

**Iowa Federation of Families
for
Children's Mental Health**

**Children's Mental Health News
February 6, 2006**

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.

Save this Date: June 12, 2006

Dr. Ross Greene:

The Explosive Child Conference

Brochure and registration form are now available at www.iffcmh.org then go to calendar of events.

Conference Registration Fee's

Early Bird Special Single \$55 Team of 3 \$45 per Person

After March 15th Single \$65 Team of 3 \$55 per Person

CEU's Available for \$10.00

Participants attending the conference will be granted 0.6 CEUs or 6 contact hours as provided by the Des Moines Area Community College for the following:

Iowa Board Of Nursing Provider Number 22

Iowa Board of Social Work Provider #0095

Iowa Board of Behavioral Science (includes psychologists) Provider AS97-17

Also available for Foster and Adoptive Parents:

The Department of Human Services has approved this training for

6 credit hours of training Certificate will be given at the conference

Some thoughts on advocacy and why we need we need it

By: Trina Osher

Advocacy is not a dirty word. Advocacy is not dangerous or subversive. Advocacy is an honorable and essential part of community life, especially in a democracy. It is the job of advocates to keep us on our toes and to hold our feet to the fire. Human service systems and providers should never get so complacent - no matter how effective we are - that we do not welcome advice or criticism or we cease to strive to do better and reach new goals.

Dictionaries define advocacy as pleading for, supporting, or recommending; active espousal for a cause. Advocates truly are an independent voice. They are uncompromising in the quest for equity and justice and keep watch to insure that the system of care fulfills its obligations to children and families.

Advocacy is not always pretty or comfortable. Sometimes a wheel has to be squeaky in order to get the grease it needs to run smoothly. Advocacy can require speaking for causes that may not be popular. Advocacy requires taking action to get the system to respond appropriately to a child and family. Advocacy tells you what you need to hear, not necessarily what you want to hear.

The goals of advocacy for overall system change are different from those for individual child advocacy.

For individual children the goals and expectations are that all families will effectively speak for their children and work in partnership with providers to achieve desired outcomes. Child and family advocates usually are family members trained to assist other family members to find their own voice, to speak effectively for themselves and their children, and to learn how to partner with providers in making decisions. This is usually accomplished through education and training, reviewing the benefits and risks of various options, peer to peer mentoring, and individual and peer group support.

For systems the goals and expectations are that family representatives will promote policies, practices, services, and supports that benefit all or most of the families in the community and specifically the children and families who are the focus of the grant program. Family representatives (like the second and third string of a basketball team), therefore, must be present in sufficient numbers to have a powerful voice, to represent the diversity of families in the community, and to be present at all the different decision making tables without burning people out. The job of family representatives is to hold the system of care accountable for

compliance and established policy and achieving better outcomes. Family representatives accomplish this by tracking and evaluating the performance of programs, agencies, and systems by educating the public about the mental health needs of children and families, by identifying what needs to be improved, by publicizing the accomplishments of good practice, and by specifying what should be done to sustain effective programs and services.

There are tensions inherent in advocacy work. Family advocates must not be constrained by the limitations of any of the existing providers and agencies in the system. Family advocates have experienced retaliation from criticized entities or individuals. Sometimes advocates have to be slightly irritating to achieve their goals - like the grain of sand that gets the oyster to produce a pearl. Mindful of their responsibility, effective advocates arm themselves with accurate information and conduct themselves with dignity and with respect, both for their allies and their opponents.

Dare to Dream

Find out what youth and families really want at home, in school, in the community and in service systems go to www.iffcmh.org then go to Dare to Dream. This is a powerful document please share it with others.

When young kids are depressed

Thirty years ago mental health experts thought it was impossible. Five years ago there was no proof.

Preschoolers with major depression?

Children 3, 4 or 5 years old so sad they think of killing themselves?

It can't be, psychiatrists theorized. The brains, egos and self-concepts of children that young, they thought, were not developed enough for major psychiatric disorders to take hold.

