

Iowa Federation of Families for Children's Mental Health

Children's Mental Health News July 24, 2007

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, emotional, behavioral and social 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.



Children's Mental Health & Awareness Week May 4-10, 2008



Children's Mental Health Matters

May is Mental Health Month. The Federation of Families for Children's Mental Health again declares the first full week in May, May 4-10, 2008 as National Children's Mental Health Awareness Week.

National Children's Mental Health Awareness Day (Awareness Day) is a day for SAMHSA and the initiatives and communities it supports to promote positive youth development, resilience, recovery, and the transformation of mental health services delivery for children and youth with serious mental health needs and their families. Awareness Day raises awareness of effective programs for children's mental health needs, demonstrates how children's mental health initiatives promote positive youth development, recovery and resilience, and shows how children with mental health needs thrive in their communities. Awareness Day will be held on Tuesday, May 8th, 2007.

Information and Resources regarding Children's Mental Health & Awareness Week are available at www.iffcmh.org then click on the Children's Mental Health Week resources.

Families Need Help to Deal with Aftermath of Suicide Attempts

Newswise — Shock. Grief. Shame. Guilt. Anger. Denial.

When a child attempts suicide, these emotions hit families like a Mack truck. Some family members bury their feelings deep inside and refuse to accept the stark reality. Others spring into action and vow never again to let the child who attempted suicide of their sight. But no matter how a family deals with the aftermath of a suicide, they are forever changed by it.

“The repercussions from a suicide attempt can go on for years,” says Daniel Hoover, Ph.D., a psychologist with the Adolescent Treatment Program at The Menninger Clinic and associate professor in the Menninger Department of Psychiatry & Behavioral Sciences at Baylor College of Medicine Houston.

Guilt and shame over a suicide attempt prevent many families from getting the help they need to work through the crisis, Dr. Hoover continues. An estimated 30 percent of families of children who attempt suicide seek family therapy, according to a study published in the Journal of the American Academy of Child and Adolescent Psychiatry in 1997, and about 77 percent of families referred to treatment after an adolescent attempts suicide drop out according to a 1993 Journal study.

Many families don't pursue treatment because they deny or minimize their child's suicide attempt. Teenagers who attempt suicide may also not admit they tried to kill themselves.

“Even when you see a young person in the emergency room right after he or she completed an attempt, very quickly the denial kicks in,” Dr. Hoover says. “She may say, ‘I never meant it,’ or ‘it was an accident,’ or denying she even made an attempt. Families do the same thing because of the intensity of the suicide issue.”

Complicating matters, teenagers may attempt suicide while in treatment for mental illness, such as depression or substance abuse. Families are reluctant to put their trust in the mental health system again--feeling it failed them.

That's unfortunate, Dr. Hoover says, because families desperately need support and direction after a child attempts suicide. Depression, which leads to suicidal thinking, affects the entire family unit. To move past the tragedy, families must address the issues that the suicide caused, and continues to cause, in their lives. Chief among the issues is the family's increased sense of responsibility for the child who attempted suicide. Worried about a repeat suicide attempt, family members, and parents in particular, feel that they have to watch their child constantly—in some cases, sleeping at the foot of the child's bed every night to make sure he or she won't attempt suicide.

“Parents feel a huge obligation to watch over their child,” Dr. Hoover says, “At first it may seem somewhat comforting to the child, but then the parents become so intrusive in the child's life he or she thinks, ‘I can't live like this anymore.’”

Helping families reach that middle ground between protecting and smothering their children is a main goal for family therapy at the Menninger Adolescent Treatment Program, which treats adolescents age 12 to 17. Patients in the inpatient treatment program struggle with family, school and social difficulties because of depression, anxiety, or other psychiatric illness or substance abuse. Some patients also have attempted suicide once or multiple

times.

Dr. Hoover recommends individual therapy as well as appropriate psychiatric medication for children who attempt suicide, as most are quite depressed and feel hopeless. Their parents and other children in the family may also benefit from individual therapy, especially if they found them after the attempt.

“Often siblings are just as stressed out as the parents because they find the brother after the overdose, or they are the ones in the background while Mom and Dad and the brother are having all of the conflict,” Dr. Hoover says. “So they have been traumatized by it and they need their own help.”

