CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT
OF PERSONS WITH A DEVELOPMENTAL DISABILITY

Champaign County Developmental Disabilities Board (CCDDB) and
Champaign County Mental Health Board (CCMHB) and
Champaign County Board of Health

TUESDAY, MARCH 17, 2009
STUDY SESSION
Brookens Administrative Building
Lyle Shields Meeting Room
1776 E. Washington St., Urbana, IL

6:00 p.m.

1. Call to Order—Deborah Townsend, President CCMHB and Joyce Dill, President CCDDB

2. Roll Call

3. Panel Discussion: Perinatal Depression
   Panelists providing range of perspectives on the topic include Crisis Nursery Perinatal Depression Program Family Specialist, a Public Health Nurse, a Consumer, an Obstetrician, and a Psychiatrist.

   The panel presentation is scheduled for 45 minutes followed by 45 minutes of discussion.

   Background material on the subject of public health-mental health collaboration is attached.

4. Discussion, Questions and Comments

5. Adjournment

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Champaign County Developmental Disabilities Board (CCDDB) and
Champaign County Mental Health Board (CCMHB) and
Champaign County Board of Health

March 17, 2009

Overview of Maternal Depression

During the fall of 2007, the Champaign County Mental Health Board and the Champaign County Board of Health mutually agreed to proceed with a jointly sponsored project allocating $25,000 for the special initiative. This decision of the two Boards was an outcome of the discussion about integrated planning between mental health and public health held during the 2006 consultation with Harry Shallcross, Ph.D., along with subsequent conversations between Dr. Rappaport, Dr. Moore and CCMHB Executive Director Peter Tracy concerning opportunities for collaboration and funding partnerships.

In developing criteria for the special initiative, several possibilities for a public health and mental health collaboration were developed and then released as part of a competitive application process. The following is the maternal depression criteria from that process that also provides a useful overview of the issue for the March 17, 2009 study session.

Maternal Depression: The frequency of occurrence of a variety of mood disorders in new mothers--ranging from modest adjustment crises to psychosis--continues to rise. A variety of explanations has been offered, but most promising seem to be the problems wrought by social isolation (created by living circumstances, transience, lack of proximity to family-of-origin, and a general tendency toward living in greater isolation in the United States), and by technological childbirth (which has resulted in very short hospital stays--cutting off the education and support once offered by nursing staff and other mothers, during a customary stay of three days or more--as well as very high c-section rates--now approaching one out of three deliveries in America--which appear to result in lowered maternal self-efficacy and increased pain, anxiety, and sorrow). A variety of treatment options have emerged, including postpartum support groups, parent-infant play groups, and medication (which is now very widely used, at enormous cost to the parent and to society). A home visitor model of prevention would break the cycle of social isolation, restore the postpartum education that served as a major source of support for new mothers for generations, and serve early detection and case management purposes, all at a very low cost. Perhaps most impressive of all, such a home visitor model would avoid the pathologizing of maternal reactions to her new role, would reduce community stigmatization of postpartum mood disorders, and begin to create a circle of security for mothers that would serve to prevent the child abuse that often results from such mood disorders, would reduce the rate of re-occurrence with subsequent pregnancies, and would reduce the needs for (and the resulting side effects of) maternal use of psychotropic medications.

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ISSUE brief

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Supporting Collaboration between Mental Health and Public Health

Introduction

Public health is characterized by concern for the health of a population in its entirety and by awareness of the linkage between health and the physical and psycho-social environments.[1] Nearly 44 million Americans, 26 percent of the population[2], experience mental health problems in any given year. This means that mental health problems affect a larger proportion of the public than diabetes or cancer (6.6 and 7 percent of adults in 2002, respectively)[3,4] and roughly the same amount as obesity (30 percent of adults over 20 years of age in 2000).[5] This is why mental health has become an increasingly pressing public health concern.

> Health is a state of complete physical, mental and social wellbeing; not merely the absence of disease or infirmity.[25]

This issue brief represents the first in a series of steps the National Association of County and City Health Officials (NACCHO) is taking to call attention to the clear and strong links between public health and mental health. This document provides a historical context for which to consider the relationship between mental health and public health, background about mental health disorders, surveillance and infrastructure, and recommended action steps federal, national, state and local entities can take in the integration of public health and mental health.