Well, tell that to physician Sharon Cain, director of child psychiatry at the University of Kansas Medical Center, where, she said, "we have had young kids who have thought about hurting themselves, who wish they were dead."

"We've had young kids, around 5 or 6, say, 'I want to run out in front of a school bus or in front of a truck.'"

Tell it to psychiatrist Dr. Joan Luby of the Washington University School of Medicine in St. Louis whose decade-long research on scores of children from ages 3 to 5 is redefining when depressive illness begins.

"I think there is social resistance to the belief that preschool kids can have mental disorders," Dr. Luby said in a recent telephone interview.

Dr. Luby's paper on "Preschool Major Depressive Disorder," which was published in a 2002 issue of the Journal of the American Academy of Child and Adolescent Psychiatry, is among the first major studies to identify depression in kids younger than 6.

"Depression, in particular, is a hard one to swallow," Dr. Luby said. "We don't want to believe it's true because the idea of it is inherently disturbing."

Yet at a handful of childhood research centers across the country - in Boston, Chicago, New Orleans, Washington, St. Louis and Durham, N.C. - mental health experts are now looking at the minds of preschoolers with fresh eyes.

More than finding depression, they are finding preschoolers with other psychiatric disorders, including post-traumatic stress disorder, behavioral disorders in which children severely injure other children, bipolar disorder (also known as manic-depression) and anxiety disorders such as OCD, or obsessive-compulsive disorder.

"We want to think of childhood and particularly infancy as a blissful, carefree time. We have the Gerber Baby as our image," said pediatric psychiatrist Dr. Charles Zeanah, director of the Institute for Infant and Early Childhood Mental Health at Tulane University in New Orleans.

"It is very discomfoting thinking of children as having psychiatric problems early on. We don't want to think about it. So we don't."

To be sure, the topic of kids and psychiatric illness has always been controversial.

Earlier this month advisers to the federal Food and Drug Administration, concerned that some of the nation's best-known anti-depressants may increase children's thoughts of suicide, recommended that the drugs (in a class known as SSRIs, or selective serotonin re-uptake inhibitors) carry the nation's strongest warning, a black box on the packaging warning of the possible suicide link. Only one anti-depressant, Prozac, has been approved by the FDA for use in children.

Experts agree that the earlier kids are identified as having depression or other psychiatric illnesses, the more the debate over kids and drugs is likely to intensify.

Last resort

In February 2000 University of Maryland pharmacy professor Julie Magno Zito stirred a national debate after she estimated, in a study published in *The New England Journal of Medicine*, that 150,000 preschoolers (10 percent of them 2-year-olds) were on psychotropic drugs in 1995, up from 100,000 only four years before.

Since then the numbers have been on the rise. Close to 11 million prescriptions for anti-depressants are written each year for children under age 17, according to testimony before the FDA advisory committee. Researchers say that although they know some preschoolers already are being treated with anti-depressants and other drugs, it should never be the first-line treatment.

"For me, I consider medication with very young children a last resort," said child psychiatrist and epidemiologist Helen Egger. At Duke University she's conducting studies on the rate of depression among preschoolers.

At least one large study on the effects of Ritalin on preschool children is being conducted at Columbia University in New York City. Ms. Egger said that other than that one study, whose results have yet to be published, "we have no empirical evidence - none - on the use of psychotropic medications on preschoolers."

"You certainly would never put a kid on meds and say, 'I'll see you in three weeks.'"

The question of how to best treat preschoolers with depression is just one among many.

Currently the therapy involves intense counseling, not just for the child, but also for the family. Sometimes medication also is used, but reluctantly.

Many questions

"The hope is that we can catch them early so we don't need medications," said psychologist Lisa Hale, director of KU's new anxiety research and treatment program.

At this point, said Dr. Luby, researchers have far more questions about depression in preschoolers than they do answers.

