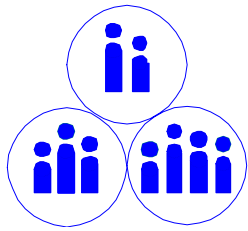


Iowa Federation of Families for Children's Mental Health

Children's Mental Health News February 4, 2005

This is a letter we got from the National Federation of Families for Children's Mental Health



The Federation of Families FOR Children's Mental Health

Lori Reynolds,
Executive Director
Iowa Federation of Families for Children's Mental Health
106 South Booth
Anamosa, Iowa 52205

Lori,

Congratulations Iowa Federation of Families for Children's Mental Health for all you successes this past year! The national Federation of Families office is always excited about what our statewide organizations are doing in their states to help improve the lives of children with serious emotional, mental and behavioral challenges and their families. Your network of volunteers is providing great family-to-family support to family members in the state of Iowa.

We at the national level know how important it is not only to support families, but to train and provide a wealth of information to them as they advocate to get the services they need for their children and to ensure that these children are safe and successful in their home, school and community.

Keep up the good work!

Sandra A. Spencer,

Executive Director
Federation of Families for
Children's Mental Health

Iowa Federation of Families for Children's Mental Health is the statewide family advocacy organization that assists families who have children and youth with mental health issues. Our mission is to ensure all these children and families receive coordinated, individualized, strength-based care and supports. We provide families across the state of Iowa with written informational materials, Information and Referral services, many different types of trainings, and legislative advocacy. Most of all, we offer families a non-judgmental support system. Families, professionals and others may access our services by calling our toll-free number (888) 400-6302, or visiting our website at www.iffcmh.org.

Iowa Federation of Families for Children's Mental Health is doing a brief e-mail survey. Please e-mail us your response to the following questions: E-mail to help@iffcmh.org

Do you find this newsletter useful? Yes No Sometimes

Do you share this newsletter with others? Yes No Sometimes

If yes approximately how many persons do you share it with?

Are there any topics of particular interest you would like information on?

Are you a Parent, Professional or Both?

What county do you live in?

Thanks so much for responding.

Police Pocket Guide: Responding to Youths with Mental Health Needs

From the Parent/Professional Advocacy League

(PAL--the Massachusetts statewide organization of the Federation of Families for Children's Mental Health:

Download and save at:

http://www.ppal.net/downloads/PPG_6-10-2002.doc

The Campaign for Mental Health Reform <http://www.mhreform.org/>

has been organized as the mental health community's united voice on federal policy. Its goal is to make access, recovery, and quality in mental health services the hallmarks of our nation's mental health system.

Campaign for Mental Health Reform: American Psychiatric Association; American Psychological Association; CHADD - Children and Adults with Attention-Deficit/Hyperactivity Disorder; Consumer Organizing and Networking Technical Assistance Center (CONTAC); Depression and Bipolar Support Alliance (DBSA); Federation of Families for Children's Mental Health (FFCMH); International Association of Psychosocial Rehabilitation Services (IAPRS); Judge David L. Bazelon Center for Mental Health Law; National Alliance for the Mentally Ill (NAMI); National Association of County Behavioral Health Directors (NACBHD); National Association of State Mental Health Program Directors (NASMHPD); National Council for Community Behavioral Healthcare (NCCBH); National Empowerment Center (NEC); National Mental Health Association (NMHA); National Mental Health Consumers' Self-Help Clearinghouse; Suicide Prevention Action Network USA (SPANUSA). For more information, visit the Campaign for Mental Health Reform's website at <http://www.mhreform.org/>

Mark your Calendars
Monday June 6th, 2005
The Explosive Child Conference

University Park Holiday Inn -

Soon to be a Sheraton

West Des Moines, Iowa

To download the brochure go to www.iffcmh.org

Go to calendar of events.

Click on Explosive Child Conference.

You will need Adobe Acrobat to open this

6 credit hour Foster Parent CEU's are also available for this conference

The President's New Freedom Commission
Report *Achieving the Promise: Transforming Mental Health in America* identifies 6 goals:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

Implementing the vision expressed by these goals has become the major responsibility of the Substance Abuse and Mental Health Services Administration (SAMHSA), and all SAMHSA work must relate to these goals.