The Historical Separation between Public Health and Mental Health

Since the early 19th century, mental health services have evolved from the provision of care in a state-run institutional setting to the provision of a range of services that are integrated into a larger health care and community- based system.[6] The 19th century social reform which brought forth new ideas about disease and social responsibility occurred during the development of the mental health system. Together with the introduction of improvements in bacteriology and sanitary health measures the movement provided the basis for public health in America.[7] The mental health system is rooted in the creation of the public health system; however, it has since evolved into a professional specialty independent, in many respects, from public health. This divergence has created challenges in the effort to offer a truly comprehensive and holistic public health care system.

Although most mental health programs are not implemented within the public health system, they remain rooted in a population-based public health model. Public health strategies focus on the health of a population in its entirety[8] and are designed to promote the prevention and treatment of mental illness throughout the United States. Faced with challenges such as combating stigma and discrimination, a population-based approach to mental health can aim to affect policies and access to care, while assuring quality treatment and incorporating stronger assessment techniques for monitoring the mental health of communities.[9] Because mental illnesses affect and are affected by chronic conditions such as cancer, heart disease, diabetes and HIV/AIDS, public health programs must incorporate support for mental health services. Untreated, mental illnesses often trigger unhealthy behavior, diminished immune functioning, and poor prognoses.[2] Through the collaboration of mental and public health, we can ensure comprehensive care and prevent the possibility of poor health behaviors, and negative disease outcomes associated with untreated mental illness.

Mental Health Disorders

Mental illness, one of the leading health indicators identified in *Healthy People 2010* as a priority public health concern for the beginning of the 21st century[10], should be addressed in a broad-based, comprehensive manner. Mental disorders are represented across genders, over a wide range of ages, racial and ethnic backgrounds. Within the United States, mental illnesses, such as major depression, are the leading cause of disability.[11] Major depression is the cause of more than two-thirds of U.S. suicides[12], resulting in 30,000 deaths each year.[13] In 1997, only 23 percent of adults who were diagnosed with depression received treatment.[14] Financial costs associated with mental health disorders are estimated at more than $79 billion, with approximately $63 billion attributable to lost productivity as a

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Comorbidity

- Thirty-six percent of people who are diagnosed with major depressive disorders have other types of medical conditions.[26]
- Thirty percent to 54 percent of patients with chronic pain have recurrent episodes of major depression. Studies suggest that more than 50 percent of patients with rheumatoid arthritis develop depressive and anxiety symptoms as well.[26]
- Depression is a strong independent risk factor for ischemic heart disease. Depression (75 percent of the time) remains undiagnosed and untreated in patients with cardiovascular disease, and only half of the 25 percent of people who are correctly diagnosed are ultimately treated for co-morbid depression. The risk of fatal and non-fatal cardiac events is directly related to the severity of depression.[26]
- Patients with diabetes are two to three times as likely to experience depression as those who do not have diabetes. According to the National Institutes of Mental Health, people who have diabetes and depression are more likely to develop depression relapse, more diabetes-related medical complications, and higher healthcare costs than people with depression who do not have diabetes.[25]
- HIV and mental illness co-morbidity is estimated at approximately 50 percent. Mental illness may arise independently of HIV infection, can predispose an individual to HIV (through risk-related behaviors) or can be a psychological consequence of HIV (e.g. depression).[27] Relief of HIV symptoms is essential to ensuring patients' mental health.[28]

According to 2001 data from the Centers for Disease Control and Prevention, 34 percent of people who were surveyed reported that they had been in poor mental health during the 30 day interval before they responded to the survey. Of these, 28 percent were men; 39 percent were women .[29]

result of illness.[15] Undiagnosed, untreated, or under-treated mental illnesses are a significant, preventable contributor to the nation's poor mental health outcomes. Methods such as early detection, assessment and treatment of mental illnesses can have a significant impact on peoples' lives.[11] Without intervention, child and adolescent disorders frequently continue into adulthood; when children with co-existing depression and conduct disorders become adults, they utilize more health services and incur higher healthcare costs.[11]

Health insurance systems further exacerbate the prevalence and cost of mental health problems in America. People who have mental illnesses are disproportionately uninsured, and many health insurance plans only offer limited coverage for mental health services. The insured who use mental health services are limited by more deductibles, coinsurance, and spending caps.[16]

Children's Mental Health

The growing number of children and adolescents in the United States who have mental health disorders is a growing concern among local public health agencies (LPHAs). It is currently estimated that one in five (more than 14 million) people are affected.[8] Furthermore, studies have shown that 75 percent to 85 percent of children with mental illnesses do not receive specialty mental health services, with most receiving no services at all.[17] A recent study also showed that only a fourth of the nine percent of children and adolescents in this country who need treatment for emotional problems receive it.[18] These young people require appropriate mental health care that is designed to address their special needs to prevent and reduce future health problems.

