

Iowa Federation of Families for Children's Mental Health

Children's Mental Health News June 12, 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.

A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a new training curriculum, which provides mental health providers with the latest information on prevention strategies and alternative approaches to avoid and reduce the use of seclusion and restraint. The training curriculum, A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages, is organized in seven modules and emphasizes the importance of creating cultural change within organizations to impact seclusion and restraint reduction. <http://www.mentalhealth.samhsa.gov/publications/allpubs/sma06-4055/>

The Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Their Families

A new Web-based resource funded by SAMHSA, titled "The Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Their Families," features eight innovative medical home practices that integrate behavioral health screening for the whole family, facilitate referrals to community services, and offer follow-up care. A must read for policy makers and practitioners who want to replicate an integrated primary care and behavioral health model.

Download at: http://www.iffcmh.org/library_start.php if this link does not work go to www.iffcmh.org then go to library of information then to resources.

Large Health Gaps Persist Between White and Minority Children

Improving Children's Health Understanding Children's Health Disparities and Promising Approaches

Children's Defense Fund: Disparities Increase Costs and Hurt Nation's Productivity New Report focuses on Racial and Income Differences and Practices That Reduce Disparities.

Download at:

http://www.iffcmh.org/library_start.php if this link does not work go to www.iffcmh.org then go to library of information then to resources. The document is titled 06 Improving Children's Health Understanding Children's Health Disparities and Promising Approaches

Poor Blood Sugar Control Linked to Depression in Youth With Diabetes

Kaiser Permanente Researcher Leads Study on Possible Indicators Behind Higher Rates of Depression

OAKLAND, Calif., April 3 /PRNewswire/ -- Poor blood sugar control and frequent emergency room visits are just two of the telltale signs that children and adolescents with diabetes may be suffering from symptoms of depression, finds a new study by researchers at Kaiser Permanente Southern California and five other study sites. These results are from the first large population-based study to look at diabetes in youth in the United States.

The study, which found that girls were more likely to have symptoms of depression than boys, estimated the prevalence of depression among 2,672 youth with diabetes, aged 10 to 21, as well as possible factors associated with higher rates of depression. The results appear in the April 3 issue of Pediatrics.

Fourteen percent of study participants had symptoms of mild depression, while nearly 9 percent had symptoms of moderate to severe depression. Depressive symptoms increased in both boys and girls in tandem with increases in Hemoglobin A1c, which is measured to determine long-term blood sugar control. Boys with moderate or severe depressive symptoms had 80 percent more emergency room visits, whereas girls had 60 percent more ER visits than did youth with no symptoms of depression.

"This study found several clear signs that a child or adolescent with diabetes may be experiencing symptoms of depression and may benefit from additional mental health screening from physicians and other health care professionals," says Jean Lawrence, ScD, MPH, the study's lead author and an epidemiologist with the Department of Research & Evaluation in Kaiser Permanente's Southern California region. Additionally, she notes, "health care providers should also consider mental health evaluations and interventions for youth who have a history of depression and who are not currently in treatment, since depression is associated with poor blood sugar control."

In addition to poor blood sugar control and more trips to the ER, researchers discovered that girls who had diabetes, along with additional health problems, were more likely to show signs of depression, compared with girls with diabetes alone. At the same time, boys with type 2 diabetes were more likely to have moderately to severely depressed mood than boys with type 1 diabetes.

"This is the first study to document the frequency of depression symptoms among youth with diabetes, in a large population-based sample," says Michael Engelgau, MD, acting director of the

Division of Diabetes Translation at the Centers for Disease Control and Prevention (CDC). "The findings of an association of depression and poor glycemic control, and of a higher frequency of depression among girls have great relevance for improving diabetes control and the quality of life for these young people and their families."

Eighty-five percent of the study's participants had type 1 diabetes, while 14 percent had type 2 diabetes. Lawrence points out that study participants were not screened for clinical depression, but rather, the study aimed to identify those at risk for depression. Lawrence also reports that youth with diabetes were no more likely to show signs of depression than youth without diabetes from similar age and racial/ethnic groups who had undergone screening using the same methodology in previous studies.

The study is funded by the Centers for Disease Control and Prevention and the National Institutes of Health, and is part of SEARCH for Diabetes in Youth, a six-center, population-based study focusing on physician-diagnosed diabetes in children and youth in the United States. SEARCH, a 10-year study that began in 2000, is aimed at identifying diabetes cases among more than 5 million American children each year. SEARCH has study centers in California, Colorado, Hawaii, Ohio, South Carolina and Washington. "The SEARCH program and studies like this one are indicative of the gains we can make in the medical community as a whole, when we partner in research, prevention, and control efforts," added Engelgau.