Researchers suspect depression in preschoolers is likely biological and environmental. Some kids, they suspect, may be born with a genetic predisposition to depression, just as some children are born with autism, or Asperger's syndrome or attention deficit/hyperactivity disorder.

But they really don't know.

Nor do they know what triggers the depression - in other words, the role of environment.

Whereas some depressed kids clearly come from parents who are depressed or have other psychiatric disorders, said Dr. Zeanah, other depressed children have been abused or neglected, sometimes from infancy.

The unknown

But not all abused kids end up with depression. Nor do all the children of parents suffering depression end up depressed. Some preschoolers, Dr. Zeanah said, seem to be depressed for no apparent genetic or environmental reason.

What is certain?

"We know how to recognize them," Dr. Luby said. "I think we do."

That's because, in many cases, the symptoms of depression in preschoolers is fairly obvious, Dr. Luby said.

Years ago researchers thought that depression in even older children was a "masked" disease. Instead of showing symptoms of deep melancholy, depressed kids might, for example, become extremely aggressive or complain of stomach aches or headaches.

Occasionally, that is still true. Even now parents rarely take their children in for a psychiatric evaluation because they think they are depressed. Typically, parents call for an evaluation because their child has displayed some extreme aggression, hitting, biting or scratching in preschool or at home that seems uncontrollable or unexplainable.

But more often depressed preschoolers truly look and act depressed, researchers said.

The word they use is "adhedonia," meaning utter joylessness in life. Their faces are sad. Their movements are sad. They play but extract no fun from their activities.

Violence in play

Diagnosing depression in preschoolers can be an intense process. It involves interviews with the child, parent and day-care providers. A long questionnaire is used. Therapists should always observe the child at play.

"In play, depressed preschoolers will sometimes have more death scenes, even suicide scenes," said Ms. Egger.

To be sure, violence in play is not unusual among kids. But among depressed kids, the violence is often intense and repeated.

A particularly controversial area of child depression involves childhood "accidents." Some question whether some of the children who seem to fall from roofs accidentally or walk into traffic or hurt themselves in other various ways are doing so unconsciously because they are laden with painful depression. Unable to express themselves, and unable to make the pain stop, they try to hurt themselves instead.

As more and more psychiatric disorders are uncovered in preschoolers, Dr. Luby said, the lesson for parents simply is to be aware.

"There is resistance and reluctance to think of children as having very serious psychiatric problems," Dr. Zeanah said. "One fear is that we will pathologize childhood and scare parents to death.

"The point is not to scare parents, but only to have them recognize that, in fact, young children can have problems. If they do, there are places they can go and people they can see."

Knight Ridder News

Check out the resources and links at www.iffcmh.org and go to library of information and to links and resources. Please share this information with others.

HOT OFF THE PRESS!

HRSA Releases Landmark National Child Health Chartbook

A new HRSA publication, "The Health and Well-Being of Children: A Portrait of States and the Nation 2005," indicates that, in general, U.S. children are in good health and grow up in healthy environments. It also points to a need to improve access to health care for children from low-income families, those with no health insurance, and children with special health care needs.

This landmark report provides an overview of broad health characteristics for children, bringing together first-ever available national and state-level data from the National Survey of Children's Health. Parents of 102,353 children ages 0-17 participated in the 2003-04 survey, supported by HRSA's Maternal and Child Health Bureau and conducted by CDC's National Center for Health Statistics. The report includes information for each state, easy-to-follow bar graphs as well as breakdown analyses by ethnic and racial group.

To view or download the report, go to: <http://www.nschdata.org/DesktopDefault.aspx> to visit the Data Resource Center for the National Survey of Children's Health and click on the chartbook icon. The Data Resource Center features an easy-to-use interactive data query that allows users to search, view and compare NSCH results at state, regional and national levels, stratified by selected demographic characteristics including age, race, household income, insurance type, and special health care needs status.

