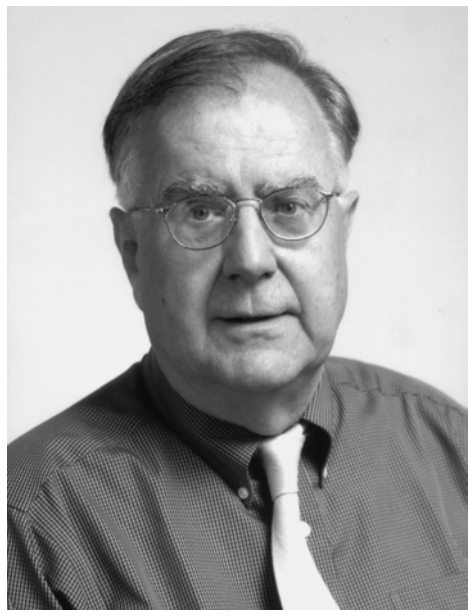
To quote Rahm Emanuel, "You never let a serious crisis go to waste - it's an opportunity." In the past decade, it's been one crisis after another: 9/11, Iraq and Afghanistan, Katrina and tsunamis', Wall Street meltdown, global warming, the gulf oil spill, Haiti, bankrupt governments, even the safety of our food, medicines and toys!

Many feel our problems are beyond the capacity of government to solve. Governments are felt to be too big, bureaucratic and political to react quickly and effectively.

A recent public opinion survey found almost two-thirds of Americans believe: "Corporations are better able than government to respond effectively to disasters." Three-quarters also believe: "Businesses bear as much responsibility as governments for driving positive social change," and eighty-six percent agree that, "It is important that companies stand for something other than profitability" (Good for Business, 2010).

Opinion studies have also shown that as the crises multiply, so do the public's belief that corporations can and should do more to solve them. If, as the Supreme Court decided this year, corporations have the same legal rights as "natural persons," then they are also expected to accept the responsibilities that come with being a part of the human family.

With the almost universal access to the internet in recent years, consumers have been able to wrest control of the dialogue away from corporations with product ratings, posted comments, hostile websites and leaked memos. Transparency was only a click away. The traditional top down, command and control style of doing business was out. The Internet had firmly put the consumer in charge – the only tenable business strategy left was to "just do the right thing." Be open, honest



Donald M. Fitch, MS

and helpful with your customers. Some corporations realized they needed to go beyond being "helpful" – they had to genuinely become world citizens. They realized that a solid reputation was worth its weight in gold and only deeds, not words, would get them there. Corporate Social Responsibility (CSR) was their ultimate solution. Today nine out of ten Fortune 500 companies have initiatives focused on CSR.

However, there are perhaps only a few dozen U.S. Corporations that are fully engaged in this exciting new social movement. IBM is, in my opinion, the world leader. As stated by Samuel J. Palmisano, Chairman, President and Chief Executive Officer of IBM, "As a global citizen, we believe that the issues facing the world are too critical and far too urgent – and the opportunities to make meaningful progress on them too immediate – not to act now. Indeed, the most interesting result of our Smarter Planet initiative, to me, is how it is causing our business strategy and citizenship strategy to merge. The barrier is no longer technology. What we make of this new reality will depend, rather, on how we pursue the timeless goals of all social and economic prosperity and individual empowerment."

The many issues IBM is seriously addressing include the environment, safe water and food, sustainable/empowered cities, smarter work force, education, energy and healthcare. (www.ibm.com/corporateresponsibilityreport2009)

Other CSR leaders' initiatives include Pepsi-Cola and Walmart. Beginning in August, the Pepsi Refresh Project will support a number of community projects, including "refreshing" the Gulf in the wake of the tragic oil spill (www.refresheverything.com). Walmart has used its buying power to reduce its carbon footprint and save over three billion dollars a year by requiring their over sixty thousand suppliers to reduce their energy consumption and packaging.

When you study these CSR websites (and I hope you will), what these leaders of tomorrow all seem to understand is that their company's futures are determined by the quality of people they are able to attract. Fortune's "100 Best Places to Work" lists a core purpose that goes above and beyond the bottom line. Increasing sales and shareholder value depends on attracting the best employees which means you'd better be a positive force in the community (The Responsibility Revolution, J. Hollander, 2010).

Here in New York City, we are very fortunate that Mayor Michael Bloomberg, self-made billionaire and social entrepreneur, has chosen to donate his extraordinary business talents to the betterment of the citizens of New York City. One of my favorite "Mayor Mike" stories illustrates how a minor and inexpensive collision between the worlds of business and government can produce a lasting increase in efficiency. The story I heard was that the weekly meetings of the five Borough Presidents, their aides and the Mayor typically lasted three hours, until the Mayor had the chairs removed! The subsequent meetings took less than an hour as folks learned to summarize and speak faster. (Oh how brief our endless meetings could be if there were no places to sit!) Bloomberg and his staff have developed a unique set of governance tools which demonstrates the power of everyday citizens to create change. The public-private partnership models they've created can turn dreams into reality throughout the country. But to accomplish this, we need courageous leaders. As stated by Mayor Bloomberg, "What we can't afford is to continue upholding a failed status quo by funding programs and sustaining approaches that don't work. The silver lining in any economic crisis is that it can force government to take necessary steps that, in more comfortable times, would fall victim to the forces of inertia – but it is up to us, all of us, to seize the opportunity."

A survey of over one-hundred social entrepreneurs across the country conducted by Duke University found the greatest barriers to systemic reform were "the network of relationships that develop among government bureaucrats, politicians, agency heads, and funders who believe that more of the same will make a difference. This iron triangle produces barriers to entry for new actors." "The political economy of social systems induces providers to seek protection over performance." An oligopoly develops when a group dominates decision making via its control over knowledge, resources and communication (CASE, 2007).

The study also found that these civic entrepreneurs, armed with innovative thinking, a bottom-line sensibility, and a willingness to tackle some of the nation's most intractable social problems, are tapping into a powerful energy and sense of purpose via the Internet. "This growing cadre of change agents is shattering traditional policy approaches and replacing them with creative solutions and unique partnerships to produce dramatic results" (The Power of Social Innovation, Goldsmith 2010).

THE MENTAL HEALTH LAWYER

Obtaining Judicial Authorization to Medicate a Minor

By Carolyn R. Wolf, Eric Broutman, and Douglas K. Stern, Esqs., Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP

A decision to give a child powerful psychotropic medication is a difficult one, fraught with uncertainty and is often viewed as the lesser of two evils. While the administration of medication to a child is itself a complicated decision the stakes are raised if either the child or the parents do not agree with the psychiatrist's treatment recommendation that medication is the most appropriate treatment path.

This article will discuss the legal landscape that treatment providers and lawyers must navigate when seeking to obtain judicial authorization to medicate a minor either over the minor's objection, or the parent's or guardian's objection. Where the parents object to medication and the child is less than 16 years of age, the legal picture of what process should be employed is fuzzy at best. Courts have alluded to recommendations on the best way to proceed, but the picture is still uncertain. This article will attempt to shed some light on the matter.

Minors, like adults, have the right to object to the administration of any medication they do not wish to take. The Supreme Court of the United States has routinely acknowledged an individual's right to bodily integrity as one of the most sacred guarantees implicitly recognized within the Due Process clause of the Constitution. In line with this right, even if parents want their child to take psychiatric medication, if the child objects, a hospital must seek Court authorization before administering medication.

In New York, this Constitutional right was recognized in the landmark case of Rivers v. Katz. In Rivers, the Court reasoned that if a hospital wished to provide medication to a patient over the patient's objection the hospital had to bring a proceeding in which it proved, by clear and convincing evidence, which is the highest burden in a civil proceeding, that the patient lacks the capacity to make a reasoned decision regarding medication, that the benefits of the medication outweigh the potential risks, and that there is no less restrictive way to administer treatment to the patient.

Where the parents consent to medicating their child, but the child objects, from a legal perspective, it is a rather straightforward process. The hospital seeks authorization to medicate the child and a hearing is held much like a hearing where the patient is an adult. The only difference being, it is presumed that the minor lacks the capacity to make a reasoned decision and so that specific criteria is dispensed with. The hospital need only prove that the benefits of medication outweigh any potential risks and that there is no less restrictive alternative.

Carolyn R. Wolf, Esq.

The much more difficult situation is where the parents object to treatment. New York's Mental Hygiene Law has created a distinction between patients who are over 16 years of age and those who are under 16 years of age. If the patient is over 16, and wishes to take medication, but the parents disagree the hospital may be able to treat the minor even without Court authorization.

If the patient's treating psychiatrist, as well as a second psychiatrist who is not an employee of the hospital, determines that (1) the patient has the capacity to make a reasoned decision to take medication; and (2) it is in the patient's best interest to take medication, the medication can be administered to the patient even though the parents object. In the event that the hospital decides to provide medication to a minor child under this circumstance the hospital must provide notice of the decision to the parents.

In instances where the treating psychiatrist believes that it would be detrimental to the patient to seek consent from the parents to treat the patient with medication the hospital does not have to inform the parents that the patient will receive medication. This is true so long as a second psychiatrist who is not an employee of the hospital agrees that (1) it would be detrimental to seek consent from the parents; (2) the patient has the capacity to accept medication; and (3) it is in the patient's best interest to receive medication. It should be noted that where the patient objects to taking medication regardless of how old the patient is the hospital must seek Court authorization to provide medication.

A whole new set of issues are raised where the patient is under the age of 16 and the parents object to medication. In such an instance the hospital must obtain a Court Order to treat the patient with medication, even if the patient consents to medication. The law, however, is not very well established in this circumstance. What exactly the hospital must prove in order to obtain a Court Order, what is the role the parents play in these proceedings, in what Court should the matter be raised? These are all unanswered questions under the current state of the law in New York.

There are very few cases that have dealt with this situation. In one of the few that has, an Appellate Court admonished a lower Court for authorizing a hospital to treat a minor patient without demanding that the parents be made parties to the case. In other words, in the lower Court proceeding the parents were not formally involved in the case and therefore had no legal right to have their voices heard before the Court rendered a decision. The Appellate Court alluded to the fact that a neglect proceeding, like the kind seen in Family Court where a parent is not appropriately caring for a child, might be most appropriate in instances where parents object to the administration of needed medication. Under this theory, the argument would follow that because the parents are the guardian and decision maker for the child it was incumbent upon the hospital to show that the parents were endangering their child by refusing medication. Although the Appellate Court opined that this would be a potential resolution, it did not conclude it was a necessary action. Hence, it is still unclear if a hospital must bring a neglect proceeding in this type of situation or merely that it is one possible route a hospital could follow. One thing is clear though, if a hospital wishes to provide treatment to a patient under the age of 16 where the parents object to giving their child medication, the hospital must make the parents parties to any action seeking Court authorization for treatment. The parents would then have the right to hire counsel to have their interests represented and to have their voices heard in order for the Court to render a fully informed decision.

Where parents consent to medication or where the child is over the age of 16 the law is fully developed with regard to the appropriate procedure to follow to obtain legal authorization to treat the patient. For children under the age of 16 the law has still not fully developed in the realm of seeking Court authorization for treatment over the patient's objection. Whether a neglect proceeding is necessary or simply a Rivers type hearing where the parents are parties to the action, it would behoove the Courts to add clarity to the situation. In its current state, the law is uncertain, which could easily lead to delays in treatment for those who need it, as well as the infringement of a minor child's right to bodily integrity and the right of parents to decide what is in the best interest of their child.

A Clinic's Initial Experiences Conducting Multiple Family Groups

By Peter Wildeman, LCSW
Clinical Supervisor
Institute for Community Living's
Guidance Center of Brooklyn Heights

Jose is an 11-year-old boy who has, for years, been threatening his family to run away and never return when he is upset with them. His family has tried to cope with these behaviors the best they could, but things reached the point that they felt they needed further assistance. His grandmother made a decision to bring Jose to the clinic to obtain assistance, and the Multiple Family Therapy Group was suggested as an approach that might be helpful.

Each fall for the past two years at the Institute for Community Living's Guidance Center of Brooklyn Heights, we have conducted a group in conjunction with Mount Sinai School of Medicine's Department of Psychiatry Research Center called the Multiple Family Therapy Group. The group runs for a 16-week cycle, including time for research data collection. The clients are children ages 7-11 diagnosed with Oppositional Defiant Disorder, and they are accompanied by their parents and other family members. The group curriculum focuses on teaching the participants the "Four R's:" Rules, Responsibilities, Relationships and Respectful Communication. The goal is for both parents and children to learn how to incorporate the four R's into their lives with resulting improvement in the child's behavior.

The first year, the group was conducted by a clinical supervisor from the outpatient clinic and a parent advocate from the Brooklyn Parent Resource Center. The second year, it was run by New York University interns supervised by the clinical supervisor. The participants are families of children in the designated age range who are diagnosed with oppositional defiant disorder. The group can consist of up to six families at the same time. A "family" is defined as those individuals who participate in raising the child and who can commit to a 16-week group treatment process. Once started, the group is closed to new members after the third meeting.

Initial group activities are focused on helping the families understand the purpose and goals of the group and to identify the concerns of each individual in the family. Every effort is made to elicit verbal participation and engagement so that all members of the group are invested in the process. After all, each member of the family contributes something unique to the culture and dynamics of the household. The process of setting rules is initiated by the group facilitators, but the children are asked to contribute rules as well. All the rules are written on a large sheet and posted on the wall for everyone to see. Then the families sign the rules to emphasize the importance of following them. Together, we also identify goals for each family. The goals are revisited frequently throughout the course of the group and provide a focus for families; something to work towards.

An integral part of this group experience is sharing a meal. Time is allocated during the group for staff and families to enjoy a meal with one another. Most of the children request pizza, so that is what we order. In an attempt to promote healthy eating and to supplement the children's food of choice -- pizza, we also order salads. The experience of sharing ideas and issues while eating together creates a bond with participants that feels like a family experience as well as a group process. Ours is a hands-on group. Many of the activities involve games and/or encourage writing and working together toward a common goal.

The first few sessions include ice breakers though which the families become acquainted and begin to understand that there are others with similar issues. With this newfound knowledge, the group becomes a safe place to share problems. As the group proceeds, the members take on specific roles, often replicating the roles they assume within their own homes. For example, one parent is the "biggest talker," often taking over the group and sharing the most frequently. One of the children may act as a "protector" for other children in the group

see Groups on page 41

Risk Assessment and Its Importance for Children and Adolescents

By Elizabeth N. Cleek, PsyD, Vice President, Adam P. Chaiken, LCSW-R, Vice President, and Michael Blady, LCSW-R, Associate Executive Vice President
Institute for Community Living

More than four years ago, the Institute for Community Living (ICL) extended its focus on risk assessment and intervention to provide staff with additional tools and strategies to support integrated and coordinated assessment and intervention of and for clinical risk. The purpose of the model is to facilitate communication, supports and a culture of mutual responsibility across disciplines and organizational boundaries to create a comprehensive and cohesive system that emphasizes integrated care and preventive interventions.

Risk and risk-taking behaviors are unfortunately as applicable to youth as they are to adults. According to the Center for Disease Control (CDC), in 2009, 13.8% of the high school students surveyed seriously considered suicide, and 6.3% attempted suicide. Further, 5.6% of students surveyed had carried a weapon on school grounds on at least one of the thirty days preceding the survey, and 7.7% had been threatened with a weapon on school property. Risk taking behaviors of others, up to and including suicide, are rarely solitary acts—at the very least, they impact family members, friends and even the broader communities in which people live. For example, in the same CDC survey, 28.3% of students rode in a car with someone who had been drinking at least one of the thirty days preceding the survey, and 5% had not attended school on at least one day out of concern for their safety either at school or on the way to or from. According to the Citizens Committee for Children, in East New York, one of the areas in which ICL operates both a clinic and services in schools, there were over 1000 juvenile misdemeanor and/or felony arrests in 2006.

In 2008, the New York State/New York City Mental Health-Criminal Justice Panel Report and Recommendations were published with guidelines for standards of care and screening for risk of violence in mental health clinics. ICL built upon this guidance in the development of an initial and ongoing assessment process to identify areas of potential danger to self and/or others. The goal of this ongoing work is to develop systems that assist staff in collecting the pertinent data and helping them to convert the data to clinically relevant information regarding factors that indicate the potential for risky behavior. Supervisory staff and clinical training and consultation can then be provided to staff to support work with consumers around identification of triggers and subsequent intervention strategies, including both in-house and linkage services, e.g., urgent clinic treatment visits, mobile crisis teams and in-patient hospital services.

In ICL's four community- and school-based clinics and on-site school services throughout Brooklyn, risk assessment begins at the initial interview with client. As the clinician completes the psychosocial interview, there are very structured and purposeful questions relating to risk. These pertain to legal involvement, abuse / trauma assessment, witness to violence or victim of such, anger management issues, history of fire-setting, use of / access to weapons, as well as adherence to prescribed medication routines. At the conclusion of the psychosocial assessment, a clinician will consider information from this process, as well as the mental status exam and other pertinent information to determine a level of risk for the incoming client.

When a client is identified as at high clinical risk, a summary of risk factors is forwarded to the clinician's supervisor for review. It serves as a trigger for ongoing discussion and possible outreach for further consultation. A case conference may be convened involving family members, clinical specialists, other self-identified supports and other individuals with systems, regulatory, medical or other expertise pertaining to the situation.

The clinical risk assessment process is ongoing—it needs to be assessed at every session, particularly with youth who may not be in control of the situation, and for whom impulsivity, fluctuating emotions and large-scale issues that could easily challenge adults, are the norm. When youth are involved, the issues are always more complex, and the terrain is changing. We are currently reviewing the child and adolescent clinic assessment process to ensure that we remain current with emerging risk factors, such as cyberbullying, as well as continue to focus on more traditional areas, such as drug and alcohol use, possession of weapons, gang involvement and others.

Concurrently, clinicians have continued to participate in an ongoing monthly training on best practice interventions, spanning from those specific to risk assessment and intervention to ongoing treatment, and family work.

It is the intent of the clinical risk initiative that we will have a better opportunity to identify those clients at risk and to facilitate a more comprehensive system of ongoing support, follow-up and monitoring. However, nothing is stagnant—as we continue to evolve this process, the field will continue to develop, and new areas of risk, as well resource, will emerge.