Kaiser Permanente has research offices in California, Oregon, Hawaii, Georgia, Colorado, Maryland, and Ohio. Results of research conducted by Kaiser Permanente physicians and investigators have been published in the Journal of the American Medical Association, the New England Journal of Medicine, the American Journal of Obstetrics & Gynecology, the American Journal of Public Health, Pediatrics, The Permanente Journal, and other clinical journals. Kaiser Permanente is America's leading integrated health plan. Founded in 1945, it is a nonprofit, group practice prepayment program with headquarters in Oakland, Calif. Kaiser Permanente serves the health care needs of 8.4 million members in 9 states and the District of Columbia. Today it encompasses the nonprofit Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and their subsidiaries, and the for-profit Permanente Medical Groups. Nationwide, Kaiser Permanente includes approximately 145,000 technical, administrative and clerical employees and caregivers, and more than 12,000 physicians representing all specialties. <http://www.kaiserpermanente.org>

Whatever It Takes: How Twelve Communities Are Reconnecting Out-Of-School Youth

This is a document that documents what committed educators, policymakers, and community leaders across the country are doing to reconnect out-of-school youth to the social and economic mainstream. It provides background on the serious high school dropout problem and describes in-depth what twelve communities are doing to reconnect dropouts to education and employment training. It also includes descriptions of major national program models serving out-of-school youth

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Family Guide to Systems of Care for Children with Mental Health Needs

This frequently requested document helps families and caregivers understand systems of care and their rights and responsibilities as partners in the care for their children as they seek services through community-based systems of care.

About the Family Guide

This bilingual family guide was first printed in December 1998 with the support of the Child, Adolescent and Family Branch of the Center for Mental Health Services, part of the Substance Abuse and Mental Health Services Administration. One of the most popular print publications of the *Caring for Every Child's Mental Health Campaign*, the Family Guide is intended to inform caregivers and families about how to seek help for children with mental health problems. Information is provided on what caregivers and families need to know, ask, expect, and do to get the most out of their experience with systems of care.

The content and format of the guide was determined by families from across the country, and it was written by a diverse team of experts led by the Federation of Families for Children's Mental Health. The initial text for the guide was developed by Families and Communities Equal Success of Stark County, OH. Rhode Island Parent Support Network of Warwick, RI, field-tested the guide's content, relevance, usefulness, and format.

The Spanish version of the guide was initially adapted by a contractor to the Federation of Families and was reviewed for readability and cultural relevance by staff from Roxbury Unites for Families and Children, Inc. of Massachusetts; Parents for Behaviorally Different Children of New Mexico; and Abriendo Puertas of Florida.

In 2005, the guide was updated to reflect the current state of the science in mental health service delivery, as well as to ensure that it supports the recommendations called for in the report of the President's New Freedom Commission on Mental Health.

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What is a Parent Partner

A parent partner is a parent or caregiver of child or youth with emotional or behavioral challenges who works to support other parents. Parent partners use their personal experiences and also receive ongoing training. They provide peer support tailored to meet the needs of each parent within the context of their culture.

Parent Partner Responsibilities

- ‡ Provide transportation and general assistance to families and youth;
- ‡ Advocate with families and youth in the court, medical, child welfare, mental health, delinquency, and educational systems;
- ‡ Help identify and connect families and youth to community resources;
- ‡ Engage families and youth in the team process and treatment activities; and
- ‡ Encourage and model self care information,.

Comparing "Family Involvement" with "Family Driven"

	Family Involvement	Family Driven
Origin and development	<ul style="list-style-type: none"> ▪ Federation of Families for Children's Mental Health staff (1998-2002). ▪ Internal process only. 	<ul style="list-style-type: none"> ▪ Collaboration between Center for Mental Health Services and the Federation of Families for Children's Mental Health. ▪ External process including wide diversity of perspectives and stakeholder across the nation (2004-2005).
Purpose	<ul style="list-style-type: none"> ▪ Philosophy providing a: ▪ Starting point for understanding what it means to include families in making decisions; ▪ Moving away from blaming and shaming families for their child's mental health problems; and ▪ Making a commitment to partnering with families. 	<ul style="list-style-type: none"> ▪ Model to guide implementing Goal 2 of <i>Achieving the Promise</i> by ▪ Refining the roles for families in making decisions; ▪ Defining the expectations for system partners; and ▪ Describing the administrative supports necessary for making the transformation to family-driven care.
Content	<ul style="list-style-type: none"> ▪ Set of principles setting out the needs, rights, and responsibilities of families with regard to systems change and getting services and supports their families need. 	<ul style="list-style-type: none"> ▪ Set of principles setting out the needs, rights, and responsibilities of families, providers, administrators, and communities with regard to transforming children's mental health care. ▪ Set of characteristics that are universal to family-driven care.
Uses	<ul style="list-style-type: none"> ▪ Introduce the concept of including families in making decisions to all stakeholders at all levels of the system of care. ▪ Introduce general audience to the Federation of Families for Children's Mental Health and its role in promoting family involvement. 	<ul style="list-style-type: none"> ▪ Provide a flexible framework to guide the development of family-driven care in diverse communities. ▪ Provide a framework for assessing the extent to which a community has moved towards family-driven practice.