I CAN, IF YOU THINK I CAN

**You asked me can I do it? Well, don't you
understand?
You're the one to answer because I can if YOU
think I can.
I have the courage and the skill, but these alone
won't do.
I must be sure that you believe I can do what
you ask me to.
So, whether or not I reach my goals, in your
hand I place the key.
Before I can ever reach the heights, I must know
YOU believe in me.**

-Ivan Fitzwater

Surviving the System

By A. Nelson

My name is Angela Nelson, and this is the story of my survival. I grew up in the child welfare system in Illinois, spending most of eleven years in psychiatric institutions and group homes. I can honestly say that the system did not help me recover from any of the problems I came in with; in fact, it created additional difficulty. The system focused on controlling my behavior with little regard to the issues that brought me into the system in the first place. In particular, I received very little education and there was no effort to keep my family unit together. Despite the lack of regard for my future, I still maintained hope and I am living independently today. I know reaching my goals will be difficult, especially since there are few resources and little support available to me now.

My mother had me the month after her 14th birthday. My father was 19. My mother's father told her to have an abortion, but she decided that she wanted to keep me, and ran away to Memphis to live with her mother. My mother left me with my grandmother until I turned six. My mother had turned 20, and decided that she could take care of a child. She fought for custody, and I came back to Chicago to live with her and my stepfather. About seven months after I came to live with her, my stepfather left. Although I didn't know it at the time, they had had an arrangement to suit both of their needs. She needed to show she had a stable home and he needed to obtain citizenship.

After my stepfather left, things went downhill rapidly. I went from one relative's home to another and occasionally I lived with my mother. When I lived with her, she beat me and left me at home by myself. There were times when I told the public defender that I didn't want to be at home with my mother because she was beating me. He said he couldn't just take a child away from her home because she didn't want to be there. But I kept telling him it was because she was beating me. I definitely had been involved with the system before I came into the system. But the system kept sending me back to her.

At the age of ten, almost eleven, things seemed somewhat normal. Then my uncle came to live with us. He started sexually abusing me and I told my teachers about it.

He was removed from my house. The system didn't offer us any support. About a month later, my mother asked me to clean my uncle's room. I turned over the mattress and I saw a Playboy magazine and some matches. I lit the matches and put them on the bed. I went into the system after I set my house on fire. I never understood why I set my house on fire until years later, when I realized my mother probably would have eventually killed me if I had stayed at home. I think deep down inside, I realized that was my way out.

Little did I know that once I came into the system my problems had not even begun. Coming into the system with a label such as a fire setter sometimes prevents people from seeing who you really are. They really can't see past that label. I really think I was a decent kid and years later, my mother said I was a pretty good kid. Damn right—I was a good kid.

I got into the system and the first place I landed was a psychiatric institution. I spent 11 months there. From the medication to the seclusion to the restraints, how was I supposed to adjust? I was surrounded by people I didn't know: nurses, doctors, psychiatrists, and other children who also had behavior problems. It was an unrealistic

adjustment I was supposed to make. Needless to say, I didn't do too well adapting. Of course, more labels followed. I rarely saw anybody from my family. I saw my mother once or twice. My teachers came to visit me once. My grandparents came to see me once. I saw none of my cousins, aunts, or uncles. To this day, I just cannot comprehend how I survived my world being flipped upside down like that. But of course since I didn't handle it well, I was the one who suffered.

I got out of the first institution and I went to a group home. More strangers. I stayed there for three months. I believe I had so many unresolved issues that, before I could be anywhere successfully, the issues that brought me into the system would have to be addressed outside of a pill bottle. But that's clearly not what my treatment plan was. Therefore, since I desperately needed to be in control of my own existence, we battled. And they always won because they had the ability to give me shots, pills, restraints, and seclusions anytime I resisted, questioned, or disobeyed their nonsense.

After leaving the group home, I went back to the hospital for three months. That was just more of the same old nonsense of them controlling my existence. I left there and went to another group home for three weeks. Still, nothing had been resolved and I was 13 at this time. The issues that got me into the system were no longer the issues at hand. I was faced with a whole new set of issues. The system wanted to control me, and I resisted.