To align our work most effectively, we need to understand the new language being used. In particular, **what does “family driven” really mean? How will we know when it is being practiced?** The Federation of Families for Children's Mental Health has been tasked with developing a working definition of “family driven.” This work is being led by Trina Osher and David Osher, who facilitated an expert panel meeting during the June Training Institutes in San Francisco. The panel was composed of family members, youth, providers, and administrators from system of care communities. In this article, we report on the status of this work, and invite your response and comment.

Definition of Family-Driven Care

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- ✓ choosing supports, services, and providers;
- ✓ setting goals;
- ✓ designing and implementing programs;
- ✓ monitoring outcomes; and
- ✓ determining the effectiveness of all efforts to promote the mental health of children and youth.

Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable, and complete information necessary to make choices for improved planning for individual children and their families.
2. Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
3. Families and youth embrace the concept of sharing decision-making and responsibility for outcomes with providers.
4. Providers embrace the concept of sharing decision-making authority and responsibility for outcomes with families and youth.
5. Providers take the initiative to change practice from provider-driven to family-driven.
6. Administrators allocate staff, training, and support resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
7. Families and family-run organizations engage in peer support activities to reduce isolation and strengthen the family voice.
8. Community attitude change efforts focus on removing barriers created by stigma.
9. Communities embrace and value the diverse cultures of their children, youth, and families.
10. Everyone who connects with children, youth, and families continually advance their cultural and linguistic responsiveness as the population served changes.

Characteristics of Family-Driven Care

1. Family and youth experiences, their visions and goals, their perceptions of strengths and needs, and their guidance about what will make them comfortable steer decision making about all aspects of service and system design, operation, and evaluation.
2. Family-run organizations receive resources and funds to support and sustain the infrastructure that is essential to insure an independent family voice in their communities, states, tribes, territories, and the nation.
3. Meetings and service provision happen in culturally and linguistically competent environments where family and youth voices are heard and valued, everyone is respected and trusted, and it is safe for everyone to speak honestly.
4. Administrators and staff actively demonstrate their partnerships with all families and youth by sharing power, resources, authority, and control with them.
5. Families and youth have access to useful, usable, and understandable information and data, as well as sound professional expertise so they have good information to make decisions.
6. All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

Definición de cuidado manejado por familias

Ser manejado por la familia significa que las familias tienen un desempeño principal en hacer decisiones acerca del cuidado que reciben sus hijos, y acerca de las políticas y procedimientos que gobiernan el cuidado de todos los niños en la comunidad, estado, tribu, territorio, y país. Esto incluye:

- ✓ Elegir apoyos, servicios, y proveedores;
- ✓ Establecer metas;
- ✓ Diseñar e implementar programas;
- ✓ Seguir resultados; y
- ✓ Determinar la efectividad de los esfuerzos para promover la salud mental de los niños y jóvenes.

Los Principios de Cuidado manejado Por Familias

11. Las familias y jóvenes reciben información certera, comprensible, y completa para poder elegir entre las opciones para planificación mejorada para los niños individuales y sus familias.
12. Las familias y jóvenes son organizados para poder colectivamente usar sus conocimientos y habilidades como un esfuerzo para transformación de los sistemas.
13. Familias y jóvenes adoptan el concepto de compartir el tomar de decisiones y la responsabilidad para resultados con los proveedores.
14. Los proveedores adoptan el concepto de compartir el tomar de decisiones y la responsabilidad para resultados con las familias y jóvenes.
15. Los Proveedores toman la iniciativa para cambiar la práctica desde manejo por los proveedores hacia el manejo por las familias.
16. Los administradores destinan personal, entrenamiento, y recursos de apoyo para hacer que las prácticas manejadas por las familias funcionen hasta el punto donde los servicios y apoyos son entregados a los niños, jóvenes, y familias.
17. Las familias y las organizaciones dirigidas por las familias entablan en actividades de apoyo para reducir el aislamiento y reforzar la voz familiar.
18. Esfuerzos para cambiar actitudes en la comunidad se enfocan en remover barreras creadas por estigma.
19. Todos que conectan con niños, jóvenes, y familias continuamente avanzan su receptividad cultural y lingüística mientras la población servida cambia..