Through a Glass Darkly: Poverty and Mental Health in The Bronx

By Julie List, LCSW, Director
Harry Blumenfeld Pelham Counseling Center, JBFCS

Each day I take a journey to the northern tip of our city, to the Northeast Bronx, where I am the director of an outpatient mental health clinic. I am a visitor from another country, Manhattan, and I inhabit this world and see it through the eyes of a white, middle-class outsider. As the 5 train snakes along the track above ground at East 180th Street, I can see the last hint of the spires of Manhattan. The Empire State Building, sharp and shining, points upward, a beacon of wealth, seemingly a million miles away. On the way to my office, walking down Astor Avenue off of Boston Road, I pass the field of dead umbrellas, broken birds. It is more an empty lot, actually, with capless soda bottles and ragged wrappers strewn alongside the metal spokes. In one block we have our Dominican bodega, the American-Albanian bakery, China Kitchen and Irving Freireich, the accountant. He may be the last Jew in the neighborhood where all our Jewish grandparents grew up. Next door to him a storefront houses two-foot figurines of Madonnas, Kings, and Saints lined up to watch the spectacle that passes daily. They've seen fistfights and fake fights and the "Albanian Boys Incorporated" threaten the Black and Latino kids who previously owned our corner. One day I looked out my office window and saw an old fashioned rumble, shirtless Albanian teens with bats and chains, challenging the kids of color who make up the majority in this neighborhood. There are some Bloods and some Crips and some gang wanna-be's.

It's the wanna-be's who make it further down the street to our door. And their parents, who are nurse's assistants, bus drivers and cashiers, as well as housing project managers and food service personnel, some teachers, waitresses and cops. And many who can't find work or are emotionally unable to work, who struggle to get by on Disability or Public Assistance. They pray they can keep their Medicaid, and thank God daily for Child Health Plus, the state government program. This is an overwhelmingly poor neighborhood, with many working low-wage and minimum-wage jobs and many more who don't work at all.

It's Spring in one of the nation's poorest counties, and the yellow forsythia is the only spot of color near streets littered with dog poop, where the churning wheels of the El make harsh atonal music amidst the groaning of sirens and the urgent horn blaring of fire trucks. There is no silence here. The poverty is evident in the grayness of the faces, the canes and walkers and wheelchairs, the expanding thighs and hips of the many eating McDonald's on the run, sipping huge Cokes. The Albanians around us are a closed and quiet people. The men have no work. They sit in groups in an all-male bar where they smoke and peer cautiously out at this American land of no opportunity. The older generation meets around the cement chess table on Pelham Parkway, with tat-

Julie List, LCSW

tered jackets and wizened faces. Women looking twenty years older than their age occupy themselves with the children. "There's no Hope in Dope" is the sign on the wall of the Albanian bakery, next to a carving of "Nene Tereza 1910-1997," their Sister of Mercy.

The Bronx is the borough New York left behind. Local physicians report that the patients in the Bronx are the unhealthiest they have ever treated. There is an increase in Type 2 diabetes, and children make up half of the diabetes cases. Bronx County has the third highest rate of asthma in the entire state. As a result of the link between obesity, air pollution and asthma, Bronx MDs see a "systemic inflammation" and breathing gets more and more laborious for these Bronx residents. The official unemployment rate in the North Bronx is about 14 percent and in the South Bronx nearly 20 percent, compared to the national rate of 10 percent (From "Health of the Bronx: Have We Created the Perfect Storm?" Lower Hudson/Bronx MDNews, April 2010, available at: http://lowerhudsonbronx.mdnews.com/). The actual unemployment rate may be twice those already appalling numbers, if you take into account people working only part time and "discouraged workers."

The rooftops are covered in graffiti the way the 9th Ward was after Hurricane Katrina, SOSs in spray paint. The boys' pants are not only below their hips, they're belted below their butts. Rows of boys with boxers billowing strut down the street from Columbus High School to reach the Dominican bodega next door. "F*** this and Mother f*** that"; the girls are shrill in their condemnation of every imaginable thing as they saunter by the clinic in tight pants and painted nails, some with sparkles or stars. At three PM there are bursts of electricity as they light up our street with excitement: they're finally leaving school, where not much seems to go in and very little seems to come out. The neighborhood is alive in a dying community where the Verizon store is the only sign of the 21st century.

I am the white ghost on the train, weaving in and around my 9 to 5 neighbors, invisible but trying to leave an imprint. We come to make a difference, but my question is: Are we able to help them help themselves? They didn't make the rules, after all; we did.

We are an outpatient mental health clinic in the Northeast Bronx run by JBFCS, a city-wide social service agency that is largely government funded and also supported by the UJA and other philanthropic donors. At my clinic we have 750 out patients at any given time; about half are kids. Our referrals are from neighboring schools, hospitals, and physicians treating patients who suffer not only from obesity, asthma and diabetes, but also depression, anxiety and post-traumatic stress disorder. It's a community without community centers. An overwhelmed school district with underperforming schools armed with metal detectors. No PTAs, and one guidance counselor for hundreds of kids. The children come to us via the psychiatric emergency room, sent there by teachers and principals who fear the thrown chair, the cursing mouth, the threat to shoot somebody dead or jump out of a window.

We are the DMZ for this part of the Bronx; we offer neutrality, sunlit offices and a bright and comfortable waiting room with colorful posters by Black and Latino artists, carpets, books and plants. Members of our Board donate books for our waiting room, as do New York City publishing companies I seek out. Our patients read, gobbling up books and magazines hungrily. They read everything, from *Brides' Magazine* to *The Nation*, *The New Yorker* and *Yachting*. The classics, autobiographies, *Golf Digest* and *The Little Engine That Could*.

One third of our staff members are people of color, with their own varied backgrounds: from the Caribbean, via England; from Puerto Rico and the Dominican Republic. We also have an Iranian American, two Iraqi Jews, and Asian and Russian support staff. We run bi-weekly Diversity Seminars for clinical and support staff, trying to deal with issues of race and racism that emerge amongst staff or with clients. This, in turn, assists the therapists in their goal of genuine interaction with the people who come to us for help. Our clients are overwhelmingly people of color, making those of us who are white especially stand out.
The problems our clients bring us, however, cross all color and class lines, and the pain they suffer is magnified by the economic and racial disparities and indignities they experience in the world around them. The rage or depression they live with can explode at a moment's notice, and the expression of it can go from zero to a hundred in a split second. There is no slow burn, no long fuse. A breakup, a verbal taunt, a slap in the face, can provoke self-inflicted cuts on the inside of the wrist, taking a whole bottle of Tylenol, or wielding a knife in self defense. Or all three responses. Most of our women clients were sexually abused as children, and they are haunted by trauma. Many of the children have witnessed their parents hit each other. Some have been taken away from their homes and sent to foster care, because one or both parents have forgotten to take them to school or are using a drug of choice. Or because their own untreated traumatic histories have wounded them so deeply they can't find the resources to parent, especially without the help of extended families. But these clients are not statistics to us. Each one has a history, a new story, a family tree, a newborn baby and dreams they aspire to. We see them every week, and listen to each detail the clients provide, to every effort they make to provide a good life for their children, and to every obstacle they encounter along the way. As much as we are able, we try to clear the road ahead of obstacles (the ones we have some control over) and open our clients to the possibility of hope.

Some of Our Patients and Their Stories:

With one small child at home and seven months pregnant with her second, Josie tried to kill herself at 22 by jumping onto the subway tracks as the train approached. She had just discovered that the father of her unborn baby had conceived another baby at the same time, and that woman called her to brag that she would give birth in two months as well. Josie lost her leg up to the knee and part of her hand, but she survived, as did the baby. She came to her first session in a wheelchair with her mother, and she was not happy about being alive.

Maria had twin teenage sons and a younger son. One of her twin sons was found hanging in the shower after he was kicked out of school for a minor infringement of the rules. The family was referred to us one week after the suicide and the mother was paralyzed with grief and guilt. The remaining boys were ashamed to go to school and could not articulate their feelings. The boys are finally coming up for air, having lived with the empty bed at home every single day. Two years after they first came, their mother gave birth to a baby girl. The mother's therapist gave her a baby shower with the members of Maria's therapy group at the clinic, with pink decorations on the office walls.

Elena was bathing the baby when she received a phone call in the living room. In an instant of poor judgment, she ran out to answer the phone and when she returned, the baby had drowned. She came to us when the authorities refused to let her keep her second child. As she mourned for her first, she grieved for the loss of her second. After a year in therapy, the authorities reunited her permanently with her second child.

Latasha is bipolar, as are her two teenage daughters. The elder daughter stabbed her father. The family was separated as the father had to leave the home. The family then moved from shelter to shelter and all three stopped taking their medications. Latasha was unable to function and risked psychiatric hospitalization; she had been many times. Once re-stabilized on her medicines, Latasha managed to hold her family together.

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The Role of the Home Care Mental Health Nurse in Identifying, Accessing, and Treating Children and Adolescents Requiring Mental Health Services

By Elizabeth Cymerman, MNH, BSN, RN-C, HNC, Assistant Clinical Manager - Mental Health Program Visiting Nurse Services in Westchester

As Assistant Secretary for Health and Surgeon General of the US, Dr. David Satcher (2001) stated, "The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country…children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met…it is time we as a nation took seriously the task of preventing and treating mental illness in youth."

This was Dr. Satcher's address to the report of the Surgeon General's Conference on Children's Mental Health. Not much has changed since that Conference due to many factors, which are still not partially or fully attained. This conference was the accumulated knowledge from many sectors of society, which concluded that the obstacles to delivery of mental health services are many, including: inadequate public awareness, fragmented services, racial/ethnic disparities, and more. The Conference also pointed out our country is facing a public crisis in mental health for infants, children and adolescents.

The World Health Organization (WHO) stated that "by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 % internationally, to become one of the five most common causes of morbidity, mortality, and disability among children." But yet, most people do not recognize that mental health is a critical component of health and wellness.

Approximately 1 in 5 (20%) of children and adolescents may have a mental health disorder, and often these children have more than one disorder. (U.S. Dept of Health and Human Services, 1999). Failure to recognize and treat mental illness can cause a cascade of events for a child with deleterious effects. It reduces the child's quality of life and ability to develop into a mature healthy member of society. These children can face school failure and drop out, possible substance abuse and addiction, incarceration, delinquent behavior and violence.

Modern psychopharmacology and health insurance reforms' push to keep patients in the community has fashioned forward thinking home care agencies to incorporate and employ mental health nursing services. We are the "glue" that encourages compliance and communication, monitors for mental health symptoms, and provides a liaison with treating Psychiatrists, mental health clinics, and outpatient day treatment programs, all in the attempt to keep individuals stable and in the community.

In order for the home care mental health nurse to be of help to children and adolescents within her area of practice, one must know the issues, which interfere with children getting mental health services.

Parents may feel guilty that the child may be mentally ill and ignore early symptoms of mental illness. Due to lack of education and knowledge of mental illness symptoms in children and adolescents, parents may conclude that the child is impudent and punish the child for their inappropriate behavior, which can cause low self-esteem in both the child and parent. Parents themselves may be suffering from mental illness and/or substance abuse, and not be able to cope or respond to the child's issues. There may also be lack of resources- money, availability of mental health resources, and a nurturing parental figure in the household.

Primary care physicians, due to required immunizations and physicals for day care and public schools, are also providers that are critical for early identification of children with mental illness, and often give counseling and prescribe psychotropic drugs, however, families do not view this as mental health services, and may not be getting the appropriate treatment.

Since children have to attend school, schools should be the place where early diagnosis would be most likely to happen, however this is not the case. Cole (2001) states, "Students with mental health needs are usually identified only after teachers cannot manage their behavioral problems. Therefore, less than 1% of children are diagnosed with depression, attention deficit hyperactivity disorder (ADHD), and post-traumatic stress disorder secondary to abuse. Consequently, these students are mistakenly treated for primary learning or language disorders. National data indicate that 22% of children ages 5 and younger live in poverty, which is a scientifically proven risk factor for mental illness. Other risk factors are prematurity, family stressors (divorce, death, illness)." Teachers, since they see the child for hours, days and months, need to be educated and evaluated on their ability to detect early signs of major mental illnesses in children, and have the support and ability to refer the child to a specialist when appropriate.

The home care mental health nurse may come upon the child or adolescent with mental health symptoms in two different venues. (1) Where the child is the primary problem. A Pediatrician, Pediatric Psychiatrist, Social Worker, school system or Clinic may have referred the child. The early problems may be parenting, sibling, and developmental, or school related issues. (2). The parent as the primary problem and its impact on the mental health of the child, either due to parental decompensation of mental or physical illness or biological issues. In either case, the home care mental health nurse will play a key role in early detection, education of parents and child, referral to appropriate services, monitoring of compliance to the plan of care, evaluation of the plan of care, and communication with all services and professionals involved.

All mental health nurse professionals must have knowledge of the most common mental health disorders in children and adolescents and their symptoms, in order to be effective in early detection.

Anxiety Disorders are the most common mental health diagnosis. 13% of 9-17 year olds have either anxiety disorders or phobias and fears of objects or situations. (A) GAD or Generalized Anxiety Disorder, seen as excessive, unrealistic worry, (B) Panic Disorder, seen as attacks with physical symptoms of palpitations and dizziness. (C) OCD or Obsessive- Compulsive Disorder, Where the child is "trapped" by repetitive thoughts and behaviors, such as repeated hand washing .

Post-Traumatic Stress Disorder, which is usually, exhibited by "flashbacks" from exposure to a psychological distressing event, such as abuse, exposure to violence, natural disasters, or war.

Severe Depression: Only in recent years have experts agreed that children can suffer from severe depression. 2% of children and 8% of adolescents may have major depression. Symptoms in children may include: (A) Affect changes- such as sadness, crying and worthlessness. (B) Loss of interest in playing and school activities, truancy, and poor school performance. (C) Physical signs may include appetite, weight, and sleeping habit changes. (D) Attitude changes may include a negative outlook pertaining to themselves and the future. (E) Suicidality . Suicide is the third leading cause of death in adolescents. 90% of children who commit suicide have a mental health disorder. 6.9% of 9-12th graders have attempted suicide. Any child or adolescent with depression is at risk for suicide, and need to be monitored for suicidal thoughts and actions.(F) Substance Abuse- 43% of youths with a mental health disorder also abuse drugs and alcohol. .19.7% of 9-12th graders have tried marijuana. Adolescence is very stressful, and poor coping skills can lead to drug and alcohol use to escape problems. These substances can reduce impulse control, making it easier to attempt suicide.

Bipolar Disorder or Manic Depression: A child or adolescent who demonstrates extreme mood changes, from highs (excited behavior) i.e manic phase, to lows ie depression, may have bipolar disorder. These extremes may follow with periods of moderated mood. When having manic behavior, the child may be hyper verbal, show a reduced need for sleep with poor judgment and impulsiveness. Adults with this disorder often experience their first symptoms during their teen years, and are approximately 1 % of the population.

Attention Deficit/ Hyperactivity Disorder (ADD and ADHD): ADD is when the child has difficulty focusing attention and/ or is easily distracted, and does not have the hyperactivity component, whereas ADHD does include it. ADHD occurs in up to 5 % of children. These children have difficulty remaining still and keeping quiet.

Learning Disorders: These children have difficulty processing information. They may have problems with spoken or written language, coordination, attention or self-control.

Conduct Disorder: Children with this disorder tend to violate the rights of others and rules of society. They act out their impulses in destructive or inappropriate ways. A child may start out lying or stealing, and move on to more serious crimes such as vandalism, aggression, and violence. 1-4% of children 9-17 years old have Conduct Disorder.

Eating Disorders: Society, culture and the Media send powerful messages about the ideal, thin body, by which our youth feel they must attain, in order to be powerful, sexy and successful in life. This sets up children and adolescents to only value themselves for the body image that they project, and can lead to poor self-esteem, poor body image and potential eating disorders.(A) Anorexia nervosa-extreme weight loss, fear of eating and food rituals. (B) Bulemia- Binging and Purging by induced vomiting, laxatives, enemas, and compulsive exercising to prevent weight gain. Anorexia mostly effects girls (.5-1% of adolescent girls). Bulemia is 1-3% of all adolescents.(C) Obesity- The causes are multifactorial- poor lifestyle choices, genetics, less structured family life, etc. The changing roles of parents in our society, where both are needed to sustain the

see Home Care on page 42

Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

- **Adjunct service to community mental health programs**
- Structure in the home environment.
- Assistance with home management focusing on inadequate levels of functioning, hygiene issues and compliance with medication regimen.
- Administration of I.M. long-acting psychotropics.
- Liaison with the community treatment team informing them of changes and important symptoms that may indicate decompensation or need for changes in the treatment plan.
- On-going assessment of all health needs relevant to the individual's diagnoses.
- Consultative services for the individual whose primary diagnosis is medical/surgical in nature, however, due to difficulty coping with illness, requires mental health intervention.
- Coordinated home care services for non-compliant individuals and those with complex combined mental health/physical needs that present ongoing problems.

Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent in-patient psychiatric hospitalization
- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

Visiting Nurse Services in Westchester (VNSW) believes in a holistic, broad approach to the treatment of mental illness, addressing the "whole person's" life circumstances and environment. VNSW fields nurses with advanced psychiatric training, and in some cases, advanced degrees in related fields. The staff provides home visits for assessment, evaluation and development of a treatment plan with interventions related to mental health issues in conjunction with medical/surgical needs. This program meets the total health care requirements of individuals utilizing a case management approach led by a psychiatric nurse specialist. Adjunct services complementing the mental health component include psychiatric social workers, home health aides, medical/surgical nurses and relevant rehabilitation therapies.

The program serves the elderly, adults, adolescents and children.

To receive further information or make a patient referral, contact:

Lisa Sioufas, LCSW-R, ACSW • Mental Health Program Manager
(914) 682-1480, Extension 648 • e-mail: MentalHealth@vns.org

Visiting Nurse Services in Westchester
Home. Health. Care.

360 Mamaroneck Ave.
White Plains, NY
1-888-FOR-VNSW
www.vns.org

VNSW services are covered by Medicare, Medicaid and other health insurance plans.

Residential Treatment Services as a Vital Part of the Continuum of Care for Children, Adolescents and Young Adults
An Interview with Harvey Newman, MSW, CEO of Wellspring Residential Treatment Facility

By Ira H. Minot, Executive Director
Mental Health News Education, Inc.

Wellspring is a residential treatment facility located in Bethlehem, Connecticut. *Mental Health News* recently met with Wellspring CEO Harvey Newman, MSW to discuss residential care and its benefit to the patients that it serves. In the interview that follows, we learn from Mr. Newman how Wellspring's residential treatment facility is meeting the ever changing needs of children, adolescents, and young adults who are experiencing emotional difficulties.

Q: Tell us about the history of Wellspring.