I left the group home and I went back to the hospital. My father's mother tried to get custody of me. Needless to say, she was not a winner. Let's just put it like this—it wasn't a good match. But at least I wasn't in the hospital. One day I got into a fight at school. The school called my grandmother, but she was not at home. Since she was not at home, they called my social worker. She came to the school with another social worker. On the way to my grandmother's house, I told her that I wanted to get out of the car because I could go home by myself. She disagreed, and we fought. This fight with my caseworker at 14 years of age landed me a 4-year stay in a state hospital. Needless to say, the restraints and the seclusion and the medication that I experienced earlier in life do not compare to the seven days in restraints and another three days in restraints and the endless amount of medication and the countless hours in seclusion. If I could do it all over again, I would have stayed at my mother's house and let her continue to beat me and let my uncle continue to sexually abuse me. By the time I got out of this institution, I can assure you if I didn't have mental health issues before I went in, I had them now.

When I was discharged from the hospital, I went to a group home in Denver. Of course, that didn't last very long. I returned to Chicago to the adult hospital. We all know that's a different ball game. I was thrown right into the mix of people there, many with serious mental illness. Thank goodness I had found a psychiatrist who was actually willing to listen to me. When I told him I didn't need medication, he said OK. He told me that if a staff member asked me to go to my room and I didn't get out of control, they wouldn't put me on medication. I haven't taken a pill since. Of course, since I had such a stellar record, programs in Chicago weren't exactly eager to take me. So I spent six months in the adult psychiatric institution. Not because I needed to but because I had no place to go.

Once the Department of Children and Family Services did find a place for me, they expected me to live alone and to basically take care of myself. Thank goodness for me there actually wasn't too much wrong with me. I have always thought I got caught up in the system. I got labeled because of my behavior, and I never had a chance after that. Unfortunately for me, I was just as uneducated when I came out of the system as I was when I went in. So I didn't have many skills or any money. I ended up on social security, yet again a financial burden to the system.

In all of this, I did come out with a wonderful gift for the arts. I was able to recognize an opportunity when I saw one. I was walking down the street one day and I saw a sign that stated, "Do you want to learn how to make tiles for free?" Being interested in the arts and not having money for materials, this was an opportunity to be creative at somebody else's expense. It was a great success. It gave me hope that I actually could do something meaningful with my life. Today I feel much better about studying for the GED because I have succeeded in something in another part of my life. I am good at art and it gives me a good sense of myself. Although there have been a lot of ups and downs in my life, I knew I could shape my own world and I have done so with the help of my creativity. I have been able to supplement my Social Security money with the sales of my artwork. Of course, making a living that way is hard, so I have been working toward my GED so that I will have more employment options. I failed the GED three times, but I am hoping to pass it this June. I am also working on a book that I plan to finish this year.

I would like to close by saying this: if people in the system could have looked to the future and could have seen both me and my mother as productive members of society, they could have given my mother some parenting classes, helped her get some kind of skill or trade, and helped to educate me. We could be productive members of this society. Instead, she's on Social Security and she receives food stamps. I, too, am on Social Security and I receive food stamps. We are both still uneducated.

The system has to meet real needs in order for people to truly function in this society, especially if they already have challenges. If you take a child from a mother and do nothing with the child, what is the point? If I had gotten some of the right kind of help at the beginning, much of what I suffered could have been avoided. So if you're trying to help children and families, look towards their futures to see what it is you can do to help them be successful when the system has left their lives five or ten years from now.

Angela Nelson lives in Chicago. Her artwork can be viewed at www.geocities.com/angelasceramics/tiles.

For information on bringing Angela to Iowa to speak call Lori at 319-462-2187

Building "Grass Roots " Family Networks
By Lisa Conlan

“Grassroots” has been defined by *Webster's* dictionary as “people or society at a local level” and as the foundation or fundamental source for an organization, movement, or activity. “Organize,” according to *Webster's*, means “to arrange or assemble into an orderly, structured whole” or to “manage or arrange systematically for united or harmonious action.” These dictionary definitions reflect the growing understanding of “grassroots organization” as a movement of individuals who assume leadership roles in their communities, voicing issues and working together to find solutions to community problems.