Características de cuidado manejado por familias

7. Las experiencias de las familias y jóvenes, sus visiones y metas, sus percepciones de fuerzas y necesidades, y sus consejos acerca de que los haría sentir cómodos manejan las decisiones sobre todos los aspectos de servicio y diseño de servicios, operaron, e evaluación.
8. Organizaciones manejadas por familias reciben recursos y fondos para apoyar y sostener la infraestructura necesaria para asegurar una voz familiar independiente en sus comunidades, estados, tribus, territorios, y el país.
9. Reuniones y provisión de servicios ocurren en ambientes culturalmente y lingüísticamente competentes donde las voces de las familias y los jóvenes son escuchadas y valuadas, todos son respetados y confiados, y es ileso para que todos puedan hablar honestamente.
10. Administradores y personal activamente demuestran sus asociaciones con todas las

familias y jóvenes en compartir el poder, los recursos, autoridad, y control con ellos.

11. Las familias y los jóvenes tienen acceso a datos e información útil, usable, y comprensible, además de habilidad profesional para que tengan buena información para tomar decisiones.

12. Todos los niños, jóvenes, y familias tienen voz biológica, adoptiva, acogida, o sucedánea abogando por ellos.

Animas su comentario. Por favor mándelos a tosher@ffcmh.org.

Nobody who has not been in the interior of a family can say what the difficulties of any individual of that family may be. Jane Austen

New Report on Children's Emotional Development

The National Scientific Council on the Developing Child recently released a new report entitled **Children's Emotional Development is Built into the Architecture of their Brain**. This paper spotlights the relation between children's brain architecture and their emotional development, and addresses the science-policy gap. The 12-page document is available to download at <http://www.developingchild.net/papers/workingpaper11.pdf>.

Challenging the Stigma of Bipolar Disorder

by Lisa Rhodes

"A bipolar young person can achieve anything he or she wants to achieve."

- Lizzie Simon

When Lizzie Simon was diagnosed with bipolar disorder nine years ago at age 17, she kept her condition a secret because she worried her peers and adults would think the worst of her. "I thought people would be afraid of me," says Simon, now 26, in a recent telephone interview from her home in Brooklyn. "I thought people would see me as 'crazy,' 'unstable,' and 'unreliable.'" Since then, however, Simon has dared to break the silence surrounding her diagnosis, and show that young people with bipolar disorder can be productive, creative, and successful. *Detour: My Bipolar Trip in 4-D* (Atria Books), a memoir released in June, tells Simon's story of her diagnosis and her mission to find other young people leading successful lives with the disorder and tell their stories as well. The book has made Simon a voice for a significant, yet quiet, population.

Diagnosis—and Label

The Child and Adolescent Bipolar Foundation conservatively estimates that 750,000 children and adolescents have bipolar disorder. The disorder used to be commonly referred to as manic depression. According to the National Institutes of Mental Health (NIMH), the illness is a brain disorder that causes dramatic shifts in a person's mood, energy and their ability to function. The shifts in mood can range from intense "high" periods, also called "mania," to intense dark periods of sadness or depression.

The NIMH reports that bipolar disorder typically develops in late adolescence or early adulthood, while the first symptoms can occur in childhood. It is a long-term illness, but it can be treated with medications and psychotherapy. "Mental illness carries one of the biggest stigmas," says Dr. Adelaide Robb, assistant professor of psychiatry at Children's National Medical Center, who runs the hospital's inpatient adolescent psychiatry unit for youth age 12 to 18.

High Achiever

"A bipolar diagnosis is not a death sentence," says Simon, noting that when young people make a commitment to proper treatment and receive support from their families, they can lead productive lives. "A bipolar young person can achieve anything he or she wants to achieve."