A: Wellspring was started 33 years ago by two therapists from Connecticut, Richard and Phyllis Beauvais. In the beginning, the Beauvais's took young adults into their home and worked with them in a therapeutic community environment. Being successful at this, demand grew quickly and over the course of its 33 year history, Wellspring has evolved into a multi-faceted clinical facility with 41 beds.

We have a 10 bed residence for young adults, a 19 bed residence for adolescent girls, a 7 bed residence for children, and a 5 bed therapeutic group home, also for children. We also have the Arch Bridge School on our campus, a 51 seat special education facility that serves our residents and community day students who struggle with academic success due to emotional and behavioral issues. Historically, about half the students are Wellspring residents and half day students. The day students travel within a 40-50 mile radius of Wellspring and come as a result of their school system not being able to serve them. We have an outpatient clinic on our campus in Bethlehem, and a larger office located in Middlebury. The Bethlehem campus is located about 90 miles from New York City in the southern part of beautiful Litchfield County. Our campus has farm animals and gardens, both part of the therapeutic work programs. Our residences provide home-like atmospheres that welcome kids and their families in a very special way. Our founders, Richard and Phyllis, are active members of our Board of Directors. I came to Wellspring in 2007 to move the facility from a very personal, small, and quiet program to a more broadly visible facility in the local community and within the professional community. The response to our expanded geographic outreach has been very well received by psychiatric hospitals and schools in the northeast and in local communities, all of whom are seeking our level of care. In the past year, we have served kids regionally from as far south as Princeton, New Jersey, and as far north as Boston - with others from as far as California and England.

We are highly professionalized with a great deal of clinical expertise, and run a program that is very clinically intense. We provide over 15 hours of treatment

Harvey Newman, MSW

and therapy per week for the children and their families. In our Adolescent program, we require parents to participate in family therapy and to be involved in multi-family group and parent support programs every other week while their children are in residence. Our biggest challenge is to return our kids to their families, communities, and schools, and to make their home and community environment a healthy and permanent place for them. This requires a lot of family involvement, because as the kids get better there needs to be simultaneous changes within the family unit itself.

Q: What is the process of a child being referred to Wellspring for care?

A: Every child who we take into Wellspring has been known to some provider, community institution, or organization that notes their emotional problems and difficulties in living at home. Right now we get a substantial number of referrals from school systems where the child is not making it because of some emotional issue that is affecting their academic performance. We have a number of referrals on a consistent basis, particularly from Westchester County, New York, and Fairfield County, Connecticut where the school systems feel a need for the child to be enrolled in residential treatment and receive residential education. They select Wellspring for those services. In other instances, we have kids who have been in higher levels of care – be it at a psychiatric hospital, an eating disorder rehab program, or a drug rehab program. After the initial rehabilitation, referrals are made to Wellspring through those institutions or the families. Wellspring works to get at the underlying issues that may have caused the child to develop these problems behaviors.

Q: Are substance abuse and eating disorder the most common diagnoses of the kids that come to Wellspring?

A: We do not view substance abuse or eating disorders as primary diagnoses, but rather as secondary diagnosis. We are seeing kids with primary diagnoses of severe anxiety, depression, bipolar disorder, and personality disorder, along with secondary diagnoses of attempted suicide or self harm. We treat these problems in a very holistic way. The core of our service is relational. We work with our kids and their families to help them increase their ability to relate to family, community, and school, to become functioning and productive members of their social community. There are often very complicated, sad, angry, and difficult relations between parents and child. Those core relationships with parents are mirrored in the community with other figures at the child's school. These are difficult situations for the kids to manage, and we work very hard to help them achieve a relational level that permits them to function in these environments.

Q: Once a child arrives at Wellspring, how do they become part of campus life?

A: In addition to schools, we frequently receive referrals from psychiatric hospitals such as New York-Presbyterian Hospital, in White Plains, New York and Silver Hill Hospital in New Canaan, Connecticut. New York-Presbyterian Hospital has residential psychiatric hospital services for children and adolescents, and Silver Hill Hospital has services for adolescents and young adults. Prior to a child coming to Wellspring, a thorough discussion takes place between the referring institution and our admissions staff to make sure the patient being referred is a good match for us. We then get paper work on the patient from the referring institution and set up a meeting to interview the prospective resident and his or her family. The next steps involve a pre-admission tour of our facility and introductions to therapists and other key personnel who will be working with that child, adolescent, or young adult.

We then set up a date for admission which includes a meeting with our psychiatrist, our nurses, and the psychotherapist who will be assigned to the case. This helps broaden our understanding of the patient and their family.

A new resident always go through an adjustment period. Along with an orientation program, she is assigned a current resident to act as a mentor. The orientation process introduces the new resident to life at Wellspring, and the mentor works with staff to make the transition easier.

Q: Can you tell us about the campus school at Wellspring?

A: Part of our pre-admission process also involves interfacing with the patient's school of origin so that we have an acceptable assessment and special education plan that meets the requirements of the sending school system. Our campus school is approved by Connecticut, Massachusetts, New York and New Jersey. Our coursework is accepted by home schools and is credited towards graduation from the school of origin. We maintain ongoing communication with our resident's school system and try to meet the individual needs of the student and her school. On occasion, we have tutored students in a foreign language and subjects such as advanced calculus so that they can complete the requirements for their home school system. Just recently, we coordinated an advanced placement class for one of our residents who received college credit for that course at a local community college. We get many educationally high-functioning kids at Wellspring and we work to maintain their academic levels and success during their residential stay with us. Our recent state approval process was outstanding and Wellspring received five commendations along with a five year approval.

Q: Do some of the kids come to Wellspring with a history of harming themselves or a pre-existing flight risk given Wellspring's open campus environment?

A: As an open and unsecured facility, we have a requirement that our kids have little or no risk of walking off campus, of returning to drugs, of having an active eating disorder or other situations in which a child may be actively involved in any dangerous self-injurious behaviors. This obviously limits the kinds of kids we can serve. We do not serve kids that require a secure locked environment.

Q: What role do medications play in the therapeutic approach at Wellspring?

A: Medications do play a part. Whether it's a big or a small part in the client's therapy depends on each individual. One of the things we do with new admissions is to lower dosages or eliminate medications, in the safest possible way, in order to find out who the child is without the blanket of these drugs. Last year, we had a child that came to us on five psychotropic medications. In 14 months, she returned home taking only Flintstones vitamins. It is our goal to reduce, eliminate, change, improve, and test out the client's medications, so we can work with the real person behind all of the screens that those medications create, and help them access and appreciate their own personal value and giftedness and build a foundation on which they can build stable, creative lives.

Q: Do all the kids attend a general schedule of programs during the day – or are there individualized daily schedules set up for each child?

A: We do have a general program, but within the program are individualized activities designed to specifically meet the needs of an each resident. All the adolescents attend school and participate in expressive therapy, art therapy, and our

see Residential on page 34

Advancing Anti-Racism Work: The First Monday Collaborative

By Peter D. Beitchman, DSW, LMSW and Onaje Muid, MSW, LMHC, CASAC, FDCL

For the past three years, as a direct outgrowth of the *Undoing Racism* training workshops provided by *The People's Institute for Survival and Beyond*, a learning and action collaborative consisting of human service executives and senior managers, as well as leaders from academia and the human service advocacy sector, has been meeting to advance anti-racism work. Brought together by the powerful training of *The People's Institute*, the cost of which was initially subsidized by United Way of New York City, a diverse group of human service leaders formed the "First Monday Collaborative" to further anti-racism efforts within our organizations and beyond.

The First Monday Collaborative is co-facilitated by Dr. Alan Siskind former Executive Vice President of the Jewish Board of Family and Children's Services (JBFCS), Mary Pender Greene, LCSW-R, Assistant Executive Director of JBFCS and David Billings, Core Trainer for *The People's Institute* who acts as a resource for the group. The Collaborative is based on the principle that *organizational leaders* have a crucial role to play in recognizing and addressing the impact of racism on the human service system and their organizations, as well as clients and staff of color. The Collaborative offers an opportunity for participants to deepen our understanding of the impact of racism in general and specifically its impact on the delivery of human services. It also provides a place to share and creatively develop strategies to transform organizational structure and practice to embody anti-racist principles.

First Monday Collaborative Members (from left): Andrea Harnett-Robinson, President, Harnett-Robinson Consulting; Lawrence Mandell; Onaje Muid, Clinical Associate Director, Reality House, Inc.; Dr. Alan B. Siskind; Mary Pender Greene, Assistant Executive Director, Jewish Board of Family and Children's Services; Maurice Lacey, Executive Director, Faith Mission Crisis Center; Michael Stoller, Executive Director, Human Services Council of New York City; David Billings, Core Trainer, People's Institute for Survival and Beyond; Dr. Alma Carten, Associate Professor, NYU Silver School of Social Work; Dr. Peter Beitchman, Executive Director, The Bridge; Dr. Robert Schachter, Executive Director, National Association of Social Workers NYC Chapter.

The Collaborative has been an important forum for learning about racism in the current American experience and in our own organizations. Many of us initially viewed racism as being individual and intentional acts of meanness, not recognizing the structural and systemic issues to be addressed. Using the framework and language offered by the *People's Institute* as a crucial common ground, including the lessons of history, tools to identify and analyze structural racism and the crucial roles of organizing, leadership and networking in addressing it, participants have learned to identify contemporary forms of racism at large, in our agencies and delivery systems. We have recognized the impact of racism on the lives of our clients and staff of color and, in recognizing institutional bias, we have focused on how to make structural changes to achieve both equity and accountability.

Since the conversation on race is difficult and acknowledgement of racial bias in our organizations takes both courage and encouragement, the Collaborative has created a safe, open environment for mutual learning and support to explore these issues and share solutions. The fact that such a safe space could be created was a major accomplishment, allowing for honest, self-reflective dialogue among the participants. During Collaborative meetings, organizational efforts to address racism are discussed, including the formulation of organizational goals, how to initiate the discussion using a common language, and models of intervention to address racism in the provision of services and in organizational operations.

Mental health agencies are particularly important in these efforts. Given our understanding of the impact of racism on personal and social development, the mental health community has a special role to play in confronting the realities of racism and the urgent need to address them in our services and organizations.

Editor's Note: This is the second of two introductory articles devoted to the impact of race and racism on mental health and human service practice. The Winter issue of *Mental Health News*, whose theme is *The Impact of Race and Racism on Clients, Practitioners, Organizations and Delivery Systems*, will include a number of invitational articles that will explore this topic in depth.

Considering Culture in Child and Adolescent Care

By Dr. Efrain Diaz
DMHAS
Office of Multi-cultural Affairs

Once upon a time our society began teaching children the story of Christopher Columbus, which inhibited children from developing critical multicultural thinking and reinforced racist ideology. A big and powerful "white" country is invading the country of poor Indians of color. You know the rest of the story.

Nowhere can issues of cultural diversity and change be addressed as clearly in the curriculum as they can be in early education, for there is a long-held belief in our field that concepts of health and disease are intrinsic to every culture and ethnicity and are, therefore variable. Multicultural behavioral health is concerned with a myriad factors contributing to disorders, etiology of dysfunction, and a variety of ways in which human populations respond behaviorally to psychological distress (clinical manifestations) and the person's experience. It is not only the assumptions concerning education, health and illness that are culturally based but the very language we use and the questions we raise that are culturally driven as well. The United Sates as a culturally diverse society provides a fertile background for teaching cultural diversity, environmental and ethical issues relating to the behavioral health of children and adolescent.

Historically, ethnic diversity in the U.S. derived from two sources the diverse indigenous populations of Native Americans, and the diverse populations of immigrants, both voluntary and involuntary. Though there has been a significant amount of gene flow between these diverse populations, patterns of socially constructed isolation and inequality of access to both physical health and behavioral health resources have led to dramatic differences in illness patterns and rates of morbidity and mortality at various points in time. Far too often explanations of these epidemiological patterns have been laid solely at the feet of "cultural behaviors and belief". Medical science has contributed to this misconception; more recent analyses have focused on inequalities of power, and the "medicalization" of difference brings new insights to the relationship between the social environment and behavioral health.

For example, the very establishment and growth of the United States was accompanied by the dislocation and destruction of a myriad of indigenous peoples who had successfully managed local ecosystems for long-term sustained use. In addition, these societies were, in general, characterized by internal social equality which allowed for satisfaction of human needs without elevating production and consumption beyond local subsistence demands. This pattern is in marked contrast to that of industrialized capitalist and post-revolutionary communist states alike. J. Bodley, (1990) noted, the notion of "progress has ushered in an explosion of population growth and consumption of resources unparalleled in scope and catastrophic in the nature of the transformation that it has initiated." Any critical examination of environmental issues related to health in the United States must focus on investigations of "race" ethnicity, gender, and the class that have accompanied this transformation of disparities.

Culture, "race," gender, ethnicity, and socio-economic status of children plays a major role in shaping the behavioral health care provided to children by health institutions. "Racial," ethnic and cultural differences influence the expression and identification of the need for services. Studies have shown ethnic and "racial" differences in youth's self-report of problem behaviors, caregivers' value judgments of what is normative behavior, and care giver expectations of the child. Ethnic and "racial" bias in who gets identified, referred and treated within certain institutions has also been documented. For example, African origin youth are more frequently referred to conduct problems for correction rather than psychological services, even with lower or equal measures of aggressive behavior. Quality of care is also impacted. For example, ADHD is less often treated by medications in "minority' groups than in "white" populations. There is also a high probability of misdiagnosis among "minority" individuals, affecting subsequent care.

Furthermore, there are challenges in identifying the mechanism by which "race" and culture accounts for disparities in behavioral and emotional problems and service delivery. Understanding this mechanism has important implications for how to intervene correctly. Factors that

see Culture on page 38

The Next Generation of Family Support Programs: MHA-NYC Leads the Way in New York City

Giselle Stolper, EdM
President and CEO
Mental Health Association
of New York City

For the past twenty years, MHA-NYC has been a champion of strength-based, family driven, youth-guided mental health service delivery. In collaboration with a dedicated group of caregivers – MHA-NYC has been a driving force in building the family empowerment movement in New York City. In 1989, we launched one of the city's first Family Support Programs (FSP) at Gouverneur for caregivers of children with serious emotional disturbance and subsequently started the city's first Parent Resource Center (PRC) in the Bronx in 1993. These two programs became the prototypes for other Parent Resource Centers and Family Resource Programs developed by MHA-NYC over the next 15 years.

Armed with lessons learned over two decades of providing family support services in NYC, MHA-NYC was well positioned to respond to the New York City Department of Health and Mental Hygiene's request for proposals to operate the next generation of Family Support Centers. In 2009, MHA was awarded 5 contracts to operate Family Resource Centers in Northern Bronx, Southern Bronx, Northern Manhattan, Southern Manhattan and Western Queens. The new Family Support Centers importantly provide services in the highest need community districts within each of the boroughs where they are located. The addition of care coordination services, warm lines and computer resource rooms at each of the centers provide families with important new resources. Our cross-site collaboration with Resources for Children with Special Needs, Inc. also helps to provide parents and caregivers with the most up-to-date information about how to access appropriate early childhood and educational services for children and youth with emotional and behavioral challenges.

Giselle Stolper, EdM

When a parent walks into one of our new Family Resource Centers , they know they are not alone, parents and caregivers immediately meet Family Advocates, who have been in their shoes- other caregivers who have struggled with the challenges of parenting a child with emotional and behavioral challenges. Youth advocates are also on hand to offer peer support and advocacy for children and youth. All of MHA-NYC's Advocates have personal experience with the mental health system either because of their children's needs or – in the case of the Youth Advocates – because of their own mental health challenges. We are proud that many of our Advocates were trained and hired from among those who initially came to us for help.

The fact that our Family and Youth Advocates share the perspectives, experiences, languages and cultures of the people with whom they work means that those who seek help are freed from the pressure and pain of constantly having to explain and justify their needs. As one staff member stated: "All I have to say is: 'I understand, Mami, I've been there,' and I can see those mothers relax a bit and let go of some of their distress and burdens. It is amazing what I have seen parents be able to accomplish on behalf of their children when they are provided with support, information and advocacy tools they need." Because Parent and Youth Advocates have "earned their stripes" coping with their own mental health challenges and negotiating the City's mental health service delivery system, their efforts have tremendous credibility. They have not only survived, but found ways to flourish and give back. They are powerful role models and sources of hope.

All newly funded Family Resource Centers provide a core set of services. They include:

1. Warmline: A call in line for parents in need of resource information and support.

2. Peer-to-Peer Empowerment Groups for Parents

3. Peer-to-Peer Empowerment Groups for Youth

4. One-on-One Advocacy

5. Public Education and Outreach

6. Care Coordination Services: Care coordination services are offered to families with complex situations for which there is a need for coordination between many providers or systems. The Family Network Model is used to help families and caregivers develop a single coordinated, individualized care plan across providers and systems.

7. Respite

8. Recreational Activities

9. Youth Advocacy

10. Workshops and Seminars for Family Members: Parenting Groups are offered as well as workshops on a variety of topics of interest, including how to access appropriate educational services for your child, services for transition age youth, childhood mental health disorders and diagnoses, what parents need to know about psychotropic medications and advocacy skills training.

11. Information and Referrals: Family resource center staff provide families with referrals and linkages to mental health services and other community resources that will help families and youth achieve their goals.

One only needs to track Joan, one of our current parents enrolled in the Northern Manhattan Family Resource Center's progress from the moment she first placed a call to to today's long list of accomplishments to see the power of peer support to reduce stress, build confidence and reclaim lives. Joan has moved from a state of despair, isolation, and being overwhelmed with her children's special needs to a confident parent who is informed and able to advocate effectively for her children. She is now part of a community of parents who are connected to each other and community resources.

To refer a family member or youth to one of MHA-NYC's Family Resource Centers call:

Northern Bronx- 718-220-0456
Director- Wanda Greene

Southern Bronx- 718-220-0456
Director- Yvette Pena

Northern Manhattan- 212-410-1820
Director- Olga Vasquez

Southern Manhattan- 212-964-5253
Director- Janet Rosa

Western Queens- 718-651-1960
Director- Lorraine Jacobs

Help People with Disabilities Get Their Federal Benefits the Safe, Convenient Way

By U.S. Department of the Treasury
Financial Management Service

In 2009, more than 440,000 Social Security and Supplemental Security Income (SSI) checks were reported lost or stolen and had to be reissued. Despite the risks, too many people with disabilities and their caregivers continue to receive their federal benefits by paper check.

The New York State Office of Mental Health (NYSOMH) encourages you to help the people you serve switch from paper checks to electronic payments for federal benefits. Electronic payments eliminate the risk of lost or stolen checks. Plus, money is available on payment day each month, so there's no need to wait for the mail to arrive or to make special trip to cash or deposit a check.