This kind of grassroots mobilization has been a key component of the Children's Mental Health System of Care efforts that have been taking place over the last two decades. These efforts have been founded on, and have held to, the principle and value that families who have children and youth with serious emotional disturbance (SED) should be fully involved in the planning, implementation and evaluation of systems of care in their communities and states. Goal Two of the *President's New Freedom Commission Report* states that mental health services will be family and consumer driven. In an ongoing struggle to make this goal a reality, families of children and youth with SED have found themselves forming grassroots family networks and strategizing ways to collaborate with local, tribal, territory, state and national leaders, providers, administrators, and policy makers. Collaboration on multiple levels and across agencies is one of the most crucial and continuous efforts required to create systems that meet the strengths and needs of their children, youth and families.

For families just starting out in their communities, supports may be available through an already established family network or grassroots movement representing families of children and youth who are at risk for or who have SED. Alternatively, a new network may need to be created. The National Federation of Families for Children's Mental Health has over 140 community and state chapter family organizations whose missions are to support, educate and advocate on behalf of children and youth with SED and their families.

One of the most important roles that a key family contact in a system of care plays is to help support the development of family leadership. Key contacts provide mechanisms and resources to help involve families at all levels of system of care and enable families to “organize” around their own strengths, needs and concerns.

Helpful steps toward building grassroots family networks

1. Recruit and reach out to diverse family members representative of children and youth with SED and who reflect the community, tribal, territory and/or state needs. This ensures a broad base of membership that respects racial, ethnic, gender or class integration.

- **Identify diverse community leaders who reflect the community population**
- **Produce and disseminate flyers, display tables and fairs, announcements, press releases**
- **Produce and disseminate information and fact sheets in multiple languages**

- **Work with the media, including television, newspapers and radio stations**
- **Present to provider agencies working with youth and families to encourage family participation**

2. Facilitate face to face forums to recognize and prioritize the concerns and needs of the families by providing opportunities to become better acquainted, honor, and learn about each other's unique backgrounds and differences. Educate those partners that want to involve you in systems of care activities. Get to know the climate and politics of what you will become involved in as you help to reform community and state systems. Assess the strengths, skills and qualities of the families and partners involved and examine who would be appropriate to take on different roles in your organizing efforts.

- **Hold focus group forums or networking events in neighborhoods**
- **Distribute information on a variety of issues**
- **Invite guest speakers**
- **Assess, prioritize and organize**
- **Provide participant supports such as childcare, translation, transportation and meals**

3. Facilitate a cooperative multi-family agreement on prioritized concerns, and develop a project around these concerns. This will help your networks gain the confidence and structure necessary for successfully addressing your identified goals. What resources do you need and how will your group go about seeking them?

- **Create a formalized agenda**
- **Begin an education campaign to raise awareness**
- **Work on relationships with partners to support your priority needs and commit resources.**
- **Fundraise**
- **Build and sustain network activities**

4. Provide opportunities for increasing skills, knowledge and development of family leadership, involving both volunteers and paid staff. Hold trainings based on the prioritized needs found by assessing the skills, strengths, skills and qualities of families and partners. Continue to find and develop additional participant supports. Key initial trainings have included:

- **Family Leadership**
- **Systems/Service Delivery**
- **Social Marketing**
- **Evaluation**
- **Policy**

5. Organize family participation to be involved in governance bodies, committees, advocacy groups and coalitions where they can share priority concerns and work effectively with partners to promote positive change and system reform.

- **Orient and introduce new members**
- **Share information and facts**
- **Communicate with and influence decision makers**
- **Create a shared vision and commitment**
- **Develop a plan of action and implement it**

6. Strategize system reform efforts around policy by collectively organizing family voice to influence and make decisions with elected officials, policy makers and legislative bodies.