Working with therapists at Menninger, patients in the Adolescent Treatment Program learn to develop agency, or the ability to take action and exert control, over their mental illness and suicidal feelings. They learn skills to cope, ways to self-soothe and to seek out sources of support other than their parents. They also learn to share their thoughts and feelings with their parents, and to communicate with their parents if they are feeling suicidal.

Parents, in turn, learn how to listen and not overreact.

“When parents witness that their child is handling his or her feelings better, and knows when to seek help, it lowers their anxiety so much,” Dr. Hoover says.

Family therapy immediately following a suicide attempt may not be productive, Dr. Hoover says, because emotions are raw, and the suicide attempt is still fresh in the family members’ minds. Once the child who attempted suicide learns how to deal with his or her hopelessness and depression, and the parents begin to deal with their own anxieties and guilty or angry feelings, then they may be ready for family therapy. Family therapy helps family members learn how to communicate better with each other and express their feelings more constructively.

Sidebar:

Is my child contemplating suicide?

Even in the most open families, teens may still be hesitant to tell their parents they are depressed or thinking about suicide. However, an estimated 80 percent of individuals who attempt or commit suicide give out signs. Following are warning signs of suicide to watch for from the National Youth Prevention Commission:

- depressed mood;
- substance abuse;
- frequent episodes of running away or being incarcerated;
- family loss or instability, significant problems with a parent;
- expressions of suicidal thoughts, or talk of death or the afterlife during moments of sadness or boredom;
- withdrawal from friends and family;
- difficulties in dealing with sexual orientation;
- no longer interested in or enjoying activities that once were pleasurable;
- unplanned pregnancy; and
- impulsive, aggressive behavior, frequent expressions of rage.

Hoover adds that extreme distress over the breakup of a relationship, or conflict with friends, may also be a warning sign of suicide. If you suspect your child may be contemplating suicide, treat it seriously. Ask directly if he or she is considering suicide and whether he or she has made a specific plan and has done anything to carry it out. Then, get professional help for your child from a psychologist, therapist, primary care doctor, community mental health provider or call a suicide hotline or local crisis center. If your

child has a detailed plan or you suspect he or she will commit suicide, seek help immediately, taking your child to a hospital emergency room if necessary.

The Menninger Clinic is a nonprofit international specialty psychiatric center, providing innovative programs in treatment, research and education. Founded in 1925 in Kansas, Menninger relocated to Houston in 2003 and is affiliated with Baylor College of Medicine and The Methodist Hospital. For 16 consecutive years, Menninger has been named among the leading psychiatric hospitals in U.S. News & World Report's annual ranking of America's Best Hospitals. Menninger is a 501(c)(3) charitable organization.

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Gang crisis in context: What's the real crisis, and what are real solutions?

“First, we must address the personal, family, and community factors that cause young people to choose gangs over more productive alternatives. The more success we have in prevention, the fewer people we'll have to prosecute for violent activity down the road.” Attorney General Alberto R. Gonzales, April 21, 2006¹

“It is the same prescription every time they have a major event. Gangs are defined as a crime problem and not a community problem. This is old-fashioned suppression in a new guise, and where is the proof that it has worked?” Malcolm Klein, veteran gang sociologist and USC professor emeritus.²

Background—Rising Youth and Gang Crime? After a nearly continuous 13-year crime drop, crime rates in the U.S. are on the rise. Nationwide, violent crime rose 2.3 percent between 2004 and 2005.³ Based on data in the FBI's Preliminary Semiannual Uniform Crime Report, released in December 2006, the upward trend appears to be continuing in 2006, as violent crime rose 3.7 percent between the first six months of 2005 and the same time period in 2006. While definitely an area of concern, rising crime rates need to be put in their proper context: After experiencing a steady drop in violent crimes since a 1992 peak, crime rates remain near a 30-year low. From the perspective of potential victims, the streets are still much safer today than they were a decade or so ago. According to surveys conducted by the U.S. Department of Justice, the odds of being a victim of violent crime are approximately 60 percent lower today than they were in 1994.⁴

The relationship between the crime change and reported gang activity is complicated. While some have attributed the rise in crime to increased gang activity, and the image of juvenile crime and gang crime have been merged and melded by the media, the true picture of crime trends and their relation to gangs is more complicated. More than 80 percent of the agencies with gang problems in both smaller and rural counties reported zero gang homicides in 2004. While cities known to have high levels of gang activity—like Los Angeles—experienced a drop in violent crime in 2006, several Los Angeles neighborhoods

¹ Attorney General Alberto R. Gonzales, April 21, 2006, http://www.usdoj.gov/ag/speeches/2006/ag_speech_060421.html.