The U.S. Department of the Treasury suggests two safer, easier alternatives to paper checks:

1. Direct Deposit: The Go Direct campaign gives people with bank accounts a free, easy way to switch from paper checks to direct deposit, and have their payments automatically deposited into a checking or savings account each month (www.GoDirect.org<http://www.GoDirect.org>).

2. Direct Express: Debit MasterCard card. People who don't have bank accounts can sign up for a prepaid debit card, called the Direct Express card, which is issued by Treasury's financial agent. Details about features and fees for optional services can be found at www.USDirectExpress.com<http://www.USDirectExpress.com>.

How You Can Help

NYSOMH encourages you to spread the message about this important issue. It's easy:

1. Display free Go Direct campaign and Direct Express card materials in your lobby.

2. Include information about the benefits of electronic payments in your presentations, workshops and public speaking engagements.

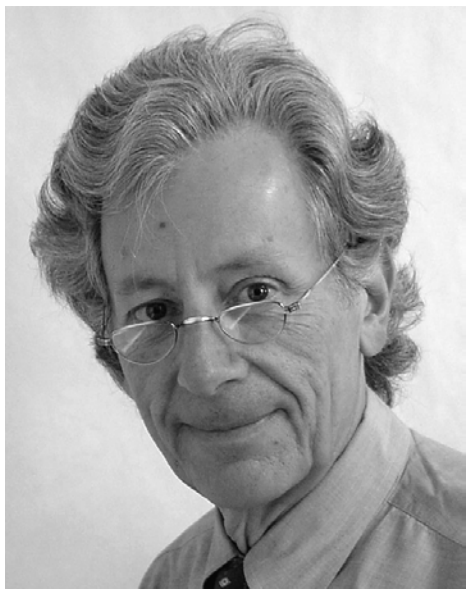
3. Distribute and display Go Direct campaign and Direct Express* card materials, including posters, fliers and pamphlets at events.

For more information, visit the Partners section of www.GoDirect.org<http://www.godirect.org/> or contact campaign representative, Ashley Czernis, at (312) 988-2419. If you would like to order free materials, please contact Ashley Czernis at aczernis@webershandwick.com. Or contact Ashley via phone to order materials, (312) 988-2419.

A Message from the CEO

By Martin A. Buccolo, PhD
CEO, Clinical Director
Four Winds Hospital

As I look back at the past year, we at Four Winds have been in a constant process of change. Paradoxically, our task has been to balance order and change, as we change the order of things. Like people, organizations often find comfort in routine and sameness. We all know that comfort doesn't necessarily lead to a better life, experience, or outcome. Over the past two years, we have committed to and embraced a process of orderly change. We have questioned our paradigms and clinical assumptions, upset the order of our routines, and set in motion a process to enhance our treatment and our service to benefit an ever-changing patient population and treatment environment. This has been an exhilarating and energizing process, and it has not been easy.



Martin A. Buccolo, PhD

Our clinical efforts have centered on creating a consistent series of assumptions and values that have yielded a philosophy that can inform our treatment. DBT (Dialectical Behavioral Therapy) has provided the tools in this process particularly for our adult and older adolescent populations. DBT has created a common language that has served as a bridge between us and our patients. The same examination and development of shared principles has occurred on our children's units through the use of Applied Behavioral Analysis. Again, shared language, expectation, and experience have produced a more cohesive treatment team and enhanced patient outcomes.

We believe that patients suffer as they fall between the gaps in the overall service delivery system. Gaps in reimbursement and insurance coverage present serious impediments to good care. We believe that patients are always best served when services are linked and integrated into a coherent whole. Patients are most vulnerable as they move between systems and they always benefit from integrated and smooth transitions. To this end, we have maintained a significant effort and commitment to improving our services in both our admission process and in our patients' transition back to the community. Most of our admissions involve a crisis and a complicated exchange of information, under time pressure, between ourselves and emergency rooms, clinics, or schools. The clarity of information exchanged and the speed of our response are extremely important to our patients and the providers who entrust them to our care. Part of our commitment to organizational change has been to analyze and improve every element of this process. Over the past year, our Admissions Department has made a transition away from paper-based systems toward real-time, technology-based solutions. We have improved our response time to crisis calls. Our outreach staff has implemented new technology and wireless based systems to enhance our

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Spirituality at Four Winds

By Janet Z. Segal, LCSW
Executive Vice President
Four Winds Hospital

This past year, Four Winds Hospital, a 175-bed psychiatric hospital and outpatient treatment center in Katonah, NY, has introduced a highly successful program that brings spirituality into the lives of patients as an effective aspect of treatment. Our weekly, voluntary gatherings incorporate singing and discussion in a non-denominational context.

While spirituality can spring from religious belief, it can also originate from daily life experiences that lift spirits beyond individual troubles and pain. In his book entitled *Treasures: Awakening our Spiritual Gifts*, Father Leo Booth describes spirituality as the 'More in Life'. He goes on to say, "It is about moving out of the box. Moving beyond the frame that keeps you encased. Transcending the rigid thinking that keeps us judgmental, fearful or angry.

Janet Z. Segal, LCSW

Experiencing a 'moment' of awakening that changes your life forever."

When we asked some of our patients at Four Winds to describe what makes them feel spiritual, many raised their hands. Here are some of the spontaneous answers:

"When I listen to music that I love, it makes me feel wonderful."

"Talking to a friend who inspires me."

"Taking a walk in the woods surrounded by nature."

"Thinking about my mother and how much I love her."

"When I feel I have overcome something that frightened me."

Patients define a vast array of feelings as "spiritual," many involving inspiration, strength, self-confidence, happiness, determination, love, nurturing, wonderment and a sense of community. None asked what we meant by spirituality. They all knew, and there was no reference to religion in any of the answers.

Our patients work hard when they are in the hospital and in our outpatient programs, so we decided that a non-denominational approach to spirituality could provide them with what Father Booth calls the 'More in Life'- a tool to give them relief from their stressors when they are overcome with their problems. Clearly many were already using spirituality to give them a sense of relief from their troubles.

We chose a weekly meeting focused on spirituality as a beginning. While Four Winds treats child, adolescent, and adult patients, we decided voluntary attendance would start at age ten. We begin the meeting with music and singing as we want to ensure that the experience is inclusive and unifying for all ages. Inspirational songs like *This Little Light of Mine*, *This Land is Your Land*, *Lean on Me*, and *He's Got the Whole World*, set the tone for the meeting and create a sense of joy and enthusiasm as every one gathers.

see Spirituality on page 24

Four Winds Hospital is the leading provider of Child and Adolescent Mental Health Services in the Northeast. In addition to Child and Adolescent Services, Four Winds also provides Comprehensive Inpatient and Outpatient Mental Health Services for Adults, including Psychiatric and Dual Diagnosis Treatment.

FOUR WINDS HOSPITAL • FALL 2010

OCTOBER

A COMMUNITY SERVICE

Thursday, October 7, 2010
2:00 – 4:00 pm

National Depression Screening Day

Free Depression Screening for Children, Adolescents and Adults

Take advantage of this free program designed to educate the public about depression. The screening process will include a written "self-test," a confidential consultation with a mental health professional, and an educational presentation.

For information, or to schedule a confidential appointment, please call 1-800-546-1754 ext. 2413.

OPEN HOUSE

Tuesday, October 26, 2010 • 4:00 – 7:00 pm

Nursing Career Day

Experience Four Winds firsthand during this informal event.

Join a Team that uses a Multi-Disciplinary Approach to Treatment.

Your Voice Will Make A Difference!

Refreshments, Tours, and an Opportunity to Meet with Nursing Leadership

Competitive Salaries/Benefits

RSVP by October 19 to 1-800-528-6624 ext. 2486

All of the Grand Rounds, Special Trainings and Special Events will be held at the Four Winds Hospital Conference Center unless otherwise noted.

Registration is Required for All Programs.
Please Call 1-800-546-1754 ext. 2413.
Register online at www.fourwindshospital.com

OCTOBER

GRAND ROUNDS

Friday, October 29, 2010 • 9:30 – 11:00 am

Cliques, Crews and Gangs: What to Look For and What to Do About Them

Presenter

James Barrett, PhD

Professor of Psychology, Psychiatry Department, Harvard Medical School and Faculty, Department of Psychiatry, Cambridge Hospital, Cambridge, MA

At the conclusion of this presentation participants will:

- Become familiar with types of cliques, crews and gangs and subsequent behaviors.
- Gain an understanding of differentiating between formal and informal gangs, especially in a suburban setting.
- Become familiar with best practices in clique and gang interventions, including school interventions and individual psychotherapeutic strategies with adolescents.

Fee: $15 payable to Four Winds Hospital

1.5 CME Credits Available

Application pending for 1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours*

NOVEMBER

Save the Date

FRIDAY, NOVEMBER 12, 2010
9:30 – 11:00 am

"Integrating Dialectical Behavioral & Psychodynamic Therapies in the Treatment of Patients"

Presenter

Charles R. Swenson, MD,

Private Practice, Northampton, Massachusetts;
Senior Trainer and Consultant for Behavioral Tech, LLC

Fee: $15 payable to Four Winds Hospital

1.5 CME Credits Available

Application pending for 1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours*

Community and Professional Education Programs

DECEMBER

A Special Four Winds Foundation Fundraising Event

Friday, December 17, 2010 • 9:30 – 11:00 am

SCHUMANN AT 200
Bipolar Disorder and the Creative Process

Presenter

Richard Kogan, MD

Director of the Human Sexuality Program, Weill-Cornell Medical Center and New York Presbyterian Hospital; Private Practice, New York City

Focusing on the music and mind of composer Robert Schumann on the occasion of his 200th birthday, Dr. Kogan, a psychiatrist and virtuoso pianist will offer a lecture and performance demonstration on the emotional life of this great composer and the way his psychiatric illness influenced his creativity.

This program will enable participants to:

- Recognize the psychological factors that influenced Schumann's artistic development.
- Understand some of the fundamental concepts about creativity.

Fee: $50 tax deductible donation payable to the Four Winds Foundation, a not-for-profit organization

1.5 CME Credits Available

Application pending for 1.5 CASAC Section 2 criteria and CPP/CPS Section 1 criteria clock hours*

Albert Einstein College of Medicine designates each continuing medical education activity for a maximum of 2.0 category 1 credits towards the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Four Winds Hospital. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

These programs will be of interest to: physicians, physician's assistants, psychologists, nurse practitioners, social workers, mental health providers, EAP's, education professionals, school counselors, RN's and consumers.

*This training is provided under New York State Office of Alcoholism and Substance Abuse Services (OASAS) Education and Training Provider Certification Number 0815. Training under a New York State OASAS Provider Certification is acceptable for meeting all or part of the CASAC/CPP/CPS education and training requirements.

Four Winds HOSPITAL

OUR UNIQUE APPROACH TO CHILD AND ADOLESCENT TREATMENT

Children and adolescents are treated in distinct, age-appropriate programs with the treatment milieu focused on each age group's developmental issues.

PROGRAMS INCLUDE:

- **5-9 years old:** provides a nurturing, therapeutic, home-like environment
- **10-13 years old:** focuses on developing social skills, mastering impulse control and promoting healthy communication
- **14-17 years old:** focuses on empowering adolescents through peer support and feedback

Each unit, led by a multidisciplinary clinical team, mirrors a school setting that promotes shared competencies and encourages bonding. Family/caregivers are a primary focus within all age groups and we encourage their active participation. Four Winds' on grounds school works closely with the home school district to assist the child/adolescent in a smooth transition back to the classroom.

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www.fourwindshospital.com

For further information or to arrange a tour of our campus please contact Marketing at 1-800-546-1754 ext. 2413

Message from page 21

communication and response to our referral sources.

We have also become more focused on enhancing the patient experience at Four Winds over the past year. We have created groups that emphasize, explore, and engage the spiritual aspects of our patients' lives. We have created regularly occurring non-denominational spiritual groups and activities, and through our involvement with local spiritual leaders, we have been able to provide individual spiritual counseling and comfort. We have reinvigorated our Adult Co-Occurring Disorder treatment program by adding daily groups led by master's level alcohol and substance abuse counselors. We have developed a highly creative Therapeutic Arts Department that utilizes and integrates art, music, and the movement modalities of yoga and tai chi as an alternative treatment emphasis. Our commitment to combine a full range of therapies, from evidence-based cognitive behavioral treatment models to spiritual and creative experiences, are all part of our belief that healing requires not only excellence in treatment but also understanding and caring about our patients from a holistic perspective. We firmly believe that polishing these facets of health is an important part of the healing experience.

The coming year will no doubt be filled with change, promise, and challenge. Our collective hope is that health care reform will enable us all to better care for patients. We share your concerns on how issues currently in play in Albany will impact our collective ability to provide excellent care. As these issues unfold, we remain mindful of the awesome responsibility that we share and remain committed to providing the best care possible as we continue our efforts to adapt, change, and grow.

Spirituality from page 21

The next part of the meeting is a guest speaker, often Pastor Paul Briggs from the local Antioch Baptist Church, who agrees with our approach to spirituality and understands the need to have our meetings be non-denominational, non-religious and all-inclusive. The focus of Pastor Briggs' talk is usually about choices made in life and the importance of believing in oneself. He gives examples of those who have overcome adversity by using their coping skills, their belief in themselves and their access to their spiritual feelings. These talks transmit a strong sense of hope and emphasize the importance of finding the 'more' in one's life. Judging by the comments and questions at the end of Pastor Briggs' talks, the patients are stimulated in a very positive way and seem eager to interact and discuss the experience. The meeting ends with more singing and light refreshments.

The staff has been extremely enthusiastic and instrumental in making the Spiritual Meeting a success, with well over 100 people attending each Saturday morning. Staff members report that the rest of the day is usually calm and quiet. It seems that the feelings of spirituality are strong and can create a lasting sense of well-being. Of course we hope the effect on our patients will continue when they are discharged and that they will be able to access their life experiences in order to feel spiritual at those times they seek relief from their daily troubles.

The Spirituality Initiative is a reflection of the on-going effort at Four Winds to continually seek out ways to help our patients feel better, stronger, happier and more productive. We have started many new initiatives such as DBT (Dialectical Behavior Therapy) for adolescents and adults, and ABA (Applied Behavioral Analysis) for our children. We have added many new creative arts programs like music therapy, art therapy, choir groups, and journal writing, as well as an array of physical activities and special events. Additionally, our on-campus school keeps our patients up-to-date on the work they are missing in their own schools. We believe the Spiritual Meetings are a valuable addition to our programs.

Mental Illness Education Does Make a Difference: "Breaking the Silence" Found to be Effective

By Amy Lax
Director of PR & Development
NAMI Queens/Nassau

Students would ask, "What's wrong with Doug, Mrs. Susin?" Those are the words heard by Janet Susin, then a teacher in the same school where her son was a student, from his high school friends twenty-three years ago when they were searching for an explanation of why he had suddenly disappeared from school. Although Susin says she was comfortable speaking to her own friends and fellow teachers about her son's hospitalization for schizophrenia, those words from his classmates left her speechless with tears streaming down her face.

Searching for a way to discuss the situation without breaking down, she sought out the school health teacher, reasoning that if she knew what students were learning about mental illness, it would be easier to tackle the subject with Doug's friends. What she found out was shocking. Although before the age of fourteen half of those who will go on to develop a serious mental illness are already showing symptoms, students in her school learned absolutely nothing about mental illness. It wasn't part of the curriculum. That was a turning point in Susin's life, as her heartache became her passion. With the help of three other retired teachers, each a NAMI (National Alliance on Mental Illness) Queens/Nassau member with children living with mental illness, Susin developed "Breaking the Silence" (BTS), innovative teaching packets with lessons, games and posters on mental illness for upper elementary, middle, and high schools.

Dr. Otto Wahl, PhD, Professor of Psychology, University of Hartford, Janet Susin, BTS lead author and BTS Project Director, and Lorraine Kaplan, BTS co-author and Director of Educational Outreach

Although the lessons, in one form or another have received much praise and been available for over 20 years and in use across the United States and internationally, their effectiveness has never been assessed. Thanks to a grant from the National Institute of Mental Health (NIMH), a recent three year study has found that the BTS middle school lessons are effective in increasing knowledge and changing attitudes and behavior relating to mental illness.

Middle school students in New York, South Carolina, New Mexico and Florida participated in the study. Janet Susin, BTS lead author and BTS Project Director and Lorraine Kaplan, BTS co-author and Director of Educational Outreach collaborated with Otto Wahl, Ph.D., Professor of Psychology, University of Hartford.

"Results of our study show that even brief instruction (2 ½-3 hours) can produce change in how students understand mental illnesses. BTS is a very promising approach to improving the way children perceive and respond to mental illnesses. We can now statistically document that instruction in BTS does result in improvements in knowledge, attitudes, and/or behavior related to mental illnesses," stated Dr. Wahl.

Susin, and/or Kaplan accompanied Dr. Wahl to the school sites to carry out the research. In an email after their visit, a South Carolina teacher wrote this about her experience, "*I just wanted to let you know how much my students enjoyed the stories and the game. They asked thoughtful questions and were intrigued to learn about mental illness. One of my students even felt compelled to share that her sister*

see Education on page 37

The Road to Independence: Addressing the Needs of Adolescents and Young Adults with a Serious Mental Illness

By Denise Molloy Vestuti, LCSW
Program Coordinator, The Mental Health Association of Westchester County, New York (MHA)

Diagnosed with schizo-affective disorder, Tom has spent most of his teen years in and out of psychiatric hospitals. He was living with his mother, who was unable to provide the support and guidance he needed, and at age 17 was about to age out of the children's mental health system. Yet he did not have the tools that prepared him for independence and the transition to the adult mental health system. Due to his hospitalizations, he regularly missed school for long periods, and as a result did not graduate from high school or create any friendships. He had no work skills, and as he saw it, no future.

Tom was referred to The Mental Health Association of Westchester County, Inc. (MHA)'s Crossroads program which serves Westchester residents aged 17.5 to 22 years who meet the New York State Office of Mental Health criteria for a serious mental illness (SMI). The only program of its kind in Westchester County, Crossroads provides developmentally appropriate services specifically designed for youth like Tom, who are considered adults, but do not have the skills, education or financial stability to live independently. Since many of these young adults cannot afford to travel, or having lived with a mental health "label" for years, are reluctant to come to a mental health clinic, Crossroads provides counseling and support in the home and in the community. Crossroads is one of the only programs to provide mobile services to this population and it is crucial to its success. Services are also provided at one of MHA's licensed mental health clinics.