In addition to writing her memoir, Simon recently served as a field producer and consultant for “True Life: I’m Bipolar,” a documentary that aired in July on MTV. As she did for Detour, Simon found young adults with the disorder for the documentary and interviewed them. “It helped to give a visual representation of what people with mental illness look like,” she says. “They’re not freaks in a mental institution, but people sitting next to you in your classroom.”

Simon was diagnosed during her senior year in high school in Paris 1993. After a serious bout of consistent sobbing, sleep deprivation, and fatigue, Simon went to a therapist who prescribed Paxil, an anti-depressant. But several days later, Simon became psychotic, believing she was a cat and a target of the CIA. A psychiatrist determined the psychosis was a toxic reaction to Paxil—a drug that can induce mania in bipolar patients. Simon was given a prescription for lithium—a mood-stabilizing drug—and has been on the medication ever since.

Simon was then able to complete college, land a job at Flea, and rent an apartment in Brooklyn. “I started settling into a normal life,” she says. “Rebuilding my self-confidence.”

In 1999, Simon saw a poster in the subway, showing a woman dressed in a business suit with the slogan “For People With Mental Illness, Treatment is Working,” written across her chest. The image inspired Simon, then 23, to come up with the idea of traveling across the country to interview other bipolar adults who “survive the illness and live full lives.”

Simon financed her idea with \$5,000 in savings and a \$5,000 grant from the Federation of Families for Children’s Mental Health, a national parent-run organization that advocates for children and youth with mental illness. Barbara Huff, executive director of the Federation, helped fund Simon’s project through a grant from the Substance Abuse Mental Health Services Administration. Simon was required to investigate the effects of substance abuse on the lives of bipolar youth as part of her work.

Struggling to Find Balance

Simon quit her job at the Flea Theatre and spent six weeks traveling to seven different cities to find her subjects. Simon interviewed a diverse group of six young adults, all under the age of 30, who manage their mental illness after years of personal turmoil. Simon discovered that many bipolar young people struggle to find the right mix of medications and when they do, must make a conscious effort to remain in treatment. Most also rely on the support of their families and tell few others of their condition—the stigma is too costly.

Matt, in his early 20’s, was diagnosed during his sophomore year in college and spent about three years trying to find the right mix of medications. He also underwent several electric shock treatments. Now that he’s taking a psychotropic drug and two anti-depressants, Matt is able to work full-time at a bookstore. He credits his family for “keeping me moving.”

Jan, a radio dj, was diagnosed in her late 20’s, and struggled with an eating disorder and drug addiction. Jan’s medications require her to have frequent medical check-ups, but she knows she can’t forsake treatment. “...Treatment allows you to be who it is you are and who it is you want to be without repercussions,” Jan tells Simon. Jan is currently raising two children.

Rachel, a young Korean woman diagnosed in high school, went on a credit card spree during her mania. Now stable on medication and in therapy, she says her family’s support is what inspires her to go on to college. But none of her peers know about her illness. “If the girls in my school ever found out about my being manic depressive, I’d be out,” says Rachel. “They’d make my life hell.”

Simon says since the publication of Detour, she receives about 20 e-mails a day from mentally ill youths and their families. “The kids worry about stigma, about getting sick again, and about stability and whether or not they will be able to have a regular life,” says Simon. Simon is careful not to give medical advice, and instead refers people to her website—www.lizziesimon.com—where she provides answers to a list of frequently asked questions about bipolar disorder and links to mental health organizations that provide information, support, and advocacy.

“This is a very serious disorder that can disrupt their lives,” says Dr. Mani Pavuluri, director of the Pediatric Mood Disorders Clinic at the University of Illinois at Chicago where she provides counseling and medication management for youths age three to 21.

Pavuluri says young people may resist treatment due to the side effects of some medications—tremors, weight gain, and decreased energy. “They don’t want to face others because they don’t want people to notice the side effects,” says Pavuluri. Yet young people are also frightened by the psychotic episodes and mood swings that occur if they don’t take proper care of themselves. Dr. Robb says that for adolescents and young adults, it is “socially acceptable” to have a drug or alcohol problem, but not a mental health disorder. Robb says that’s one reason many young people with bipolar disorder use drugs and alcohol to mask their illness. “People don’t understand it (mental illness) and they’re afraid of it,” says Robb.