² Richard Winton and Patrick McGreevy, “Will L.A.'s strategy to battle gangs work?” L.A. Times, February 11, 2007.

³ FBI Uniform Crime Reports, Crime in the United States, 2005.

⁴ Butts, Jeffrey A. and Snyder, Howard N. Too Soon Too Tell: Deciphering Recent Trends in Youth Violence. (2006). Chicago, Illinois: Chapin Hall Center for Children, University of Chicago.

continue to face serious gang crime challenges. Just as most young people “age out”, or desist from delinquency and crime when they reach adulthood, research on gangs published by the Justice Department found that, “gang-membership tends to be short-lived, even among high-risk youth...with very few youth remaining gang members throughout their adolescent years.”⁵ Law enforcement estimates of nationwide juvenile gang membership suggest that no more than 1 percent of youth aged 10-17 are gang members.⁶

Incarcerating gang members does not necessarily curb re-offending. There is a growing body of research that suggests that increased imprisonment could negatively impact youth who may otherwise “age out” of delinquent behavior, and aggravate public safety goals.⁷ A 2004 Illinois report on recidivism rates of gang members tracked 2,500 adults prisoners released in 2000, one quarter of whom were gang members.⁸ They found that more than half (55 percent) of the gang members were re-admitted to prisons within a two-year follow-up. A study of youth in the Arkansas juvenile justice system found that prior incarceration was a greater predictor of recidivism than carrying a weapon, gang membership, or poor parental relationship.⁹

“Primary responsibility for developing and operating delinquency-prevention programs should be assigned to an appropriate agency in HHS unless immediate public protection is an overriding concern....Criminal justice agencies rarely evaluate the effectiveness of their programs or activities, while HHS programs are more often evidence-based and subject to evaluation. Delays in adopting proven programs will only cause additional victimization of citizens and unnecessarily compromise the future of additional youth.” Dr. Peter Greenwood, the founder of RAND's Criminal Justice Program, author of *Changing Lives: Delinquency Prevention as Crime-Control Policy*.¹⁰

Education is a protective factor against juvenile delinquency and recidivism. Providing education and employment services have been shown to correlate with lower crime rates. According to the Office of Juvenile Justice and Delinquency Prevention, the U.S. Justice Department's juvenile justice branch, “If, as research has found, educational failure leads to unemployment (or underemployment), and if educational failure and unemployment are related to law-violating behavior, then patterns of educational failure over time and within specific groups may help to explain patterns of delinquent behavior.”¹¹ Providing education and employment services for at-risk youth to increase graduation rates, as well as wages and employment rates, could greatly reduce crime, benefiting both young people and society as a whole.¹² According to research published in the *Journal of Labor Economics* a 10 percent increase in wages would render a 1.8 percent decrease in the crime participation

⁵ Snyder, Howard N., and Sickmund, Melissa. (2006). P.83

⁶ Snyder, Howard N., and Sickmund, Melissa. (2006). *Juvenile Offenders and Victims: 2006 National Report*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

⁷ Benda, B.B. and Tollet, C.L. (1999) “A Study of Recidivism of Serious and Persistent Offenders Among Adolescents.” *Journal of Criminal Justice*, Vol. 27, No. 2 111-126.

⁸ Olson, D. E., Dooley, B., and Kane, C. M. (2004). “The Relationship Between Gang Membership and Inmate Recidivism.” *Research Bulletin*, 2(12). Chicago, IL: Illinois Criminal Justice Research Authority. <http://www.icjia.state.il.us/public/pdf/Bulletins/gangrecidivism.pdf>

⁹ Benda, Brent B. and Connie L. Tollett. “A Study of Recidivism of Serious and Persistent Offenders Among Adolescents.” *Journal of Criminal Justice* 27 (2) (March/April 1999): 111-126.