The period from adolescence to adulthood is challenging, even more so for older teens who are struggling with a serious emotional disturbance or severe mental illness. Crossroads participants are returning to the community from a residential treatment facility, hospitalization, foster care and other living situations and are usually from families who need support. Like Tom, these young adults typically have high rates of school absenteeism and difficulties completing high school due to disruptions caused by their mental illness, such as psychiatric hospitalizations and family problems. In Crossroads, approximately 50% of young adults in Crossroads do not have a GED or high school diploma upon entering the program. Other issues they confront are a lack of skills to live independently and to establish and maintain supportive relationships; limited facility with problem solving; poor decision making skills; limited impulse control; and difficulty in developing work skills. In addition, many have developmental delays.

On their own, they are frequently unable to successfully continue their education or secure employment. Transition-age youth with a diagnosis of a serious emotional disturbance (SED) or SMI have higher rates of substance abuse than any other age groups with mental illness and are three times more likely to be involved in criminal activity than those without an illness. In addition, serious mental health conditions in adolescence generally continue into adulthood and young adulthood is also a high-risk period for developing new disorders. (Seeking Effective Solutions: Partnerships for Youth Transition Initiative (PYT), June 2007, http://ncyt.fmhi.usf.edu/index2.cfm)

see Independence on page 36

Engagement in the School Based Clinic Setting: Challenges and Opportunities

By Erin Alvarez, LCSW-R
Program Coordinator
WJCS - SCOPES

The early phase of mental health treatment called "engagement" marks the beginning of an emerging collaboration among provider, child and family. During engagement, clients develop important senses about their providers: Do I like this person? Can they help me? Does it seem like they care about me? Clinicians develop their own set of senses about clients: Is this someone I can really help? Is this client seriously committed to getting better? Is this case interesting or appealing? It is during engagement that a history is shared and areas for work are prioritized and agreed upon mutually. It is also during that time that the boundaries of treatment are set, tested at times, but ultimately established. For these reasons, engagement is a critical time in the treatment relationship.

All of these aspects of engagement pertain to clients who have demonstrated some interest in seeking help, as have many families who have sought help for their children in school-based clinics. In the school setting, too, there are parent populations who do ***not*** actively seek treatment for their child or family. In these cases, engagement involves challenges beyond those described above. Factors such as denial, avoidance, fear of stigma, excessive psychosocial or economic stressors, parental substance use or mental illness all complicate the engagement process. It is difficult for any family to hear their child is struggling at school, and when additional barriers to engagement exist, other measures are needed. A program within a school-based clinic provides some flexibility to reach out to families repeatedly, allowing them time to assimilate information about the services available. It is also essential to clarify repeatedly that the program and agency are separate entities from the school. This is crucial because at times families have received what they perceive to be a barrage of calls and complaints about their child from school administrators or teachers. Helping the family view the school-based clinic as separate, confidential, and supportive of the child's functioning at school is important. Meeting with families off-site in locations such as at Head Start, in the community or in the family home are ways to connect on a level that may be more accessible and friendly.

Fortunately, most children easily and readily engage with program staff. They are exposed to the clinical staff daily from the onset of the school year, and the program offices appear inviting with toys and materials. The issue of engagement is not usually a challenge in gaining the child's cooperation, but rather in collaborating with teaching staff around scheduling and best times to remove a child from class for treatment. Classmates can grow curious. They want to know why a particular child "gets to go play with you" and why they are not allowed. Being prepared with an answer that is appropriate to a young child's understanding and preserves the privacy of the client/family is important.

A challenging aspect of engagement in the school setting is the development of a collaborative and mutually satisfying relationship with partners in the school – faculty and administration. Particularly when the school-based clinic is new or re-establishing itself with new school personnel, identifying "who we are and what we do" on a regular basis is essential. There should ideally be clarity and a mutual desire for the existence and successful operation of the school-based clinic from top administration to supportive staff. Reviewing and revisiting themes of how to identify children in need of mental health counseling beyond the expertise of Pupil Personnel staff, when and how to refer families, and why it's important to use the school-based clinic for consultation should occur on an ongoing basis. Utilizing faculty meetings or other forums when all school personnel convene is optimal. Allowing faculty to ask questions about the school-based clinic in an open manner always, in this writer's experience, results in an increase in both referrals to and consultations with the program.

Establishing clarity early on in the clinic-school partnership about the boundaries and limits of the program helps offset future misunderstandings and disappointments. For example, helping the school understand that family participation and consent to treatment is mandatory and that children are otherwise unable to be served encourages school personnel to become partners in the engagement process with families. Highlighting the difference between mental health treatment and constant crisis intervention is also important in order to avoid misuse of the program as a receptacle for misbehaving children. Marketing the program's clinical services as offering both mental health counseling to children and consultative services to faculty in order to support their management of behavior challenges makes the most sense. When excessive clinical time is occupied by tending to children who have been removed from the classroom, the program cannot function optimally. Teasing out with faculty and administration those issues that are really disciplinary and require administrative intervention versus those that require mental health support on a regular basis allows for optimal collaboration.

In the fields of social work and psychology, the clinical supervision process enables the clinician to meet and discuss with a supervisor on a regular basis areas of work that are challenging. There is an implicit understanding that to reveal areas of challenge or even countertransferential experiences is a positive way to work through aspects of the clinical work that stagnate. The field of teaching offers a different culture relative to the worker-supervisor relationship. While teachers are offered some administrative support and are backed by strong unions, the implicit message is that teachers need to figure out a way to independently handle problems as they arise. Therefore, faculty tends to hold on to problems and attempt to manage hard situations, avoiding asking for help until the situation reaches a crisis level. When teachers are encouraged to consult with the school-based clinic from both clinic staff as well as from their own administrators, engagement among clinic, school and families is best.

There are additional ways that the school-based clinic works to engage both clients and school partners. In terms of clients, the participation by a larger agency that maintains excellent relationships with outside resources to provide financial and supportive services can be particularly beneficial. The school-based clinic participates in programs that offer families additional supports: a pajama program, a back-to-school clothing and school supplies drive, camp scholarship funds, and other miscellaneous donations throughout the year. Families experience this concrete support as extremely helpful and as clear evidence that the agency is interested in their wellbeing. For faculty members, the support offered by clinic staff is often helpful in an immediate way. Implementing a successful behavior plan for a disruptive child or offering a teacher useful strategies in dealing with a certain situation allows a teacher to understand the potential success of the program, value it more highly, and be more inclined to collaborate in the future.

In conclusion, successful engagement relies upon consistent communication and clarity on all levels in a school-based mental health clinic. Schools are busy places and the constant bustle of children and demands of the day make such communication a challenge at times. It is the job of the program manager to ensure that communication and clarity remain a priority, and this is achieved by arranging regular meetings with school administrative staff and faculty. Program staff must be adept at approaching faculty, being direct and clear about the collaboration, and revisiting issues when miscommunication and misunderstandings arise. Together, school personnel, families and school-based mental health clinicians can work cooperatively to improve functioning of children with behavioral, emotional or mental health issues.

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New York, NY 10021
888-694-5700

NewYork-Presbyterian Hospital/ The Westchester Division
Payne Whitney Westchester
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White Plains, NY 10605
888-694-5700

Positive Behavioral Interventions and Supports for Children

By Jeannette Palmesi, RN, Program Director/Nurse Manager, Child Unit at Cliffside, Four Winds Hospital Katonah, New York

Our Cliffside Child Inpatient Unit, treating children ages 5-10, has implemented a unit-wide positive behavior support plan known as Positive Behavioral Interventions and Supports (PBIS). This program has been derived from the principles of Applied Behavior Analysis (ABA). Decades of research and extensive use in education verify the effectiveness of strategies and tactics based on ABA. ABA is the branch of behavioral science that deals with the application of scientific principles to improve socially significant behavior. It includes the methods by which behaviors are observed and measured, and new behaviors are taught. Since ABA has a significant research history, especially for children with disabilities, it is the primary approach taken at many schools and psychiatric treatment centers.

Learning is defined as change in behavior due to experience. PBIS is a systems approach to evaluate the purpose of a child's behaviors, reinforce appropriate behavior and effectively manage disruptive behavior. The primary goal is to create an environment that provides positive reinforcement for improved socially appropriate behavior and prevents challenging behavior. Four Winds staff have been trained to understand what purpose each behavior serves for an individual patient and what maintains or reinforces specific behaviors.

Our treatment teams, which include therapists, nurses, mental health workers and teachers, have adopted PBIS. All of our staff are in the process of ongoing intensive training to identify disruptive behavior early so that they can redirect the child to use the coping skills that they are learning. Four Winds' approach is based on the belief that there are reasons behind difficult behavior, that children should be treated with compassion and respect, and that behavior can be predicted and managed when the principles of behavior are understood.

So how is PBIS used at Four Winds? Expectations for every activity are clearly defined. Having clear expectations sets each child up for success. Posters displaying the expectations are on the walls. Staff selectively praise children for appropriate behavior instead of focusing on undesired behavior. The development of social skills is the foundation for all activities. Each child participates in academic instruction and social skills groups on a daily basis. Both activities are co-lead by the teacher, clinical and the nursing staff and PBIS is implemented during every activity. Education is a very important part of the program. Our goal is to have school time in the hospital resemble a day of school in the community and to have the child practice appropriate behaviors.

Throughout the day our children earn stars for engaging in expected behaviors. The children choose various rewards such as time playing video games, a later bedtime and other reinforcing activities, depending on the number of stars earned. Appropriate behaviors increase as the children are consistently reinforced.

During the past year using PBIS, our behavior management incidents have decreased significantly. We remain committed to this approach and continue to enhance the training our staff receives. We are confident that PBIS has made a major impact on the quality of the treatment.

For further information please call 1-914-763-8151 ext. 2413.

Annual Maniscalco Lecture Held at Saint Joseph's Medical Center

Staff Writer
Mental Health News

Mark Olfson, M.D. presented the 21st Annual *Anthony Maniscalco, M.D. Lecture in Public Psychiatry* to the Department of Psychiatry of Saint Joseph's Medical Center in Yonkers, New York. The lecture was created in honor of Dr. Maniscalco who had been the Director of the Department of Psychiatry from 1970 until 1980, a period during which a number of the full range of mental health services currently available at Saint Joseph's were established.

Dr. Barry B. Perlman, Director of the Department of Psychiatry, introduced this year's lecturer. Dr. Olfson is Professor of Clinical Psychiatry at Columbia University's College of Physicians and Surgeons. Widely published in scholarly journals, he has received awards from such organizations as the American Foundation for Suicide Prevention and the National Association for Research on Schizophrenia and Affective Disorders. This recognition reflects his research interests in the identification, provision and economics of mental health care and its interface with primary care and other medical specialties. He also shapes perspectives on contemporary practice and delivery systems through his participation on the editorial boards of a number of prominent journals including *Psychiatric Services*, *Administration and Policy in Mental Health* and *Mental Health Services Research*.

Dr. Olfson addressed two important issues for those involved with the care of persons with serious and persistent mental illness. They were why persons with schizophrenia disengage from care and how best to affect the transition from inpatient to outpatient care. Noting the importance of successful linkages, he noted that when studying a national Medicaid data set only 40% of those discharged were seen within seven days and 60% within 30 days. Those for whom there was no successful linkage had much greater likelihood of readmission. Noting that we are not good predictors of who would receive timely aftercare, he elaborated upon the many influences on the process beyond the individual clinician and patient. Among the poor predictors were age, sex, race, and an history of substance abuse treatment. Factors which had a significant impact were items such as whether the individual had been in treatment prior to their admission and whether they had been receiving antipsychotic medications prior to the admission. At more macro levels, type of coverage generally did not matter although those enrolled in managed care were less likely to be seen for aftercare. The auspice of the hospital influenced the outcome with those discharged from private for profit institutions being less likely to be seen after discharge than those discharged from units in general, non profit, hospitals. Also influencing the process was richness of available services in the county and the poverty level in the area in which the hospital was located. The need for prior authorization of outpatient visits also weighed against successful aftercare. In trying to improve aftercare linkages and outcomes important factors include setting appointments, having transportation accounted for, visits by aftercare providers with the patient prior to discharge, and setting visits for substance use disorder treatment. After discharge, checking for kept appointments with the patient and/or family is helpful as is use of intensive case management in the immediate period after hospitalization.

Grant Mitchell, MD, Commissioner, Westchester Dept. of Community Mental Health, Ms. Nancy Maniscalco, Mark Olfson, MD, and Barry B. Perlman, MD, Director, Dept. of Psychiatry, Saint Joseph's Medical Center

Dr. Olfson went on to underscore the importance of patients taking prescribed medications as a critical variable in reducing emergency room visits and hospital readmissions. He noted that psychiatrists are not good at predicting which of their patients is compliant with their medication regime. Several elements to focus on with the aim of improving adherence are simplification of the medication schedule, building a trusting alliance with one's patients, use of a variety of reminders, skill training and use of long acting depot injectible antipsychotics. Dr. Olfon's lecture presented data which offered practical approaches to improving linkages to aftercare and improving medication compliance, each of which can contribute to improved outcomes and lives for persons involved in treatment.

The Department of Psychiatry at Saint Joseph's Medical Center includes a wide array of outpatient and inpatient mental health services as well as substance use disorder treatment programs.

If you are experiencing a difficult time in your life, always remember that you are not alone.
There is a caring and helpful mental health community nearby that can help you get through this difficulty.
Don't feel embarrassed or afraid to ask for help, it is not a sign of weakness.

Best Wishes from Mental Health News.

Creating a Team of Professionals to Manage the Patient with an Eating Disorder

By Ann L. Engelland, MD
Specialist, Adolescent Medicine

Earlier this Spring an 18 year old graduating senior came to my office for a checkup and told me about the stomach pains she was experiencing. She had already seen a gastroenterologist who had instructed her to eat more fiber and check back in six weeks. Upon further questioning, it became clear that other symptoms included a strong urge to vomit after meals and the need to exercise up to three hours a day especially after dinner.

It also became clear that we needed to nail this incipient eating disorder. How would she manage in college if the problem was not addressed now? I could imagine her returning the following Spring, unable to complete her courses, metabolically unstable or worse. Within a week—and in no small part because she was able to talk openly with her parents and because they were understanding about the addictive nature of disordered eating behavior—we were able to assemble a team of people to help her.

How did this come about? It was made possible by the extraordinary resources available to all of us who care for patients in Westchester. As an adolescent medicine specialist, this sort of situation comes

Ann L. Engelland, MD

up very frequently and I rely on a network of professionals in the mental health field to collaborate with me. Adolescent medicine is a sub-specialty composed largely of pediatrics and internal medicine practitioners who care about and for adolescents and young adults.

In my particular practice I see patients from age 12 to 25. It's not uncommon for parents or patients to come or be referred to me *first* for evaluation of a problem that is *ultimately* diagnosed as a mental health concern. What makes our specialty different is the comprehensive medical and *developmental* approach to this age group. Many choose to visit a medical doctor who uses a comprehensive approach because they are not sure if the underlying issues are physical, emotional or psychological.

The team for a patient with a confirmed eating disorder may consist of a psychologist, a dietician, a psychiatrist, and a medical doctor. In addition, other participants in care may include the school social worker, psychologist, or coach. Sometimes clergy are brought into the mix if their approach and insight can be helpful. As a physician, the role I play in this group is to lend support to a diagnosis, consider all medical possibilities, and act as the "orchestra conductor," as one of my early mentors taught me. Often my role includes:

- translating a clinician's thoughts and concerns to the patient or the family,
- supporting fellow clinicians to avoid splitting the treatment team,
- interpreting medical test results to the family, patient and team,
- collaborating on decisions about higher levels of care, eg hospitalization,
- coordinating responsibilities among the team leaders, and
- evaluating other treatment options when current strategies are not working.

In addition, I often will have the siblings in my care and have learned to pay special attention to them. In a recent article in the Journal of Adolescent Health by Areemit, Katzman and colleagues, 80% of twenty siblings of ED patients reported that their quality of life was negatively affected by the onset of their siblings' ED.

Much of this kind of intensive work is made possible by our ability to use email and electronic communication. Although there are pitfalls and concerns with this new way of connecting a team, we all know that reimbursement for time on the phone or even team meetings is minimal or non-existent. Truly, the ability to compare notes, share information and give each other a heads-up on progress and problems makes it possible to treat complex disorders and share the stress and responsibility we all experience.

For more information visit Dr. England at www.AnnEngellandMD.com.

Maternal Depression and Children's Behavior in School

By Andrew Malekoff, LCSW, CASAC
Executive Director, North Shore Child and Family Guidance Center

Care to venture a guess as to what grade level of student has the highest rate of expulsion from school because of problematic behavior? Let's see how you did.

According to a research study at Yale University, led by Dr. Walter Gilliam, the rate of expulsion in pre-kindergarten programs serving three- and four-year-olds is more than three times that of children in grades K through 12. According to Dr. Gilliam the study did not explore reasons why the children were expelled, "We weren't measuring behavioral problems, we were measuring the decisions teachers make." So, we are left to speculate and to study the risks that pre-school children face that contribute to this astounding statistic.

Early childhood mental health expert Jane Knitzer offers a clue when she tells us that "research indicates that babies whose mothers are depressed…may 'act out' in early childhood programs, and sometimes be ejected from them." At the Marks Family Right from the Start 0-3+ Center (RFTS), a division of North Shore Child and Family Guidance Center, we know that the emotional health of a parent influences a child's development. In a survey we found that over 60% of families of 147 recent admissions reported serious behavior problems in children as young as 2 years of age. A review of the

Andrew Malekoff, LCSW, CASAC

histories of these families found between 50 and 75% of the children were living with a depressed parent, most often a mom with a history of depression.

Sandra Radzanower Wolkoff, RFTS director, advises that we need to pay attention not only to maternal depression, but to the mood disorders that accompany childbirth and that are often an unexpected complication of pregnancy. Although we are not always sure of the causes for onset, what we do know according Wolkoff, is that "danger lies in how they incapacitate mothers, frighten fathers, and embroil infants."

One young mother who is recovering from post-partum depression at RFTS recently told a rapt audience at a recent North Shore Child and Family Guidance Center event, about how she could barely lift her head off of her pillow, let alone lift and hold and cuddle and care for her baby.

The Center for Disease Control (CDC) reports that postpartum depression affects up to 20% of mothers within the first year after giving birth. The rate of depression for mothers living in poverty is close to a staggering 50%. Mental health experts agree that constancy of relationship from early childhood is the single best predictor of positive outcomes in later life. Promoting safe and warm relationships with parents and other caregivers is key to young children's healthy development and later success in school and beyond. Maternal depression, left untreated, may be a key factor leading to the expulsion of pre-schoolers.