- **Provide policies and procedures information**
- **Learn about legislative and decision-making processes**
- **Share and collect stories and data**
- **Identify champions**
- **Promote policy change and transformation**

For more information on how to develop a family or youth network in your area call: Iowa Federation of Families for Children's Mental Health 888-400-6302 or e-mail Lori@iffcmh.org

"Children have never been very good at listening to their elders, but they have never failed to imitate them." James Bladwin

Studies link psychosis, teenage marijuana use Some adolescents carry genetic risk

Globe Staff January 26, 2006

Researchers are offering new ammunition to worried parents trying to dissuade their teens from smoking marijuana: Evidence is mounting that for some adolescents whose genes put them at added risk, heavy marijuana use could increase the chances of developing severe mental illness -- psychosis or schizophrenia.

This week, the marijuana-psychosis link gained ground when two major medical journals reviewed the research to date and concluded that it was persuasive. In PLOS Medicine, an Australian public health policy specialist wrote that genetically vulnerable teens who smoke marijuana more than once a week "appear at greater risk of psychosis," while the British medical journal BMJ cited estimates that marijuana use could contribute to about 10 percent of cases of psychosis.

The new research has little hint of "Reefer Madness" alarmism. Rather, a half-dozen long, careful studies published in the last several years have tried to determine whether marijuana-smoking is a cause rather than an effect of mental illness. And groundbreaking research has begun to try to pinpoint which genes and brain chemicals could do the damage.

The conclusions remain controversial, in part because it would be unethical to randomly assign teens to smoke or not smoke marijuana -- which would be necessary to perform a gold-standard study to definitively show that adolescent marijuana use causes mental illness. It could be the other way around, or some other factor could put teens at risk of both.

But the recent research has attempted to get around these hurdles by controlling for factors such as the presence of psychosis before the use of marijuana, family income, education, other drug use, and childhood traumas.

"No single study is perfect," Wayne Hall, author of the PLOS Medicine essay and a professor at the University of Queensland, said in an e-mail interview. "But the fact that so many individually imperfect studies so consistently find this relationship adds confidence to the conclusion that the relationship is causal."

The recent research points to adolescence as a particularly risky time to smoke marijuana heavily for those genetically predisposed to mental illness. Brain scientists theorize that marijuana may induce temporary changes in brain chemistry that, when reinforced over time, become permanent.

Among the research cited by both papers appearing this week was an intriguing study published last year that followed a group of more than 800 New Zealanders from birth until age 26. The study looked at people with a gene variant that apparently predisposes them to developing psychosis, and people without it. The variant was carried by 25 percent of the study's participants.

The study found that among those with this variant, smoking marijuana as teens increased their risk of psychosis in young adulthood nearly tenfold compared with those who did not smoke as teens. Those who smoked marijuana but did not have the gene variant incurred little or no added risk.

No test of such gene variants is widely available. Dr. Robin Murray, a psychiatry professor at Kings College London and an author of the New Zealand paper, said he and other researchers like to joke that they should set up a DNA-test tent at rock concerts and tell customers whether it is safe to get stoned. In reality, however, the gene research is at too early and tentative a stage to justify offering a test, he said. Other studies cited in the BMJ article found that teens and young adults who smoked marijuana had roughly double the risk of later developing psychotic symptoms, but these studies did not distinguish between carriers and noncarriers of the gene variant.

Still, even among marijuana smokers, the absolute risk of developing schizophrenia was low, Murray said -- about 2 percent. And the added risk from smoking marijuana was small compared to, say, cigarette smoking, which multiplies a person's chances of lung cancer by 15, he noted.

Overall, schizophrenia affects about one in every 100 people, and two more in every 100 experience a lesser form of psychosis.

This week's PLOS Medicine essay suggests that teens should be considered vulnerable if they have psychosis in the family, an indication their genes may predispose them to it, or have had "unusual psychological experiences after using cannabis."