¹⁰ Greenwood, P. (2006). *Changing Lives: Delinquency Prevention as Crime-Control Policy*. Chicago, IL: University of Chicago Press. P182

¹¹ *Juvenile Offenders and Victims: 2006 National Report*. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention. <http://ojjdp.ncjrs.org/ojstatbb/nr2006/downloads/NR2006.pdf> p.14

¹² Raphael, S. and Winter-Ebmer, R. (2001). “Identifying the Effects of Unemployment and Crime.” *Journal of Law and Economics*. Vol. XLIV; Grogger, J. (1998). Market Wages and Youth Crime. *Journal of Labor Economics*, 16(4); Lochner, L. and Moretti, E. (2004). “The Effect of Education on Crime: Evidence from Prison Inmates, Arrests, and Self-Reports.” *The American Economic Review*.

rate.¹³ Furthermore, the authors found that an increase in wages would have a great effect on young men, who are often the most impacted by wage rates and who commit the majority of crimes.

There are proven programs that work with seriously violent and at risk youth. While the science on preventing gang crime is limited, there are evidence-based practices that work with at-risk and delinquent youth, the same youth who often join gangs. Whether these programs work with gang members depends more on the youth individually than whether he or she belongs to a gang. In addition, studies have shown that evidence-based practices that work with violent and seriously delinquent youth are more cost effective and produce more benefits than traditional punitive measures.¹⁴

The loss of federal funding for juvenile justice programming will make it difficult to continue providing services for youth violence perspective. The President's budget proposal would end the commitment of the federal government to a dedicated effort focused on juvenile justice. The proposal would cut juvenile justice funding by 25 percent, and permanently close the Office of Juvenile Justice and Delinquency Prevention (OJJDP), which has led national efforts to reduce youth crime and make communities safer for over 25 years. The budget does not make any commitment to continue with the OJJDP's critical functions, and the loss of the federal role in technical assistance, training, research and support for innovative and proven practices will hamper local efforts to curb juvenile crime and delinquency.

The public supports bigger investments in youth interventions that work. A new poll from the National Council on Crime and Delinquency, conducted by Zogby International shows that the public overwhelmingly supports rehabilitation and treatment for young people in trouble, not prosecution in the adult court or incarceration in adult jails or prisons. 9 out of 10 people polled believe that rehabilitation and treatment for incarcerated youth can help prevent future crime, and 8 out of 10 thought spending money on rehabilitative services and treatment for youth will save money in the long run.¹⁵

¹ Steve Aos, Marna Miller, and Elizabeth Drake. (2006). *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. Olympia: Washington State Institute for Public Policy.

¹Krisberg, Barry and Marchionna, Susan. *Attitudes of US Voters toward Youth Crime and the Justice System* (2007). Oakland, CA: National Center on Crime and Delinquency.

Free reproducible language and early literacy activities in English and Spanish

Developed by Angela Notari-Syverson, Ph.D. and Kristin Rytter, Ph.D, with Judy Challoner, Faith Haertig Sadler, Young Sook Lim, Ph.D., Marilyn Sturm, and Rodd Hedlund (2005).

To download materials go to www.wlearning.com and click on the purple button that says "Free Parent Education Handouts" on the home page.

These materials include forty-six home and community activities for adults and preschool children that encourage early language and literacy development in young children. They

¹³ Grogger, J. (1998). Market Wages and Youth Crime. *Journal of Labor Economics*, 16(4).

are appropriate for children with disabilities as well as children who are developing typically.

Each of the forty-six activities includes 1) An activity description, 2) Hints for making the activity fun and developmentally appropriate, and 3) A brief self-evaluation form that cues parents and other caregivers to notice their children's skills, and also cue adults to examine and grow their own interactions with their children.

The materials are specifically designed to address the three key skills of 1) language development, 2) phonological awareness, and 3) general print awareness.

The files are in PDF format to allow easy and secure downloading. Five files for each language (Spanish and English) include:

- Table of contents listing the 46 activities
- Level 1 activities (activities designed for developmentally younger children)
- Level 2 activities (activities that include a stronger focus on print)
- Level 3 activities (activities that focus on more complex language use)
- A brief activity self-evaluation form

The materials are made available by Angela Notari-Syverson and colleagues, and may be copied and distributed as long as they are not sold.

To download materials go to www.wlearning.com and click on the purple button that says "Free Parent Education Handouts" on the home page.