Trina W. Osher (2005)

A Family-Driven Journey

Trina W. Osher

Picture a car. The traveling companions in this car, who are paying for the ride, are experts in child development, education, health, family support, psychology, literacy, housing, employment, and so on. The passenger in the front seat is a child who has an emotional or behavioral disorder. Sometimes there are also members of other families that have taken a trip like this before. The driver is the child's parents and family. The driver and front seat passenger know where they want to go but need help getting there. There are many routes to this destination. They consult the traveling companions in the back seat. Each offers the route they prefer along with the reasons they think it is THE BEST! Serious drawbacks and dangers to any choice are pointed out. The driver and front seat passenger also use maps and traveling tips provided by an information exchange run by other families that have taken similar journeys.

The entire carload respectfully discusses the merits of the alternatives and then carefully plans a safe route they all agree on. If they are likely to cover dangerous terrain unfamiliar to the driver (like an icy road) additional equipment or special training is provided (like anti-lock brakes or how to handle skids). Stops to attend to basic needs (like getting food, fuel, or rest) are carefully and deliberately planned into the route. Time to enjoy the scenery is scheduled and landmarks are identified so they can be sure they are on the right track. Mileage is recorded to monitor progress and know when they are approaching the end of each leg of the journey. If they encounter a roadblock, they regroup and find a way around it. If they have an emergency or disaster, they get off the road and attend to it immediately – resuming the original route as quickly as possible.

GREAT CARE is taken to be sure the vehicle is in good condition and is well maintained. GREAT CARE is taken to make sure the driver is awake and alert. One of the traveling companions is always looking ahead for the next turn in the road or unexpected change in road conditions ready to warn the driver as they approach it. At the journey's end, they celebrate together and congratulate each other on the success of the trip.

The family tells the story of their journey to others – including to the information exchange that supplied the maps and tips. They help other families plan similar trips. They recommend good traveling companions, nice places to see and stay along the way, and strategies to get through the traffic jams.

As their child grows, families may make many different journeys, with different destinations, and different traveling companions – some with no one in the back seat at all. One day, their child will learn to drive – with their family as passenger in the front seat at first and eventually on their own. When this child – now a young adult – needs to take another journey, childhood memories of how their family planned such trips will help them know how to find the right companions to arrive safely at their destination.

This journey illustrates putting the rhetoric of family involvement into action. The people who care for and know children the most and the best – their parents and families – must have a substantial role in making decisions about how their individual children are treated. And they, and their children, must have a significant voice in determining how the resources in their communities will be allocated. This is the best way to insure all systems and agencies take collective responsibility, COLLECTIVE responsibility, collective RESPONSIBILITY, for promoting the mental health of all children and providing the array of specialized services needed by children with serious emotional or behavioral disturbances.

Each system has only its own mandates and perspective as a frame of reference. Only families and the children they are raising who are served by multiple systems have the full view and can see through the barriers erected to protect existing system or agency “turf.” The journey is a metaphor for both an effective, family-driven system of care and a metaphor for how sound children’s behavioral health policy develops. Policy is the platform that supports effective practice. Sustaining family involvement a community or system of care will depend, in some part, on effective policy work in that community and state. Make no mistake about it - it is families in communities, speaking with a collective voice through their independent family-run organizations, who will be key players in policy change. Families will be educating city and county councils, state agencies, legislatures, and governors so they understand and support policies that sustain into the future the systems of care you are building today.

As you build your cars and plan your journeys, for individuals, systems, and communities remember to **KEEP FAMILIES IN THE DRIVER’S SEAT** and the best interest of children in your heart. With helpful traveling companions, even the roughest journey can end in a safe haven and celebration.

Web Resources:

National Association of Multiethnic Behavioral Health Associations (NAMBHA)

<http://www.nambha.org>

National Center for Cultural Competence <http://www.gucchd.georgetown.edu/nccc/>

CENTER FOR MENTAL HEALTH QUALITY AND ACCOUNTABILITY

MATRIX OF CHILDREN’S EVIDENCE-BASED INTERVENTIONS

<http://www.systemsofcare.samhsa.gov/headermenus/docsHM/MatrixFinal1.pdf>

Research and Training Center on Family Support and Children’s Mental Health (Portland State University)

<http://www.rtc.pdx.edu/>

National Technical Assistance Center for Children’s Mental Health

<http://www.gucchd.georgetown.edu/>

Web References on Family-Driven Care

- ✓ Working Definition and tools: www.fcmh.org/systems_whatism.htm
- ✓
- ✓ Webinar and supporting documents – follow links under Defining Family Driven Care to: View the PowerPoint slides for the Webinar; View the definition of family-driven care; Read the story “Journey to Family-Driven Policy;” or post a message to the discussion board:
www.tapartnership.org/advisors/family/the_family_page.asp
- ✓
- ✓ Achieving the Promise: Report of the President’s Commission on Mental Health:
www.mentalhealthcommission.gov/reports/FinalReport/toc.html
- ✓ www.systemsofcare.samhsa.gov

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