According to Wolkoff, "Depressed mothers tend to perceive their children as being more difficult and frequently viewing their children more negatively. Mothers who are suffering from depression can respond with too little emotion or energy, or overreact with aggression and irritability. The origin of this inconsistency in parenting is not a lack of desire. Rather, it is consequence of utter exhaustion."

The Center on Disease Control in Atlanta administered a surveillance project aimed at identifying maternal depression early on. Two questions that they asked moms are: *1) Since your new baby was born, how often have you felt down, depressed, or hopeless?* and *2) Since your new baby was born, how often have you had little interest or little pleasure in doing things?* The women who answered "often" or "always" to either question were classified as experiencing self-reported post-partum depressive symptoms. Detecting the problem is the first step in getting moms and their families the help they need.

We must encourage primary care physicians and other health professionals to incorporate these questions into their encounters with pregnant women and mothers of infants. If you are reading this article, highlight these two questions and pass it along it to your local pediatrician, obstetrician and gynecologist or pediatric hospital unit. Add a personal note. Who knows, maybe it will keep one more child from being expelled.

Children grow best when they feel safe and are safe. Healthy attachments are not about children getting what they want, but getting what they need—the assurance that an adult caregiver is by their side, looking out for them, teaching them how to manage their own feelings, and learning about the give and take of relationships. All children deserve this. Let's take a small step to make sure they get it.

For more information on post-partum depression and perinatal mood disorders call Sandra Wolkoff, *Zero-to-Three Fellow* and Director of the Guidance Center's Early Childhood Services at 516-484-3174 ext. 222 or Email at: swolkoff@northshorechidlguidance.org

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Link Between Child Care Academic Achievement and Behavior Persists Into Adolescence

By the U.S. Department of Health and Human Services, National Institutes of Health (NIH), Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

Teens who were in high-quality child care settings as young children scored slightly higher on measures of academic and cognitive achievement and were slightly less likely to report acting-out behaviors than peers who were in lower-quality child care arrangements during their early years, according to the latest analysis of a long-running study funded by the National Institutes of Health.

And teens who had spent the most hours in child care in their first 4½ years reported a slightly greater tendency toward impulsiveness and risk-taking at 15 than did peers who spent less time in child care.

Although the study followed children's experience in child care, it was not designed to determine cause and effect, and so could not prove whether a given aspect of the child care experience had a particular effect. It is possible that other factors, not measured in the study, were involved.

The study authors noted that the differences in these measures among the youth in the study were small, but the magnitude of both patterns was consistent from early childhood to adolescence. Previous studies have noted similar trends, but the study is the first to track children for a full decade after they left child care.

"Previous findings from the study indicate that parents appear to have far more influence on their child's growth and development than the type of child care they receive," said James A. Griffin, Ph.D., deputy chief of the Child Development and Behavior Branch, at the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the NIH institute that funded the study, "The current findings reveal that the modest association between early child care and subsequent academic achievement and behavior seen in earlier study findings persists through childhood and into the teen years."

The study results appear in the May/June issue of the journal Child Development.

The 1,364 youth in the analysis had been evaluated periodically since they were 1 month of age, as part of the NICHD Study of Early Child Care and Youth Development (SECCYD), the largest, longest running and most comprehensive study of child care in the United States.

Families were recruited through hospital visits to mothers shortly after the birth of a child in 1991, in 10 locations in the United States. Although the children studied were not a representative sample of children in the U.S. population, the families that participated in the study were from diverse geographic, demographic, economic and ethnic backgrounds.

From 1 month of age through sixth grade, children were evaluated at least annually on tests of cognitive and academic progress. In addition, researchers queried parents regularly and recorded the type, quantity and quality of child care during the children's first 4½ years. The researchers also observed child care interactions to evaluate the quality of care. Of the children studied, nearly 90 percent spent some time in the care of someone other than their mother by the time they reached 4½ years of age. High-quality care was characterized by the caregivers' warmth, support, and cognitive stimulation of the children under their care.

The researchers also requested that caregivers or teachers evaluate the behavior of children under their care at 4½ and every two years through elementary school. When the students were 15, the researchers tested the students' academic achievement and, using a questionnaire, had the students evaluate their own behaviors. These included measures of behavioral problems (acting out in class); impulsivity (acting without thinking through the consequences); and risk taking (engaging in behaviors that might harm themselves or others).

Rating child-care quality on a scale of 1 to 4, researchers found that more than 40 percent of the children experienced high-quality or moderately high-quality care. They noted a modest correlation between higher quality care and higher results on cognitive and academic assessments, including reading and math tests. This correlation was similar at age 4½ and age 15. A new finding that emerged at age 15 was that youth who had spent more time in quality child care as young children reported fewer acting-out behavior problems as teenagers.

"These results underscore the importance of interaction between children and their daytime caregivers," said first author Deborah Lowe Vandell, Ph.D., professor and chair of the Department of Education at University of California, Irvine. "We're seeing enduring effects of the quality of staff-child interaction."

Similarly, the researchers noted a correlation between the average number of hours children spent in child care each week through age 4½ and the youths' own evaluations of impulsivity and risk-taking tendencies at 15. This correlation was independent of the quality of child care the children experienced.

Moreover, the correlation reflected earlier associations between hours in child care and caregivers' reports of problem behaviors that the researchers had originally detected when the children were 4½. Hours in child care were calculated as the average number of hours per week a child spent in child care in infancy, as a toddler, and as a preschooler.

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adventure program. In addition, each participates in individual and family therapy sessions. We pay close attention to the type of therapy each client responds to, and structure more time around those modes. For example, some of our kids respond better to nonverbal therapies such as working with our farm animals or art. In these instances, we make sure these specialized activities are added to their schedule. On any day, you might see kids working in the garden, two or three kids working with animals, and another group working on art projects that may be therapeutically directed.

Q: Do you provide vocational guidance for the older kids who are approaching high school graduation?

A: We don't have a vocational program per se. However, our school staff and therapists work with our students' college advisors and other educational consultants to prepare for their future. We do have a work program that is related to serving the needs of residents that includes taking care of the house, working in the kitchen, working in the gardens and caring for our farm animals. In that sense, we are preparing kids to return to their homes and community better capable of taking care of themselves. These activities give them needed skills to take charge of their own daily living responsibilities - skills that many don't have when they come to Wellspring. Many of the parents are thrilled that their kids can cook and care for themselves when they return from Wellspring, and that's not a bad outcome from a residential stay – in addition to being emotionally healthier.

Q: Do the kids all dine as one group?

A: Yes, everyone dines family style at dining room tables along with therapists and milieu counselors. This creates a real environment with room to engage in meaningful personal and group discussions during mealtime. The dining room tables in our adolescent residence can seat twenty people at a time, along with several side tables. The side tables can be used by a therapist or outside consultant who needs to meet with a child one-on-one, and still be part of the group.

Q: It sounds like you have created an extended family environment for the kids.

A: That's a good description. We work to create a family environment in Wellspring's basic philosophy which is "high nurture – high structure." There is always a lot of verbal support as well as a very structured day and a structured means for developing relationships, and communicating within those relationships. We also work with the parents to develop a means for them to carry through a high nurture/ high structure kind of environment when the kids are home on passes for weekends and when the kids return home on a permanent basis.

Q: Let's talk more about the parents. What are some issues that parents themselves come in with when enrolling their child at Wellspring?

A: Each set of parents is unique. Because some of the children who come to Wellspring are approaching young adulthood, many parents have already experienced their child being at one or more inpatient or longer-term facilities, where they might not have had a successful outcome. Therefore, these parents are experienced with having their child at a residential facility. On the other hand, it's usually a first placement for our youngest population of kids between eight and twelve, so it's also a first placement for those parents. First time placements are a particularly emotionally wrenching experience. We have found that on a number of occasions – even though we advise differently – the parent doesn't tell their child that they are going to a residential facility until they actually arrive at the campus or at some point after they arrive on campus. The emotional angst about leaving their child at a residential facility is very high, no matter how competent the staff or comforting the environment. On the other hand, we have had foster care kids who have had 18 previous placements with foster families, psychiatric hospitals, group homes, and other residential treatment facilities with little ongoing parental contact.

In our children's programs, we have kids who don't have legal families, as well as kids who have been in foster or adoptive homes. In our adolescent program we require children to have families – adoptive or biological families – or some related adult in their life. In our adult facility where the residents are free to sign themselves out at any point, we almost always have family involvement, and we usually require the resident to permit us to talk with their family and engage their family with them as part of the treatment process.

Q: When you speak about engaging families of Wellspring residents, how does this work for the siblings of residents?

A: One of the most fascinating treatment activities that I found when I came to Wellspring is something we call "multi-family group." Every two weeks on a Sunday evening, parents and other family members are required to participate in a whole-community therapeutic family group. Each family comes with their own configuration. It can be mom and dad, grandparents, and often siblings of the resident. We often get as many as 15 family units, with 2 to 4 people in each unit participating around a large circle, for a total of as many as 50 people working with two very experienced Wellspring therapists.

We engage the families in public affirmations, identification of issues, concerns and supports that are both inter- and intra-family. Quite often you will hear from a mom whose child has been here for 10 months tell a rookie mom and dad that "It will take a little time to get adjusted to this environment, but in the long run it will become productive – so stay with it." Or you may hear a dad saying to his daughter, "I am so thrilled with the progress you are making, I have always loved you, but I am so much more comfortable being able to communicate with you in a more positive way." Those kinds of things are said and discussed in the multi-family group. The kids provide a lot of support for each other in a visible way. Siblings often participate in the group process. The small family groups are part of the larger multi-family group, creating the potential of all groups becoming more cohesive. On occasion we see magical things happening with kids and families in this kind of environment. Parents groups and multi -family groups engage parents to support each other as much as possible.

Q: Is there an average stay at Wellspring?

A: Yes, there is an average stay. For young children it is 12 to 18 months; for adolescents, 9 months to 1 year; and for young adults, 6 to 9 months. However, these numbers do not reflect the real picture. What we look for is an appropriate and flexible length of stay for each individual.

Q: What are your goals for the kids at Wellspring?

A: Our goal is to always return a child to their family, community, school, or work situation. We hope to accomplish this as quickly as possible with mutual agreement with parents, therapists and other facilitators that are involved in each case. We also need to have an assurance that there is a local support system (therapist, home visitors, mentors, etc.), whatever is necessary, to make the return to community permanent. We also must coordinate with the school systems, which are the most important out-of-home activity that children will be engaged in. For that reason, the rhythm of our admissions and discharges are timed to be in sync with the school year. On June 18th, we graduated four residents and two day students from our campus school who returned home, went on to a new therapeutic school, or on to college.

The Arch Bridge School works closely with the school districts to identify the appropriate time and place for a student to return. Often, that's a difficult process, because of the limited resources in local schools where they only see one or two kids like ours a year.

Q: When kids return to their homes and communities following a stay at Wellspring, do they encounter any forms of stigma towards them relating to where they have been and what might have caused them to be sent to a residential facility?

A: I am ashamed to say that stigma is still a terrible burden that children with serious emotional issues have to endure. Kids who have been is residential treatment can have a difficult time upon return to their community and school. There are always "bumps" in the road to recovery. Quite often their peers will press them with questions such as: Where were you when you were away? Why were you away? What were you doing? These questions tend to stigmatize the kids that have been in treatment, and so we try to work with the least stigmatizing approach when returning our kids back to their communities. We find that a structured approach to this issue helps. We make sure that the kids' return to school coordinates with the beginning of the term or school year. This gives them the opportunity to keep up academically and socially. People (neighbors, even school personnel) who don't understand the depth of the emotional problems our kids have can make it very difficult for the child when they return. We help our kids understand that there will be bumps in the road, no matter how well they are doing when they leave our campus. We try to keep abreast of the kids that we return home without intruding on their home-based support system, so we can provide additional support for them.

This coming October, we'll be hosting an Alumni Family Day here at Wellspring, and one of the workshops will be called 'Bumps in The Road,' to be presented by kids and families who have experienced these bumps firsthand. Our process of addressing stigma is to stress the importance of getting parents to understand what stigma is, how harmful it can be for the kids, and to teach them creative ways to be supportive and to help their kids deal with this issue. For some parents it is very difficult because they feel guilty that their child had an emotional problem and that they might have contributed to their child's problem.

Q: In closing, would you like to comment on some of the challenges you see in combating the current tide of disfavor that some treatment advocates are promoting against residential treatment facilities?

A: As a CEO of what I believe is a high-quality, open door residential treatment facility, I am very concerned and upset about the flood of advocacy, governmental activity, and literature against residential treatment. This wave of sentiment has reached a point where some advocates feel that residential treatment is not a meaningful part of the continuum of care. In Connecticut, Massachusetts, and New York State, generally speaking, residential treatment facilities are not the dark vision of the Dickens orphanages that the advocates are using in their arguments against residential treatment.

Wellspring is a very thoughtful, deliberate, professional, and experienced service that is a vital part of the community-based treatment system. There are some kids that can't live in their home community without some form of intensive clinical residential intervention. These kids need our help to temporarily remove them from the tensions they are experiencing in their home community so that they can work with us to figure out and develop the means and competence to return home. Open door residential treatment, in comparison to locked door psychiatric hospitals, is a way back for them into the community. For many of these kids, our campus facility provides the means of making their home and community life more stable. We provide a means for the child to repair and rebuild their damaged sense of family as well as helping them to build their own self-confidence in order to grow and develop into successful and happy young adults.

Independence from page 25

These young adults have the same goals as their peers who do not have a mental illness: They want to attend and finish school, obtain a job and have meaningful relationships. When asked their priorities for assistance, youth with a diagnosis of SED/SMI identify finishing school and career training; securing a decent job; learning independent living skills; managing and living within a budget; finding an affordable, safe and comfortable home; and coping with their family issues. (ibid)

Established more that 15 years ago, Crossroads has proven its effectiveness in providing mental health and support services to this underserved sector of Westchester's population. The program has created a strong network of collaboration with other service providers and is perceived as a leader in the community in addressing the mental health needs of this population.

Studies show that programs like Crossroads, which provide continuity of care and developmentally appropriate services can improve outcomes for young people with a SED/SMI. Over time, these young people are more likely to be employed and to be pursuing high school or post-secondary education. They are less likely to drop out of high school and less likely to experience interference in their lives from their mental health conditions or from drug or alcohol abuse. (ibid)

Crossroads' multi-disciplined team of licensed clinicians, case managers, and psychiatrist help these young adults move toward self-sufficiency and economic security by providing a full range of mental health treatment and case management services. Both Intensive Case Management with four visits per month, and Supportive Case Management, two visits per month are provided. Therapy sessions are available weekly and psychiatric services are generally provided on a monthly basis. All services can be provided more often as clinically indicated.

With the case manager, each Crossroads client establishes two or three long-term goals that become the basis for the Service Plan that guides services, and identifies the individual's strengths and possible barriers to achieving goals. The program strives to empower these young adults, normalize their lives through connections to social and peer support programs, and help them to navigate systems by themselves.

Crossroads respects the young adult's developmentally appropriate need for greater independence and greater control over goals, services and life decisions. For Tom, that meant his case manager did not give up when he wouldn't stay in a GED program, or insist that he accept an apartment in a supportive housing program when he said that he wasn't ready. Over time, Tom achieved success. His case manager connected him with a peer support program which provided him with acceptance and friends who understood his experiences. No longer isolated, his confidence improved. He obtained his GED and is now enrolled in a community college and is a leader in the peer support program. Though still living at home, he now can see a future. He is interested in a career in human services, and has told his case manager that he is ready for greater independence. With his case manager's support, he obtained a leaner's permit – a milestone that most youth take for granted, but one that is a crucial step to self-sufficiency for Tom.

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has obsessive compulsive disorder. I also wanted to let you know how much I learned while teaching the Breaking the Silence lessons. My mom was diagnosed with bipolar disorder last year and these lessons actually taught me a lot about what she is going through. Thank you for sharing this wonderful program with me and my students."

"Substantial research has established that the public holds inaccurate negative beliefs about those with mental illnesses, seeing them as dangerous, unpredictable, unattractive, unworthy, and unlikely ever to be productive members of society; creating an environment that impedes both treatment seeking and recovery. Children and adolescents are particularly sensitive to public opinion and attitudes. Ostracism, rejection, teasing, and damage to self-esteem, as well as reluctance to seek or accept mental health treatment, are among the possible consequences. The results of this study establish that, by educating children about mental illnesses, we can change attitudes and foster more accurate understanding and acceptance of people with psychiatric disorders," says Dr. Wahl. Lorraine Kaplan adds "These results will help us with our goal of moving mental illness into the mainstream; we look forward to a time when schizophrenia and depression will be discussed as openly in the classroom as diabetes or cancer."

NAMI is a nationwide grassroots, self-help, and advocacy not for profit organization dedicated to improving the lives of all those affected by severe mental illness. For more information on BTS and the NIMH study visit www.btslessonplans.org. For NAMI Queens/Nassau call 516-326-0797or visit www.namiqn.org. The project described was supported by Grants Number R01MH076093 and R01MH075837 from the NIMH. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIMH or the National Institutes of Health.

Celebrating the Life and Resiliency of Young People

By Odell Jno-Charles, BA
and Andres Esguerra, MA
Institute for Community Living (ICL)

Linden House is a Child Community Residence in East Flatbush, Brooklyn. At any given time, up to eight adolescent boys participate in treatment while residing at the house. All the young men who come through the program's doors have experienced hardships during their lifetime, which have impacted the way they view themselves and the world around them. Despite some of the challenges they have endured, these young men persevere every day to attain the same goals that other adolescents strive for, from finding employment to completing high school, while also attempting to build and nurture relationships with peers and family.

The month of May has been recognized as Children's Mental Health Month. As a means to honor and acknowledge the young men and their resilience, the boys decided to share poetry with friends and family at an event held at Linden House one Friday evening. The idea of holding a poetry event had been explored with the boys at their weekly Community Meeting and was met with no resistance. A sense of eagerness took hold of the young men, as this particular group uses writing as a means to share their thoughts and feelings. This formal event provided them with the opportunity to put their pain, struggle, resilience and triumph on stage.

It was a Friday afternoon, as the invited guests slowly began to creep into the residence. A bit of nervous energy filled the room, perhaps in anticipation of what was in store. Or it may have been the raw emotion of what the young men were about to reveal that was gnawing at them. Either way the first youth valiantly rose and began to give those in attendance a glimpse into his state of mind. He shared how his mental health diagnosis has left him "feeling like an outsider" needing to mask a part of himself in order to maintain the respect he has gained. He went on to share how half a year was wasted in the hospital, before he found himself and changed the expectations he had regarding his future. Instead of continuing to mask his diagnosis and spending unnecessary time in the hospital, he likened that period of time to "a fresh breeze that opened a new door of opportunity." This allowed for "a new life to emerge" and as stated in the last stanza of his poem: "I will see my life as it begins to unfold."