Current and past issues of eNotes can be viewed online at <http://www.nectac.org/enotes/enotes.asp>

New Knowledge Path Focuses on Child and Adolescent Social and Emotional Development

Source: MCH Alert - June 29, 2007

The Maternal and Child Health Library has developed an electronic guide to resources for professionals on healthy social and emotional development in infants and young children, school-age children, and adolescents. Selected topics include developmental stages; factors that impact social and emotional development; policies and programs to promote social and emotional well-being in homes and community settings; and strategies for integrating health, development, and education services. A section for families is also included. It is available at: http://www.mchlibrary.info/KnowledgePaths/kp_Mental_Healthy.html.

Most teenagers with social network profiles online are taking steps to protect themselves from the most obvious risks

A new report, based on a survey and a series of focus groups conducted by the Pew Internet & American Life Project examine how teens, particularly those with profiles online, make decisions about disclosing or shielding personal information.

Still, 63% of teens with online profiles believe that a motivated person could eventually identify them from their online profile

The majority of teens actively manage their online profiles to keep the information they believe is most sensitive away from the unwanted gaze of strangers, parents and other adults. While many teens post their first name and photos on their profiles, they rarely post information on public profiles they believe would help strangers actually locate them such as their full name, home phone number or cell phone number.

At the same time, nearly two-thirds of teens with profiles (63%) believe that a motivated person could eventually identify them from the information they publicly provide on their profiles.

A new report, based on a survey and a series of focus groups conducted by the Pew Internet & American Life Project examine how teens, particularly those with profiles online, make decisions about disclosing or shielding personal information.

Some 55% of online teens have profiles and most of them restrict access to their profile in some way. Of those with profiles, 66% say their profile is not visible to all internet users. Of those whose profile can be accessed by anyone online, nearly half (46%) say they give at least some false information. Teens post fake information to protect themselves and also to be playful or silly.

Here is a rundown of the kinds of information they post on their profiles, whether they are public or shielded:

82% of profile creators have included their first name in their profiles

79% have included photos of themselves.

66% have included photos of their friends.

61% have included the name of their city or town.

49% have included the name of their school.

40% have included their instant message screen name.

40% have streamed audio to their profile.

39% have linked to their blog.

29% have included their email address.

29% have included their last name.

29% have included videos.

2% have included their cell phone numbers.

6% of online teens and 11% of profile-owning teens post their first and last names on publicly-accessible profiles.

The new survey shows that many youth actively manage their personal information as they perform a balancing act between keeping some important pieces of information confined to their network of trusted friends and, at the same time, participating in a new, exciting process of creating content for their profiles and making new friends. Most teens believe

some information seems acceptable, even desirable, to share, while other information needs to be protected.

The majority of teen profile creators suspect that a motivated person could eventually identify them. While most teens take steps to limit what others can know about them from their profiles and postings, they also know that the powerful search tools available to internet users could help motivated individuals track them down. Some 23% of teen profile creators say it would be "pretty easy" for someone to find out who they are from the information posted to their profile, and 40% of teens with profiles online think that it would be hard for someone to find out who they are from their profile, but that they could eventually be found online. Another 36% say they think it would be "very difficult" for someone to identify them from their online profile.

"Teens realize that in some ways they are more accessible when they are online," says Amanda Lenhart, senior research specialist at the Pew Internet Project and co-author of a new report based on the survey. "They try to strike a balance between being safe from strangers and keeping things private from their parents and other adults, while at the same time sharing enough information that allows them to socialize with friends and perhaps even make new friends."

The survey also suggests that today's teens face potential risks associated with online life. Some 32% of online teenagers (and 43% of social-networking teens) have been contacted online by complete strangers and 17% of online teens (31% of social networking teens) have friends on their social network profile who they have never personally met. The report also addresses how teens make new friends and interact with strangers online.

32% of online teens have been contacted by strangers online, this could be any kind of online contact, not necessarily contact through social network sites. 21% of teens who have been contacted by strangers have engaged an online stranger to find out more information about that person (that translates to 7% of all online teens). 23% of teens who have been contacted by a stranger online say they felt scared or uncomfortable because of the online encounter (that translates to 7% of all online teens).

"Social networking sites are not the first online application to spark worries among parents," says Mary Madden, senior research specialist at the Pew Internet Project and co-author of the report. "In our first study of teen internet usage in 2000, well before social networking sites emerged, many parents were worried that strangers would contact their children online through email and chat rooms. At the time, parents responded to these worries by taking precautions such as monitoring their child's internet use and placing the computer in a public area of the home much as they do today."