In recent months, the White House has emphasized a causal link between marijuana and schizophrenia as part of an antimarijuana campaign, but the National Institute on Drug Abuse does not list psychosis as a marijuana risk on its informational website. The evidence for a link is becoming more convincing, said Dr. Wilson Compton, who directs the institute's public health research program. But he said the agency wants "to make sure we don't overblow" the risk, because that would make teenagers likelier to discount the warnings.

The controversy stems in part from the challenges of the research. Consider a boy

who has shown early signs of schizophrenia since childhood, lacking friends and seeking isolation. In his early teens, he starts hanging out with marijuana-smokers, gets increasingly withdrawn, and is finally diagnosed with schizophrenia at 19. In a case like that, it is likely that the early symptoms of the disease led to the marijuana-smoking rather than vice versa, said Dr. Harrison Pope, director of the Biological Psychiatry Laboratory at Harvard's McLean Hospital.

"I'm not saying the studies are wrong," he said. "I'm saying this is a caveat you have to bear in mind even when you see six studies all in agreement -- it's very, very difficult in retrospect to tease apart the chain of causality."

But even marijuana advocates allow that there could be a link, at least for a small minority of marijuana smokers.

Marijuana has an excellent safety record when used in moderation by adults, emphasized Paul Armentano, senior policy analyst for the National Organization for the Reform of Marijuana Laws. But "I would not rule out that heavy use of marijuana at a young age, particularly combined with other drugs, could precede onset of some symptoms of mental illness."

The New Zealand study, published last year in the journal Biological Psychiatry, looked at a gene called COMT, which is involved in the breakdown of dopamine, a chemical known to play a role in psychosis.

Though the researchers found a dramatically higher risk when teenagers with the wrong variant of the gene regularly smoked marijuana, they cautioned that even so, that combination accounted for only one-fifth of the people in the study who became psychotic.

"People who smoke pot don't [automatically] go on to become schizophrenic -- boom boom boom," said Alan Budney, a professor and federally funded addiction researcher at the University of Arkansas for Medical Sciences. "There's an intricate level of risk factors that don't apply to Tom, Dick, and Harry -- it just applies to, say, Jim."

At least, said Murray of London, he now has better answers for schizophrenic patients who ask, "Why is it you're telling me that cannabis contributed to my going psychotic when all my mates smoked more than me and nothing ever happened to them?"

The Sound Of The Old Dance Shaking

Systems are not simply collections of individuals,

They are patterns of relationship-----

Top/Bottom,

Ends/Middle,

Provider/Customer,

Dominant/Dominated.

We exist only in relationship-----

sometimes on one side,

sometimes on the other.

We dance in relationship,

and in the dance,

we grow apart from one another-----

becoming the Burdened

and the Oppressed,
the Unsupported and the Torn,
the Judged
and the Screwed,
the Righteous
and the Wronged.

We dance
without seeing the dance.

On the inside
there is no dance,
only our feelings,
our beliefs-----

so solid,

so sure,

“Reality,”

The way things really are.

Can we change the dance?

Maybe,
maybe not.

Maybe we will go on dancing
to the end of our days-----

not seeing one another,

not loving one another,

misunderstanding,

hurting, and destroying one another.

Or maybe we will see the dance.

And maybe we will stop the dance.

And maybe we will create a new dance.

But first,

There will be the sound of the old dance shaking.

What would you like to see in our newsletter? E-mail us at help@iffcmh.org and let us know.

For many parents who are raising children and youth with mental, emotional and behavioral disorders it is very hard to find resources, training, services or someone to talk to that understands what they are going through. For over 10 years Iowa Federation of Families for Children's Mental Health has provided families and providers that service. Please use the below form to send in your donation.

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:

\$50.00 \$75.00 \$100.00 \$200.00 \$500.00 Other \$ _____

or go to <http://www.iffcmh.org/donateform.htm>

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Address: _____

City: _____ State: _____ Zip: _____

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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:

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