Another youngster spoke of the lack of understanding he feels his mother has regarding his diagnosis. "I am a young man who has been in hospitals diagnosed with ADHD, ODD and Mood Disorder. I am a son with no mom to love, living with another person's mom, that doesn't trust me, who doesn't understand". These powerful words came from a young soul who lost his biological mother at a very young age, and feels that his adoptive mother does not understand him. He shares how his diagnosis makes it difficult for him not to be "impulsive and aggressive," which then leads to conflict and misunderstanding regarding his behavior and true intentions.

All the young men took turns reading their poems. Staff became involved as well, sharing poems written by other boys who were not at a place to offer their work to an audience themselves. Each young man poured his heart into their work, leaving everyone at the residence feeling the numbing impact of their experiences and words. Everyone at Linden House, including the young men was able to acknowledge that their experiences, although painful, were predecessors to their strengths in character and overall resiliency.

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The study's findings were consistent among boys as well as girls. In addition, previous studies had suggested that child care could have benefits for children from economically disadvantaged homes. So the researchers created a risk index with such factors as family income, the mother's level of education, and mothers' reports of depression symptoms, dividing their group into three based on risk. Both the achievement and behavior patterns they had found were consistent across all three groups.

"High quality child care appears to provide a small boost to academic performance, perhaps by fostering the early acquisition of school readiness skills," said James A. Griffin, Ph.D., deputy chief of the NICHD Child Development & Behavior Branch. "Likewise, more time spent in child care may provide a different socialization experience, resulting in slightly more impulsive and risk-taking behaviors in adolescence. These findings underscore the importance of studying the linkages between early care and later development."

A video of Dr. James Griffin discussing the study findings can be viewed on YouTube at: <http://www.youtube.com/watch?v=sVw3V06ZLfg>

The NICHD sponsors research on development, before and after birth; maternal, child, and family health; reproductive biology and population issues; and medical rehabilitation. For more information, visit the Institute's Web site at <http://www.nichd.nih.gov/>.

The National Institutes of Health (NIH) -- The Nation's Medical Research Agency -- includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit <www.nih.gov>.

Culture from page 18

mediate such challenges may be related to lack of early detection by providers and parents; untrained and culturally biased providers; lack of parent and provider knowledge of efficacious treatment. For example, "Latino" youth have the highest rate of suicide, yet they are less likely to be identified by their caregivers as having problems. Disparities in service may be due to different barriers such as insurance status and setting where behavioral health services are delivered. "Minority" children tend to receive behavioral health services through the juvenile justice and welfare systems more often than through schools or special settings.

Unfortunately, efforts to address "racial" and ethnic disparities in behavioral health delivery are constrained by profound socio-environmental, institutional and market forces. Currently young people in the U.S. are increasingly ethnically diverse. Data indicates that children and adolescents of "color" make up as much as 40% of the U.S. population. It is estimated that the "Latino" population will become the largest ethnic group in American society. Asian and Pacific Islander make-up the second fastest-growing "minority;" of that group 50% are new immigrants, and about one third are younger than age 17. The African origin population is expected to increase 12.5% with 50% of those individuals being under age 17. The Native American Indian population is expected to increase to 6.0%, 25% of whom will be adolescent. Concurrently, the population of Caucasian children in the U.S. is expected to decrease by about 3.0% (U.S.Census Bureau, 2007). Alarmingly, 7 million children, or 10% of the population under age 18, have a parent under some form of correctional supervision, (Bureau of Justice, 2006).

Failure to adapt children and adolescent services to various socio- cultural perspectives can result in the underutilization of services and consequently can result in unmet needs. The increasing magnitude of poverty, substance use/abuse, violence, illiteracy and teen pregnancy have profound effects on the unmet service needs of diverse populations. Our efforts must focus not only on equalizing access to services, but also on equalizing outcomes of care. Moreover, we must move beyond policy interventions to more socio-education approaches, where government agencies are not agents of control but agents of support and change. Early identification and education about psychosocial disparities and culturally flexible definitions of behavioral problems can assist in the prevention and provision of services to multicultural children and adolescents.

Mental Health News 2011 Theme and Deadline Calendar

Winter 2011 Issue:
"The Impact of Race and Racism on Mental Health Clients, Practitioners, Organizations and Mental Health Delivery Systems"
(Please Note: Articles for this issue are by Invitation Only)
Deadline: November 1, 2010

Spring 2011 Issue:
"The Mental Health Needs of Older Adults"
Deadline: February 1, 2011

Summer 2011 Issue:
"Women's Issues in Mental Health"
Deadline: May 1, 2011

Fall 2011 Issue:
"Health Reform and Mental Health Parity and their Impact on People and Service Providers"
Deadline: August 1, 2011

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become overwhelming.

The thought of inpatient hospitalization can be frightening to parents, guardians, and siblings as well as the child. The separation alone can be cause for significant anxiety and concern. Some parents may ask questions such as: Why can't this be done on an outpatient basis? Do I have to give my child up to these people/ strangers? Will they just drug my child? What will she do all day in there? How do I know this place is any good? Will I get to have contact with my child? Can I call and visit him? Youngsters may ask: Are they taking me from my parents? Are my parents sending me there because I was "bad? When will I get out? Can I see my family? Will I ever see my friends again?

These are the type of concerns that have been perpetuated by the stigma of psychiatric care and the artifacts of negative inpatient experiences. It is important to remain cognizant of the fact that inpatient is NOT just a place, but rather a treatment intervention. The role of expert inpatient care has improved just as mental health care in general has adjusted to external pressures, new treatment options, data collection and analysis, and the feedback of those receiving treatment.

As providers in an established inpatient program, Four Winds-Saratoga has found that the role of the hospital has to be multifaceted in order to meet the diverse needs of the children and adolescents we serve. A comprehensive psychiatric evaluation occurs in the context of 24 hour nursing care and skilled milieu programming. Multiple assessments are conducted including, a psychiatric evaluation, a nursing assessment, medical/ physical evaluation, and a social and leisure skills assessment. A therapist is assigned to each youngster who will conduct individual and family therapy as well as actively working toward establishing a comprehensive discharge plan. The unit Medical Director (psychiatrist) provides clinical oversight and medication management, when necessary, for each child. In addition, school services are provided which includes collaboration with the child's home school in order to maintain as much continuity as possible. The multidisciplinary team also collaborates with the child and parents/ guardian to develop a plan for treatment and discharge.

This description may be similar to other inpatient programs. What is it that sets one apart from the other? How do you know what components of the program actually contribute to its positive outcome? We believe that one of the most critical aspects of a treatment program is the intimate involvement of the child and their parent or guardian. It is critical that parents and collateral individuals, such as extended family and outpatient providers are involved in the assessment, treatment, and discharge process throughout the hospital stay. We believe that professionals on the treatment team need to be expert in the areas of child development and psychiatric care and that

Joseph Commisso, PhD

parents and their children are expert in their knowledge of their own lives, functioning, strengths, and areas of concern.

The focus of treatment is to help the child and family to identify the issues contributing to the crisis that lead to admission and most importantly, the strengths of the child and family which can be emphasized to facilitate the mitigation of problematic issues. These strengths are idiosyncratic and vary greatly from situation to situation and family to family. For instance, strengths may include a supportive family, above average intelligence, favorable premorbid functioning, a comprehensive outpatient plan for some, a history of medication compliance (which is often overlooked as strength), a sense of humor, readily engaging with adults, and a history of engaging in hobbies, athletics, or other extracurricular activities. Furthermore, emphasis is placed on helping the child to identify triggers to his or her distress, which frequently relates to interpersonal issues such as teasing or bullying at school, abandonment or rejection by a significant adult in his or her life, or trauma related issues, among many others. Simultaneously, children and family members are encouraged to recognize the early warning signs of a beginning crisis and potential deterioration in functioning – emphasis here is on "early." Again, there are many variations to these signs. Some examples include, subjective feelings of agitation and impatience, observable changes in facial expressions or body movements such as leg shaking or finger tapping, thoughts of self-harm, changes in the youngster's choice in music or clothes (i.e. darker, more moribund themes relative to the typical presentation), and sleep and appetite changes among many, many others. New coping and target skills are identified by the child and family within the treatment program and practice is encouraged.

All of these aspects of the treatment plan - triggers, early warning signs, developing and practicing new skills - are an integral aspect of programming throughout the day. They are established in the context of the child's chronological and developmental age and/or level of functioning and these issues are addressed throughout the hospitalization in the milieu, recreational activities, skill building modules including daily goal setting where goals for the day are established and discussed, Focus and Wrap Up meetings to discuss progress, and Dialectical Behavior Therapy interventions where target symptoms are identified, the severity is rated and progress noted daily. A token economy system is in place on each of the respective children's programs and adapted to the child's age. It is important to note that emphasis is placed on "earning" and not losing points, tickets, or privileges. This positive perspective, the strength based emphasis, and the comprehensive and reinforcing approach to treatment planning and interventions have been critical to quality care. Furthermore, and most importantly, the individualized nature of the approach to care has greatly contributed to successful outcomes.

The commitment to quality care and the intensity of the involvement with children and family members is critical to the success of the treatment process. An attempt to engage the patient in treatment often begins at the time of the referral and the admission assessment by gathering as much information as possible during each interaction. After the initial interview the child and family are oriented to the living unit, staff members and many aspects of the treatment program. Family members are encouraged to regularly visit and speak with their child in order to maintain the connection. Contact with the physician and therapist occurs very quickly in order to gather further data, discuss treatment options and discharge planning. It is important to engage quickly since the treatment in the hospital is relatively brief (six to twelve days in many cases) and the intervention is one aspect of the continuum of care for children and adolescents.

At Four Winds- Saratoga we are committed to quality patient care and actively obtain and utilize empirical data obtained during the hospitalization in the form of feedback from the youngster's experience in treatment. We also utilize a structured patient and parent satisfaction survey in the data gathering process. We use the Piers Harris Children's Instrument Self–Concept scale, 2nd edition, which is a well established tool developed by Ellen V. Piers PhD, Dale B. Harris, PhD, and David S. Herzberg, PhD. This instrument provides an overall view of a youngster's (ages 7-18) self perception. This is a hand scored tool with test items that cover six different subscales, as well as two subscales that account for biased responding and random answering. Items are presented as descriptive statements and the youngster answers in a "yes" or "no" fashion indicating whether or not the statement applies to himself or herself. The subscales address the following concepts: physical appearance and attributes, freedom from anxiety, intellectual and school status behavioral adjustment, happiness and satisfaction, and popularity. We have over a decade of data from this instrument and a response rate of over 80%. Results consistently indicate a clear change in the youngster's self perception from the time of admission to the inpatient unit to the time of discharge. Specifically, over the last year alone, a thousand children rating themselves on Piers-Harris, scores improved 30% to 40%. The individual subscales consistently showing the greatest change during hospitalization are the child's self-perception scores related to "anxiety", (a 55%-65% improvement) and "happiness", (a 50%-60% increase), both of which are key to a young persons experience of depression.

Simultaneously, youngsters and parents are asked to complete an anonymous satisfaction survey relating to their experience in the hospital encompassing all aspects of their experiences from the admission process, financial arrangements, comfort of the physical environment to clinical interventions such as individual and family therapy, discharge planning, medication management, and direct nursing care, among others. The child and parents are also given the opportunity to provide a narrative about his or her experience during the hospitalization. The results have been overwhelmingly positive including some surprising results from our youngsters who are asked the following question: Would you come back to Four Winds? Most, we thought, would interpret the inquiry in such a way as to discount the value of their experience and want to separate them from the setting, particularly at the time of discharge. While the rating is without exception, the lowest of the survey, the children and teenagers typically respond in a positive fashion as evidenced by the 80%-90% favorable response.

In conclusion, it is important to recognize that "inpatient" is a complex intervention and the quality and treatment approach of these programs can vary widely. Those programs that are characterized by the following qualities would seem to be most effective: Respecting the youngster and family members, emphasizing individualized care, maintaining a focus on strengths (and avoid the trap of a purely pathological perspective), include a trained committed group of providers in the program that is reflective of an organization whose mission is driven by quality care, compassion, and safety. In addition, a program that is focused and places emphasis on target symptoms and coping strategies, comprehensive follow up care, and the creation and utilization of a constructive feedback loop involving both young people and their families are critical aspects of a quality program and provides the best opportunity for change.

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in your child's behavior. For example, the birth of a sibling may cause a child to temporarily act much younger than he or she is. It is important to be able to tell the difference between typical behavior changes and those associated with more serious problems. Pay special attention to behaviors that include: Problems across a variety of settings, such as at school, at home, or with peers; Changes in appetite or sleep; Social withdrawal, or fearful behavior toward things your child normally is not afraid of; Returning to behaviors more common in younger children, such as bed-wetting, for a long time; Signs of being upset, such as sadness or tearfulness; Signs of self-destructive behavior, such as head-banging, or a tendency to get hurt often; and Repeated thoughts of death.

Q. Can symptoms be caused by a death in the family, illness in a parent, family financial problems, divorce, or other events?

A. Yes. Every member of a family is affected by tragedy or extreme stress, even the youngest child. It's normal for stress to cause a child to be upset. Remember this if you see mental, emotional, or behavioral symptoms in your child. If it takes more than one month for your child to get used to a situation, or if your child has severe reactions, talk to your child's doctor.

Check your child's response to stress. Take note if he or she gets better with time or if professional care is needed. Stressful events are challenging, but they give you a chance to teach your child important ways to cope.

Q. How are mental illnesses diagnosed in young children?

A. Just like adults, children with mental illness are diagnosed after a doctor or mental health specialist carefully observes signs and symptoms. Some primary care physicians can diagnose your child themselves, but many will send you to a specialist who can diagnose and treat children.

Before diagnosing a mental illness, the doctor or specialist tries to rule out other possible causes for your child's behavior. The doctor will: Take a history of any important medical problems; Take a history of the problem - how long you have seen the problem - as well as a history of your child's development; Take a family history of mental disorders; Ask if the child has experienced physical or psychological traumas, such as a natural disaster, or situations that may cause stress, such as a death in the family; and Consider reports from parents and other caretakers or teachers.

Very young children often cannot express their thoughts and feelings, so making a diagnosis can be challenging. The signs of a mental illness in a young child may be quite different from those in an older child or adult.

As parents and caregivers know, children are constantly changing and growing. Diagnosis and treatment must be viewed with these changes in mind. While some problems are short-lived and don't need treatment, others are ongoing and may be very serious. In either case, more information will help you understand treatment choices and manage the disorder or problem most effectively.

While diagnosing mental health problems in young children can be challenging, it is important. A diagnosis can be used to guide treatment and link your child's care to research on children with similar problems.

Q. Will my child get better with time?

A. Some children get better with time. But other children need ongoing professional help. Talk to your child's doctor or specialist about problems that are severe, continuous, and affect daily activities. Also, don't delay seeking help. Treatment may produce better results if started early.

Q. Are there treatment options for children?

A. Yes. Once a diagnosis is made, your child's specialist will recommend a specific treatment. It is important to understand the various treatment choices, which often include psychotherapy or medication. Talk about the options with a health care professional who has experience treating the illness observed in your child. Some treatment choices have been studied experimentally, and other treatments are a part of health care practice. In addition, not every community has every type of service or program.

Q. What are psychotropic medications?

A. Psychotropic medications are substances that affect brain chemicals related to mood and behavior. In recent years, research has been conducted to understand the benefits and risks of using psychotropics in children. Still, more needs to be learned about the effects of psychotropics, especially in children under six years of age. While researchers are trying to clarify how early treatment affects a growing body, families and doctors should weigh the benefits and risks of medication. Each child has individual needs, and each child needs to be monitored closely while taking medications.

Q. Are there treatments other than medications?

A. Yes. Psychosocial therapies can be very effective alone and in combination with medications. Psychosocial therapies are also called "talk therapies" or "behavioral therapy," and they help people with mental illness change behavior. Therapies that teach parents and children coping strategies can also be effective.[2]

Cognitive behavioral therapy (CBT) is a type of psychotherapy that can be used with children. It has been widely studied and is an effective treatment for a number of conditions, such as depression, obsessive-compulsive disorder, and social anxiety. A person in CBT learns to change distorted thinking patterns and unhealthy behavior. Children can receive CBT with or without their parents, as well as in a group setting. CBT can be adapted to fit the needs of each child. It is especially useful when treating anxiety disorders.[3]

Additionally, therapies for ADHD are numerous and include behavioral parent training and behavioral classroom management. Visit the NIMH Web site for more information about therapies for ADHD.

Some children benefit from a combination of different psychosocial approaches. An example is behavioral parent management training in combination with CBT for the child. In other cases, a combination of medication and psychosocial therapies may be most effective. Psychosocial therapies often take time, effort, and patience. However, sometimes children learn new skills that may have positive long-term benefits.

More information about treatment choices can be found in the psychotherapies and medications sections of the NIMH Web site.

Q. When is it a good idea to use psychotropic medications in young children?

A. When the benefits of treatment outweigh the risks, psychotropic medications may be prescribed. Some children need medication to manage severe and difficult problems. Without treatment, these children would suffer serious or dangerous consequences. In addition, psychosocial treatments may not always be effective by themselves. In some instances, however, they can be quite effective when combined with medication.

Ask your doctor questions about the risks of starting and continuing your child on these medications. Learn everything you can about the medications prescribed for your child. Learn about possible side effects, some of which may be harmful. Know what a particular treatment is supposed to do. For example, will it change a specific behavior? If you do not see these changes while your child is taking the medication, talk to his or her doctor. Also, discuss the risks of stopping your child's medication with your doctor.

Q. Does medication affect young children differently than older children or adults?

A. Yes. Young children handle medications differently than older children and adults. The brains of young children change and develop rapidly. Studies have found that developing brains can be very sensitive to medications. There are also developmental differences in how children metabolize - how their bodies process - medications. Therefore, doctors should carefully consider the dosage or how much medication to give each child. Much more research is needed to determine the effects and benefits of medications in children of all ages. But keep in mind that serious untreated mental disorders themselves can harm brain development.

Also, it is important to avoid drug interactions. If your child takes medicine for asthma or cold symptoms, talk to your doctor or pharmacist. Drug interactions could cause medications to not work as intended or lead to serious side effects.