The report, entitled, "Teens, Privacy, and Online Social Networks," is based on a survey conducted by telephone from October 23 through November 19, 2006 among a national sample of 935 youths ages 12 to 17 and on a series of seven focus groups conducted with middle and high-school aged teens in June 2006. The survey has a margin of error in the overall sample of plus or minus 3 percentage points.

The [Pew Internet Project](#) is a non-profit, non-partisan initiative of the Pew Research Center that produces reports exploring the impact of the internet on children, families, communities, the work place, schools, health care, and civic/political life. Support for the non-profit Pew Internet Project is provided by [The Pew Charitable Trusts](#).

Know Your Mental Health Insurance Benefits

By the American Academy of Child and Adolescent Psychiatry

Insurance benefits for mental health services have changed a lot in recent years. These changes are consistent with the nationwide trend to control the expense of health care. It is important to understand your mental health care coverage so that you can be an active advocate for your child's needs within the guidelines of your particular plan. Here are some useful questions to ask when evaluating the mental health benefits of an insurance plan or HMO:

- Do I have to get a referral from my child's primary care physician or employee assistance program to receive mental health services?
- Is there a "preferred list of providers" or "network" that you must see? Are child psychiatrists included? What happens if I want my child to see someone outside the network?
- Is there an annual deductible that I pay before the plan pays? What will I actually pay for services? What services are paid for by the plan: office visits, medication, respite care, day hospital, inpatient?
- Are there limits on the number of visits? Will my provider have to send reports to the managed care company?
- What can I do if I am unhappy with either the provider of the care or the recommendations of the "utilization review" process?
- What hospitals can be used under the plan?
- Does the plan exclude certain diagnoses or pre-existing conditions?
- Is there a "lifetime dollar limit" or an "annual limit" for mental health coverage, and what is it?
- Does the plan have a track record in your area?

Some of the language used in describing your health care plan may be unfamiliar to you. Managed care refers to the process of someone reviewing and monitoring the need for and use of services. Your insurance company may do its own review and monitoring or may hire a "managed care company" to do the reviewing. The actual review of care is commonly known as "utilization review" and is done by professionals, mostly social workers and nurses, known as "utilization reviewers" or "case managers." The child psychiatrist treating your child may have to discuss the treatment with a reviewer in order for the care to be authorized and paid for by your insurance. The reviewers are trained to use the guidelines developed by your health care plan. A review by a child and adolescent psychiatrist reviewer usually must be specially requested.

The review process often takes place over the telephone. Written treatment plans may also be required. Some plans may require that the entire medical record be copied and sent for review. Reviewers usually authorize payment for a limited number of outpatient sessions or a few days of inpatient care. In order for additional treatment to be authorized, the psychiatrist must call the reviewer back to discuss the child's progress and existing problems. Managed care emphasizes short term treatment with a focus on changing

specific behaviors.

Preferred providers are groups of doctors, social workers, or psychologists which your insurer has agreed to pay. If you choose to see doctors outside of this list, (out of network caregivers), your insurer may not pay for the services. You will still be responsible for the bill. Similarly, care given in hospitals designated as "in network" is paid for by your insurance, while care given in hospitals "out of network" is usually not paid by your insurance and becomes your responsibility. Even when using preferred providers and in network hospitals, utilization reviewers still closely monitor treatment.

Another change is the variety of services and diagnosis paid for by different plans. In the past, only inpatient care and outpatient care was covered by insurance. Now, depending upon your particular plan, other services such as day hospital, home-based care, and respite care may also be covered. These lower cost services may offer advantages to inpatient hospitalization.

A limiting feature of some mental health care plans is a low lifetime maximum or a low annual dollar amount that can be used for mental health care. (i.e. Once this amount is used, plan coverage ends.) You, as parent or guardian, are responsible for paying the non-covered bill. If your child/adolescent needs continued care, you may need to seek help from your state public mental health system. This usually means changing doctors which may disrupt your child's care.

It is important to understand as much as possible about your particular insurance plan. Understanding your coverage will put you in a better position to help your child. Sometimes you may need to advocate for services that are not a part of your plan, but which you and your child's psychiatrist feel are necessary. Advocacy groups may provide you with important information about local services. The support of other parents is also useful and important when engaged in advocacy efforts.