Robb and Pavuluri say most young people keep their diagnosis to themselves. “They’re afraid they’ll be called nuts... They want to be cool,” Pavuluri explains. “They want to be normal.” The doctors say that to fight the stigma of bipolar disorder, particularly among young people, the media must do more to create a positive image of health and normalcy for the mentally ill. “Famous people with bipolar disorder have to come out and talk about it,” says Robb.

Robb says Simon’s MTV show on bipolar disorder was “excellent,” and should be followed by other youth-oriented programs on mental health. Says Pavuluri, “we have to create empathy and show the mentally ill as real people.”

Simon is trying to do just that. Simon and her father are working to develop a scholarship fund to support the work of young writers with mental illness. She is also touring the country to promote her book and gives lectures on mental health issues.

At a recent lecture at the University of Pennsylvania, Simon says the students showed an interest in learning more. “Many of them know that the onset of bipolar disorder can occur in the college years and they worry about friends who may have it,” says Simon. “They were open to my message—get diagnosed, commit yourself to treatment and pursue what you are passionate about so you can have the life you want to have. You are not your diagnosis.”

Resources:

Visit Connect for Kids' [children's mental health](#) topic page
[Federation of Families for Children's Mental Health](#)
[Child & Adolescent Bipolar Foundation](#)
[National Alliance for the Mentally Ill](#)

“If the girls in my school ever found out about my being manic depressive, I’d be out,” says Rachel.
“They’d make my life hell.”

Lisa R. Rhodes is a freelance writer living in Maryland. She is a member of the National Alliance for the Mentally Ill.

WRAP, Peer Support and Recovery: Tools for System Change

By Shery Mead, MSW, and Mary Ellen Copeland, MS, MA

Ms. Mead consults nationally on the development of peer run initiatives and resides in New Hampshire. Ms. Copeland is a mental health educator and is the author of Wellness Recovery Action Plan and other mental health resources.

Not too many years ago, I was Mary Ellen Copeland, manic depressive. Because I had this label my family was told not to expect much of me. I learned not to expect much of myself. I became dependent on the mental health system to maintain, at best, a minimal life style. I avoided thinking about the future; the present was bad enough. I saw myself through a mental health system lens that was confining and oppressive. Now I see myself through a different lens, a lens that is Mary Ellen Copeland, educator, author, mother, wife, woman.

- Mary Ellen Copeland

Even in these days, when recovery, peer support and Wellness Recovery Action Planning (WRAP) are buzz words throughout the mental health system, it is not uncommon in many mental health environments, including peer support, to hear people describe themselves as their label and to see themselves through a 'mental illness' lens.

In the past, this label and this lens has meant life-long professional care while expecting periodic

episodes of difficult times. Now, in the era of recovery we have come to expect that people with a label can learn coping skills and can learn to manage their 'symptoms,' if they are medication compliant. They may even be employed and play some role in the larger community. But when will they become people instead of their label? And when will it be commonly accepted that people who, from time to time, have troubling feelings, thoughts, behaviors, and experiences (this might include everyone), can also have control over their own lives, do the things they want to do, and be the way they want to be?

Recovery in mental health is an exciting concept. Even more exciting is the concept of life change and transformation, not returning to a former way of being, but going forward to create a new, exciting, and rewarding life. The service delivery system can inhibit the process if it continues to see people through the 'mental patient lens.' But it can support and enhance this process if it is willing to see people through this new lens.

The 'mental patient lens' is the one many of us (who have labels of mental illness) have learned to look through every time we are uncomfortable, have intense feelings or experiences, or difficult relationships. It is a lens that reminds us that our feelings and thoughts are different than other peoples' and that we must take care. We must avoid stress, risk-taking, and challenges, assume others know better than we do, and that there is a medication for everything. Recovery without understanding this lens still only means 'symptom' management and becoming more 'functional' rather than true recovery and transformation.