Q. How should medication be included in an overall treatment plan?

A. Medication should be used with other treatments. It should not be the only treatment. Consider other services, such as family therapy, family support services, educational classes, and behavior management techniques. If your child's doctor prescribes medication, he or she should evaluate your child regularly to make sure the medication is working. Children need treatment plans tailored to their individual problems and needs.

Q. What medications are used for which kinds of childhood mental disorders?

A. Psychotropic medications include stimulants, antidepressants, anti-anxiety medications, antipsychotics, and mood stabilizers. Dosages approved by the U.S. Food and Drug Administration (FDA) for use in children depend on body weight and age. NIMH's medications booklet describes the types of psychotropic medications and includes a chart that lists the ages for which each medication is FDA-approved. See the FDA Web site for the latest information on medication approvals, warnings, and patient information guides.

Q. What does it mean if a medication is specifically approved for use in children?

A. When the FDA approves a medication, it means the drug manufacturer provided the agency with information showing the medication is safe and effective in a particular group of people. Based on this information, the drug's label lists proper dosage, potential side effects, and approved age. Medications approved for children follow these guidelines.

Many psychotropic medications have not been studied in children, which means they have not been approved by the FDA for use in children. But doctors may prescribe medications as they feel appropriate, even if those uses are not included on the label. This is called "off -label" use. Research shows that off-label use of some medications works well in some children. Other medications need more study in children. In particular, the use of most psychotropic medications has not been adequately studied in preschoolers.

More studies in children are needed before we can fully know the appropriate dosages, how a medication works in children, and what effects a medication might have on learning and development.

Q. Why haven't many medications been tested in children?

A. In the past, medications were seldom studied in children because mental illness was not recognized in childhood. Also, there were ethical concerns about involving children in research. This led to a lack of knowledge about the best treatments for children. In clinical settings today, children with mental or behavioral disorders are being prescribed medications at increasingly early ages. The FDA has been urging that medications be appropriately studied in children, and Congress passed legislation in 1997 offering incentives to drug manufacturers to carry out such testing. These activities have helped increase research on the effects of medications in children.

There still are ethical concerns about testing medications in children. However, strict rules protect participants in research studies. Each study must go through many types of review before, and after it begins.

Q. How do I work with my child's school?

A. If your child is having problems in school, or if a teacher raises concerns, you can work with the school to find a solution. You may ask the school to conduct an evaluation to determine whether your

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child qualifies for special education services. However, not all children diagnosed with a mental illness qualify for these services.

Start by speaking with your child's teacher, school counselor, school nurse, or the school's parent organization. These professionals can help you get an evaluation started. Also, each state has a Parent Training and Information Center and a Protection and Advocacy Agency that can help you request the evaluation. The evaluation must be conducted by a team of professionals who assess all areas related to the suspected disability using a variety of tools and measures.

Q. What resources are available from the school?

A. Once your child has been evaluated, there are several options for him or her, depending on the specific needs. If special education services are needed, and if your child is eligible under the Individuals with Disabilities Education Act (IDEA), the school district must develop an "individualized education program" specifically for your child within 30 days.

If your child is not eligible for special education services, he or she is still entitled to "free appropriate public education," available to all public school children with disabilities under Section 504 of the Rehabilitation Act of 1973. Your child is entitled to this regardless of the nature or severity of his or her disability.

The U.S. Department of Education's Office for Civil Rights enforces Section 504 in programs and activities that receive Federal education funds. Visit programs for children with disabilities for more information.

Q. What special challenges can school present?

A. Each school year brings a new teacher and new schoolwork. This change can be difficult for some children. Inform the teachers that your child has a mental illness when he or she starts school or moves to a new class. Additional support will help your child adjust to the change.

Q. What else can I do to help my child?

A. Children with mental illness need guidance and understanding from their parents and teachers. This support can help your child achieve his or her full potential and succeed in school. Before a child is diagnosed, frustration, blame, and anger may have built up within a family. Parents and children may need special help to undo these unhealthy interaction patterns. Mental health professionals can counsel the child and family to help everyone develop new skills, attitudes, and ways of relating to each other.

Parents can also help by taking part in parenting skills training. This helps parents learn how to handle difficult situations and behaviors. Training encourages parents to share a pleasant or relaxing activity with their child, to notice and point out what their child does well, and to praise their child's strengths and abilities. Parents may also learn to arrange family situations in more positive ways. Also, parents may benefit from learning stress-management techniques to help them deal with frustration and respond calmly to their child's behavior.

Sometimes, the whole family may need counseling. Therapists can help family members find better ways to handle disruptive behaviors and encourage behavior changes. Finally, support groups help parents and families connect with others who have similar problems and concerns. Groups often meet regularly to share frustrations and successes, to exchange information about recommended specialists and strategies, and to talk with experts.

Q. How can families of children with mental illness get support?

A. Like other serious illnesses, taking care of a child with mental illness is hard on the parents, family, and other caregivers. Caregivers often must tend to the medical needs of their loved ones, and also deal with how it affects their own health. The stress that caregivers are under may lead to missed work or lost free time. It can strain relationships with people who may not understand the situation and lead to physical and mental exhaustion.

Stress from caregiving can make it hard to cope with your child's symptoms. One study shows that if a caregiver is under enormous stress, his or her loved one has more difficulty sticking to the treatment plan.[4] It is important to look after your own physical and mental health. You may also find it helpful to join a local support group.

Q. Where can I go for help?

A. If you are unsure where to go for help, ask your family doctor. Others who can help include: Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors; Health maintenance organizations; Community mental health centers; Hospital psychiatry departments and outpatient clinics; Mental health programs at universities or medical schools; State hospital outpatient clinics; Family services, social agencies, or clergy; Peer support groups; Private clinics and facilities; Employee assistance programs; Local medical and/or psychiatric societies.

You can also check the phone book under "mental health," "health," "social services," "hotlines," or "physicians" for phone numbers and addresses. An emergency room doctor can also provide temporary help and can tell you where and how to get further help.

More information on mental health is at the NIMH Web site. For the latest information on medications, see the U.S. Food and Drug Administration website.

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Still another is the “jester” who makes jokes and does not listen well. As these roles surface, they are acknowledged by the staff and the other families and associated behaviors and patterns are identified and discussed.

Communication is both verbal and non-verbal. Children learn how to communicate from their parents and their peers. What they learn is not always respectful communication. One of the goals in the program is to increase communication between parents and children and to teach listening skills as well. To warm up the group, we play a game of telephone where a statement is whispered around the room. This illustrates that if the communication is not clear and attention not focused, the idea does not get across accurately. Children and parents are asked separately how they know if someone is listening: eye contact, verbal acknowledgement, body language and ultimately the response are the answers we tend to get. Families know how to listen and how to talk to each other but they do not always exercise these skills effectively.

There are challenges that we face during the group; some are physical, some are emotional. The room in which we run the group is very small, which makes it difficult to walk around and check in personally with all of the families. Staff makes an effort to move about and touch base with each family and their progress. There is also a good amount of coordination required to ensure that the group runs smoothly. Ordering food, writing notes, distributing Metro Cards and preparing material are a few of the concrete tasks involved.

The first year that we ran the group we had a particularly challenging group of participants. Children with oppositional disorder presented unique behavioral issues beyond actions and symptoms associated with the majority of children in treatment. Children do not always feel like talking about their issues from school or home and they tend to act out their anger instead of verbally expressing it. Video games, phones and Mp3 players are not permitted in the group since they tend to distract everyone. Asking a child to put aside a video game to talk about stress at school may provide the group with a clear and immediate example of defiant behavior.

One added benefit of having multiple parents in the room is that they act as parents to all the kids. If a parent is not managing her own child, rest assured another parent will let the child know they are acting out. For instance, one child in the first group consistently talked back to his grandmother and the grandmother was unable to redirect her grandson. One of the other mothers became exhausted with this routine and firmly told the child that he was disrespecting his grandmother and that if he lived in her household, that behavior would not be tolerated. The behavior stopped and the grandmother shared that she felt more empowered.

Relationships are our key to interacting with the world. The relationships we have with our parents and the relationships our parents have with each other teach us how to behave with those outside the family. To help families understand the importance of relationships, we focus on positive activities the families can do together. Individual families choose their activities, and then as a larger group we discuss rules around family time, obstacles to spending time together and how to prioritize family fun time.

We learn new lessons every time we run the group. During the first year, we found that a reward system is an extremely effective tool to encourage the kids to participate. Even a small, inexpensive toy is an incentive to get children back on track. We used the star system. Children start out with 5 stars in the beginning of the group. If they participate in an activity, they receive an additional star. If they act out, a star is taken away. By the end of the group, if the children have 10 stars, they are rewarded with a toy. Our goal was to create a system in which every child is rewarded with a prize by the end of group, and it worked.

Both groups of families expressed verbally how much they gained from attending the multi-family group. Approximately one-half of the participants completed their treatment following the group and acknowledged that their goals had been achieved. The remaining families stayed on and were assigned an individual therapist. We plan to run the group again this fall in a different setting: the ICL Emerson-Davis Family Development Center. While this will add a new set of challenges concerning different age groups and confidentiality among residents of the same congregate facility, a positive aspect is that residents will not need to travel to get to the group. Since families live where the group takes place, there should be fewer instances of absenteeism. We look forward to extending our experiences within a clinic setting to a residence and to continue learning from the challenges that will present.

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Patrice, a victim of years of domestic violence at the hands of her husband, was unable to work as the result of an unmedicated case of bipolar disorder. Her estranged husband kept her on his health insurance so she was unable to get Medicaid and he refused to pay her co-pays or cover any medical expenses. Off medication, Patrice often felt unable to care for her young teenage sons and asked her ex-to keep them for a few extra days. Instead he dropped them off at her home when she was feeling acutely depressed. She went to the emergency room for medication and while there, social workers observed bruises on the boys; the boys indicated that their father had hit them. Patrice felt so overwhelmed she stated she couldn't take them home and they were sent to a foster home. There are times when she cannot afford food or household supplies, often has no money for tampons or toilet paper. She had no winter coat. The older boy began writing about death on his Facebook page, and soon after had carved a broken heart on the inside of his arm.

Our patients' lives are so difficult not only because of their personal histories, but because of the poverty they live in, the racism they encounter, the language barrier faced by our Latino population, and the lack of steady work or affordable health insurance. As a result of these disparities, they have lived in constant crisis, and have experienced a series of complex traumas. In these times of economic stress, we see an increase in domestic violence and substance abuse, and consequently, a higher frequency of suicidal thinking in children. Every week there are a handful of child and adolescent patients taken to the Psychiatric Emergency Room for an assessment of suicidal intent. About half are hospitalized.

Tiana was 13 when she attended a "hooky party", where she consumed a lot of alcohol and willingly had sex with a boy she didn't know. Later on at the party she was raped by another boy. Her mother called the police, who are conducting an investigation. Tiana had a history of self-cutting. Since the rape she has had to have multiple examinations for STDs and is taking HIV medications prophylactically.

A 15-year old Latino boy accepted that he was gay, but his mother could not and continued to shame him with insults and subtle slights. He ran away from home for a week and stated he just "hung out at Barnes and Nobles in the city" until closing. After he returned home, it was never clear where he had really been or what he had been doing. A lot of gay kids of color in the Bronx are in the closet, in spite of efforts to provide them extra support.

In session, eight-year old Darnell admitted his father hits him on the head with the wooden pole of the broomstick, with wet shoes and a belt. He said he really tries to be a good boy. We reported it to the State Central Registry in Albany. The parents continue to come to us for marriage counseling and psychoeducation on ways to set limits with their children without resorting to violence.

Sixteen-year old Thomas told his therapist that he had fantasies of hurting some of the kids in his high school. He had been fascinated by the murderous events at Columbine and Virginia Tech and was reading articles about them online. A psychiatric evaluation revealed that Thomas had very low self esteem and was constantly comparing himself to his very successful younger brother. We continue to monitor him very closely, and his fantasies have lessened.

Edwin, 13, had been in treatment at our clinic for over a year, for sexualized behavior towards girls in school and one psychiatric hospitalization for suicidal thinking. Over one summer weekend, we learned that his father had allegedly strangled Edwin's pregnant, 16 year old sister and tried to hide the nude body in the furnace of his building. Edwin's mother's world crashed around her, since she had let the kids visit her ex-husband knowing his past history of violence towards her. The family was destroyed as Edwin's father went to jail and his sister was dead. Later we learned that the father was responsible for the sister's pregnancy.

So many questions arise when working in this parallel universe. How is it that so many African -American and Latino boys aged 6 to 13 have "Attention Deficit Disorder"? Is it because they no longer have recess at school so the boys are literally bouncing off the walls or because a label and medication are easier to dispense than a response to the larger crises they live through? If kids have been physically or sexually abused, how can they sit still and learn geometry? What happened to school personnel handling things that happen in school? Now 911 is the first response and children no taller than a sapling are transported in ambulances to a psychiatric emergency room in a hospital for a mental health evaluation. There they are prematurely saddled with a label, a diagnosis and a stigma. When parents stop bringing their depressed or suicidal children to us for therapy, we have to call ACS and we lose our role as neutral parties. We scout out neglect like squirrels foraging for nuts. Since the majority of our clients are people of color, and many on staff are white, the racial hierarchy is even more pronounced. We are the strictest mothers and fathers, we follow rules and respect limits. We also acknowledge the strength they show in the face of terrible odds: they start at a disadvantage and never quite catch up.

There is an advantage to being a white, middle class ghost in the Bronx. As in most situations when one is white, I have the choice to come or to leave when I want to. But, I am always deeply affected by the stories I hear day after day. I am never inured to the heartbreaking tales of human betrayal, as male family members and strangers alike steal the innocence from their young girls, leaving them fearful of going to the dentist where their mouths feel exploited once again; untrusting in relationships with men who may have no wish to hurt them when they grow up; or passing on fear and twisted notions of sexual development to their daughters. My staff, who hear the stories in great detail week after week, do tend to get numb, and my job is to try to prevent the vicarious traumatization to which they are vulnerable. They have to have a place to debrief, to cry if they need to , to take a long, steady exhale between the stories of grievous loss and destruction of the spirit. It is these close encounters with the cruelty of human nature that can dehumanize us, and we have to keep fighting to believe that there is goodness left in resilience and in the struggle itself. Sometimes it just takes your breath away; all of it.

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household financially has impacted the way a family spends their time and effort. Many rely on fast and convenience foods as a quick and easy way to feed children in the evenings, rather than a meal that is home cooked. These fast and easy foods are much higher in fat, sugar and salt. The after school time is when children can be more active, doing fun activities outside. However, due to parents working, children may be required to go home, lock the door, and stay at home until the first parent arrives home. This encourages sedentary activities and unmonitored snacking. The lack of proper adult/parent availability does not lend itself for time to talk about their daily stresses and concerns. This may lead to emotional eating to fend off their mood. These children are at increased risk for mental disorders. In one study, 13-14 year old girls were four times more likely to suffer from self-esteem issues. Low self-esteem apparently leads to loneliness, sadness, nervousness, poor body image, and are at high risk for substance abuse, smoking, and depression, which, if left untreated, may contribute to the cause or effect of obesity. In a recent University of Minnesota study, overweight children who are teased by family and other children, 26% had considered suicide, and 9% attempted suicide. In another study Schwimmer, et al (2003), obese children rated their quality of life with scores as low as young cancer patients on Chemotherapy.

Autism Spectrum Disorders: These children have problems interacting and communicating with others, and are identified prior to age 3. The behaviors include; repetitive behavior such as banging their head, rocking, and spinning objects, poor awareness of others and are at increased risk for other mental disorders. Autism affects 1 in every 110 children.

Schizophrenia: Children have psychotic episodes with hallucinations, withdrawal, delusions, disordered thinking, and loss of contact with others and reality. Schizophrenia affects 5 out of 1,000 children.

As a home care nurse, in order to develop a plan of care for a child with a mental illness, he or she must be treated within a holistic paradigm. The child lives with other family members one (or two) of which is the primary caregiver. Along with earning trust with the child, it is of utmost importance to earn trust with the caregiver (s). Building upon a trustful therapeutic relationship will most likely make the difference between compliance or noncompliance. This person will play a key role in whether a child gets to MD or Clinic appts, obtaining and administering medications to the child and being alert to any changes in the child's physical and mental status.

Other siblings in the home also need attention and support of the home care nurse. Other children may suffer from lack of attention of the caregiver, especially during a period of crisis. Giving some brief attention to them, and helping them understand, at their developmental level, what is happening to their sister/ brother, may help ally fears and concerns.

Education of the child and caregiver is an ongoing part of the Home Care nurses visit. Anxiety of both the child and caregiver are to be expected. It is difficult to retain information when you are very anxious, so, it is better to allow the first part of the visit to be used for therapeutic interaction, followed by educational issues. Education regarding services, diagnosis, symptom management, emergency management, medications and administration, and need for continued follow up and treatment are some of the items addressed. Safety regarding medications and children is an issue, which may be solved with the use of a locked box to prevent accidental overdose. The learning must not be given all at once, but based on comprehension and degree of importance.

Since the mental health home care nurse sees the child in the home, we have access to knowledge the other mental health caregivers do not. We can evaluate how the caregiver functions within the home. Is the caregiver organized, appear competent and willing to support the child? Does the caregiver have illnesses of her/his own to deal with? Is the caregiver employed? How will the caregiver take the child to his or her appts or obtain medications? Will the caregiver remember what to do in an emergency? How well are they adhering to the plan of care? All of this information is important to the treating Psychiatrist, Clinic, and Therapist to know in order to fashion a plan that will take into account the willingness and ability of the caregiver in the home.

The home care mental health nurse can be an invaluable tool in preventing, accessing, treating, and monitoring children and adolescents with mental health issues, in preventing relapses in children with mental health problems, supporting and encouraging the parents/caregiver to continue treatment and reinforcing good parenting skills, and preventing acute hospitalization of the child with a mental health disorder.

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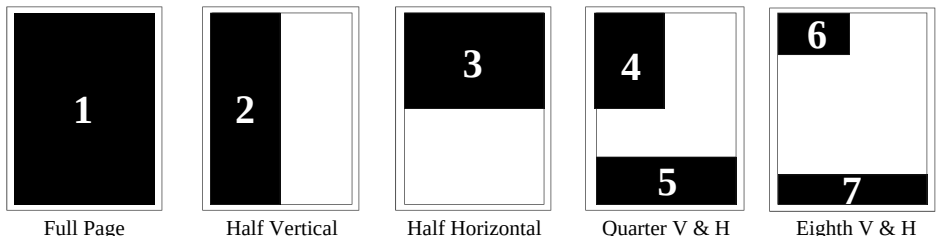

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