For additional information see the AACAP's Policy Statement on Psychiatric Diagnostic Evaluations

Extreme Irritability: Is It Childhood Bipolar Disorder? *Brain's electrical signals provide clues.*

Results of a new study may help improve the diagnosis and treatment of two debilitating childhood mental disorders — pediatric bipolar disorder (BD) and a syndrome called severe mood dysregulation (SMD). When the brain's electrical signals were measured during mildly frustrating situations, researchers from the National Institute of Mental Health (NIMH), of the National Institutes of Health, found a very different pattern in children with SMD, compared with children who had BD. The results indicate that different brain mechanisms may lead to irritability in children with SMD, suggesting that they may have an illness other than BD and may require different treatments.

“These aren't children with the occasional bad moods you see in most kids. They're typically very ill, with symptoms that interfere with their lives in major ways. Establishing clear diagnostic criteria is an essential step toward making sure they get the help they need,” said NIMH Director Thomas R. Insel, M.D.

Children have a comparatively low rate of BD, but the rate increases with age, to approximately 1 percent among adolescents. About 3 percent of pre-adolescent and adolescent youth are estimated to have SMD. Mood-stabilizing and antipsychotic

medications are used to treat children with BD, although the data on their effectiveness are limited and several studies are underway. Since SMD was only recently defined, there are no systematic studies on its treatment, and children with SMD are often treated as if they have BD.

Defining pediatric BD is a major issue in child psychiatry, because the disorder tends to be severe in this age group and the rate of diagnosed cases is rising. Until recent years, most studies of BD were conducted in adults. Some researchers maintain that pediatric BD should be defined more broadly to include children with SMD, an assertion countered by the new finding. Results of the study were published in the February 2007 issue of the *American Journal of Psychiatry*.

The classic definition of BD (<http://www.nimh.nih.gov/publicat/bipolarupdate.cfm>) includes extreme, sustained mood swings that range from over-excited, elated moods and irritability — the manic phase of the disorder — to depression. In contrast, children with SMD are extremely irritable and hyperactive, but do not have clear-cut manic episodes. One component of irritability is the tendency to get acutely frustrated when a goal is not met. Thus, through electroencephalograms (EEGs), the researchers could observe the brain's electrical signals that occurred during frustration while children with either disorder performed simple tasks.

The new study shows that clinicians some day could use biological measurements, such as EEGs, to help make psychiatric diagnoses, in combination with clinical symptoms. Currently, clinicians diagnose mental illnesses based on symptoms alone. The difficulty of diagnosing BD in children is compounded by the frequent co-occurrence of one or more other mental disorders.

“We’re approaching the day when we’ll be able to use neuroscience techniques to improve psychiatric diagnoses. Pediatric BD has some of the most pressing needs in this regard, because of its severity and because of questions about how to best make the diagnosis,” said senior author Ellen Leibenluft, M.D., Chief of the Unit on Bipolar Spectrum Disorders in the Emotion and Development Branch of the NIMH Mood and Anxiety Disorders Research Program.

In this study, scientists obtained EEGs of 35 children with classic BD, 21 children with SMD, and 26 healthy children (average age 12 to 13) while they performed a task repeatedly; each time they did the task, they won or lost 10 cents. The task was frustrating because the children often lost money.

The researchers found that while both the children with BD and those with SMD became more frustrated than did healthy children performing the same task, the brain mechanisms associated with their frustration differed. Children with BD had an abnormality in the brain’s P3 electrical signals, which measure ability to purposefully direct attention, but children with SMD had abnormalities in N1 signals, which occur when a stimulus grabs someone’s attention. Both abnormalities suggest deficits in the brain’s attention-related activity, but in different phases of that activity.

“If future research indicates that BD and SMD are two separate disorders, this could guide parents and physicians toward the right treatments,” said first author Brendan Rich, Ph.D., of the NIMH Unit on Bipolar Spectrum Disorders. “A good example is that medication prescribed for symptoms seen in SMD, such as stimulant medication, might be inappropriate for a child with classically defined bipolar disorder,” he said.

NIMH scientists Mariana Schmajuk, B.S., and Daniel Pine, M.D., also contributed to the research, as did University of Maryland scientists Koraly E. Perez-Edgar, Ph.D., (*currently at George Mason University*) and Nathan A. Fox, Ph.D.

The National Institute of Mental Health (NIMH) mission is to reduce the burden of mental and behavioral disorders through research on mind, brain, and behavior. More information is available at the NIMH website: <http://www.nimh.nih.gov/>.



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.

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