'Sarah,' a member of a peer program, has been in the system for many years. She lives on Supplemental Security Income (SSI) income and her housing is contingent on her disability. Sarah is hearing her friends and even the clinical staff talking about recovery & What does that mean? She starts talking to others who say they've gotten jobs and gotten their high school equivalency or gone on to college. Her case manager has changed her title to recovery counselor and says that instead of doing a treatment plan they will do a recovery plan. Sarah is going to the peer center more often. But she is beginning to feel uncomfortable. If she 'recovers,' where will she live? What if her benefits are taken away? Can she really support herself? One day there is some conflict at the center and she starts feeling a bit overwhelmed. Sarah decides she should call her case manager.

Sarah tells her case manager that her symptoms are really bad. Her case manager asks her if she's taken her medication and asks if she's safe. Sarah responds by saying that she's taken her medication but it doesn't seem to be working and she is not feeling safe & we know the end of the story.

How could a different response have changed the outcome? What if the case manager said, 'Help me understand what it means for you when you say my symptoms are really bad,' or, 'What's going on at the peer center,' and, 'Maybe that's a pretty normal reaction to conflict' Or even, 'So what will you do to feel more comfortable?' Responses such as these could lead to potentially very different conversations and ultimately to much less dire outcomes.

Some of the current thinking in peer support and Wellness Recovery Action Planning has much to teach us about 'unlearning the mental patient role.' These forums and environments can openly address roles, relationships, assumptions and worldview. New approaches are teaching people to challenge each other when they become aware of stuck roles and relational dynamics. Instead of responding from an assumption of "I'm fragile or sick," more and more people are helping each other think differently about their experiences.

Now let's look at another path for Sarah:

Sarah decides to join a group of peers who are working together developing Wellness Recovery Action Plans. She takes a close look at all the resources and strengths she has: her love of hiking, her interest in photography, her ability to write compelling short stories and to keep things well organized. She uses things like this, including other ideas from members of the group, to build her own Wellness toolbox.

She works with them to develop a list of things she can do every day to stay as well as possible.

She thinks about things that are upsetting to her and develops a plan of simple safe things she can do to help herself feel better (things from her Wellness Toolbox) when upsetting things happen. She works with others as they all develop lists of signs that they are not feeling so well--signs they formerly ignored. Then, she uses her Wellness Toolbox to develop a list of things she could do to help herself feel better when she is not feeling so well. Next the group discusses those times when you are feeling really bad, very anxious and upset, hearing voices, wanting to abuse substances, thinking about self harm. Sarah says that in the past, when she felt this bad, she would call the crisis line and get herself admitted to the hospital. But others encouraged her to look at her Wellness Toolbox and see if there were some things there she could do instead. She decided that if she spent some time talking to a peer, wrote in her journal about how she was feeling, spent some time diverting her attention with a project, or took her dog for a long walk, she could probably get through this hard time.

The group even worked through the process of developing Advanced Directives that included lists of when people want others to assist them, who they would want to do it, what they want them to do, and what others can do to help. She developed, with the support of her peers, a plan so she could stay at home or in the community, even when she was feeling very bad.

As Sarah began using this, her own recovery plan as a guide to living each day, she realized that along with her plan and the support of her peers she could make choices about her life. She could take risks. She could begin to plan for living in her own apartment, going back to school, getting a job that she would enjoy and perhaps even getting into an intimate relationship. She could see herself through a new lens, the lens of a capable and competent woman.

She also realized in working with others that being 'uncomfortable' and having difficult feelings is something she could deal with. She didn't have to call them symptoms of anything. She could be with these feelings for a time and/or use her strengths and resources to get through it.

As you can see in this example, Sara is changing her lens from mental patient to person. You may also notice another contributing factor to this 'unlearning' process: the intentional use of non-medical language. Talking, for example, about our 'experiences' and 'feelings,' instead of our 'symptoms,' as we do when we are developing a WRAP, opens us up to a different conversation in which our lived experience can be explored through multiple lenses.

Implications for Mental Health Services

The recovery movement has challenged the way we think about mental illness and even the concept of mental illness. It has helped many people begin to have hopes and dreams, something they had been discouraged from having in the past.

At its core, recovery challenges the stories that we've been told about our experiences and what they mean. It opens up the possibility of discussion about how we can work together in ways that really share power, risk, and expertise. It must be a process in which everyone moves out of old, comfortable roles and begins to talk about mutuality, boundaries, risk, and who gets to define and decide on treatment. For this to happen, everyone involved must challenge his or herself to respond in new ways.

In addition, we need to have inclusive up-front conversations about power and how we perceive power. Although it is nice to say the words 'partnership' and 'collaboration,' they are empty unless there is some talk about each of our pre-conceived notions and the reality of choice. By speaking directly about who has the power to do what, and what that means in a collaborative relationship, we can establish guidelines and strategies for handling difficult situations and working through potential conflict without coercion.

Finally, if we are to research and evaluate recovery, it is important to understand the cultural shift in mental health. We need to see beyond measuring 'how people are doing' and to see beyond getting a job or fewer hospitalizations as meaningful outcomes. Qualitative research that examines people's stories will help us look at the extent to which relationships, dynamics, and assumptions are changing, and help us to see how they need to change to support recovery and life transformation. We must all hold ourselves truly accountable to meaningful system change, leaving

behind the 'mental illness lens.' Rather, we must see people as whole human beings who can cope with adversity and determine the course of their own existence.

Source: [NASMHPD](#)

YOU ARE INVITED
Mental Health Advocacy Coalition's
Mental Health and Substance Abuse Awareness Day
State Capitol
Tuesday, February 22, 2005
8:00 a.m. - 2:00 p.m.

The Mental Health Advocacy Coalition is a coalition of organizations and individuals working to get passage of mental health parity legislation. The Coalition has held a legislative day annually to educate legislators on the need for insurance coverage for mental health services.

As you are well aware, mental health services in Iowa have faced severe cuts in the past few years and the budget outlook for 2005 still looks grim. Now more than ever, advocates must take an active role in educating legislators and government officials about the crises happening in Iowa. This is a great opportunity for advocates to talk to legislators and tell them how budget cuts are affecting persons with mental illness as well as the need for parity legislation.

This year we want to broaden the representation of mental health organizations. We will have 40 tables set up in the rotunda of the Capitol for associations, organizations and programs dealing with mental health issues to display materials.

The RAINBOW Center will host a presentation called *Voices* that throws an intimate light on the central societal issue of mental illness. This will be held from 12:15 p.m. to 1:00 p.m., also in the rotunda. This is an exciting program and hopefully will be an attraction to get legislators to the rotunda to see the displays and talk to advocates.

The Coalition will continue to make plans to promote the day to legislators and the public and you will be encouraged to help contact legislators from your area. Please call Karen Loihl if you have any questions - 515-633-0341.

Iowa Federation of Families for Children's Mental Health is a statewide family advocacy organization that assists families who have children and youth with mental health issues. Our mission is to ensure all these children and families receive coordinated, individualized, strength-based care and supports. We provide families across the state of Iowa with written informational materials, Information and Referral services, many different types of trainings, and legislative advocacy. Most of all, we offer families a non-judgmental support system. Families, professionals and others may access our services by calling our toll-free number (888) 400-6302, or visiting our website at www.iffcmh.org.

**HELP SUPPORT
IOWA FEDERATION OF FAMILIES
FOR
CHILDREN'S MENTAL HEALTH**

Yes, I would like to help children and adolescents with special mental health needs and their families. Enclosed is my gift of:

___\$25.00 ___ \$50.00___ \$75.00___ \$100.00 ___\$200.00___\$500.00___Other___Family Member
unable to pay

Name_____

Address:_____

City:_____ State:_____ Zip:_____

County of Residence_____

Optional:

Parent/Family Member _____Professional_____Both_____

E-mail:_____ Phone:_____

Please make checks payable to:

**Iowa Federation of Families for Children's Mental Health
106 South Booth Anamosa Iowa 52205**

If you would like to dedicate this gift, please specify:

In Honor of In Memory of

Thank you for your generosity.

Your gift is tax-deductible to the full-extent of the law. Iowa Federation of Families for Children's Mental Health is a not-for-profit 501(c)3 organization.