President's New Freedom Commission on Mental Health: Recommendations for Promoting the Mental Health of Young Children

- Improve and expand school mental health programs
- Screen for co-occurring mental and substance use disorders
- Link with integrated treatment strategies.
- Screening for mental disorders should take place in primary health care, across the life span, and connect to treatment and supports.[11]

Comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay, and reduce average days of juvenile detention by about 40 percent.[19] There is an acute need to develop systems of care for these vulnerable populations, through complementary efforts. Systems that incorporate public health

President George W. Bush established the President's New Freedom Commission on Mental Health in April 2002 as part of his commitment to eliminate inequality for Americans with disabilities. The President directed the Commission to identify policies that could be implemented by federal, state and local governments to improve the usefulness of existing resources, improve coordination of treatments and services, and promote successful community integration for adults with serious mental illnesses and children who have serious emotional disturbances.[11]

practice and address children's mental health needs should focus on improving access, developing a broad array of services, ensuring coordination, and providing the service delivery vehicle for clinical treatment and support services.[20]

The President's New Freedom Commission report *Achieving the Promise: Transforming Mental Health Care in America* (2002) provided several recommendations for ways that children's mental health care could be integrated into other public health activities to provide a more comprehensive system of care. To transform the mental health system, the Commission concluded that early mental health screening, assessment, and referral to services should become common practice.[11]

In addition to children, there is a growing recognition of how crucial the first three years of life are for the healthy emotional development of children. Infant mental health, as defined by the National Center for Infants, Toddlers and Families: Zero to Three, Infant Mental Health Task Force, is the development of a child's capacity to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn.[21] Infant mental health is synonymous with healthy social and emotional development, and healthy infant development can help prevent behavioral problems that may affect children as they mature.[21] Local public health agencies (LPHAs) and other organizations that are involved in the health and development of infants can strive to incorporate strategies to promote infant mental health into the existing array of early childhood programs and services including early intervention, health care, child welfare, and early care and education.[22]

Infrastructure Building

There is growing recognition that the historical separation between mental health and public health is an artificial one that threatens the health and well being of individuals, families, and communities. Both the 1999 U.S. Surgeon General's Report, *Mental Health: A Report of the Surgeon General*, and the President's New Freedom Commission on Mental Health state that mental health is fundamental to overall health, and call on the nation to recognize this fact.

The final report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, also calls for the current fragmented and disjointed mental healthcare delivery system to be fundamentally altered toward facilitating recovery and resiliency of persons living with mental illnesses.[11] The Commission's vision calls for integrated, comprehensive, and collaborative planning, service delivery, and financing of mental health services at the federal, state, and local levels. NACCHO is committed to fostering this collaboration among its members and encourages other mental health and public health entities to do so as well.

In 2003, the Oklahoma State Board of Health developed a report, The State of the State's Health, which reports disturbing trends in the burden of disability from mental health and substance abuse disorders. The burden of disability from these disorders is greater than that from cardiovascular disease or cancer.[30]

Mental Health Surveillance and Epidemiology

The nation's mental health system lacks standardized data, uniform measures, and an accessible and effective information system.[16] Mental health services need to be well organized within a balanced system of community care with a broad spectrum of services and clear focus on responsibility and accountability.[6] Mental health services will improve with enhanced epidemiological and surveillance information and a data collection system that can be linked to other service data collection systems.[16]

The public health system encompasses epidemiologic surveillance, health promotion, disease prevention, and access to services. Public health practices can identify risk factors for mental health problems and implement preventive interventions that may block the emergence of severe illnesses, ultimately enhancing the public's health.[8] Public health agencies serve as a valuable resource for epidemiological data on health indicators within localized communities. As presented by the Institute of Medicine (IOM) in *The Future of*

"A constellation of barriers deters minorities from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness. But additional barriers deter racial and ethnic minorities; mistrust and fear of treatment, racism and discrimination, and differences in language and communication."[12]

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Public Health, one of the core functions of a public health agency is community assessment to systematically collect, assemble, analyze and disseminate information on health statistics and health status, community health needs, and studies of health concerns.[7] State departments of mental health can benefit from the data collected by local public health agencies to capture accurate measurements of risk factors related to mental health, as well as the local needs, conditions, and mental health status of populations within their jurisdiction. Some local public health agencies, like Island County (WA), routinely include mental health information and data in local health status reports.[23]

Addressing Health Disparities

Mental health and public health systems, providers, and policy makers seek to improve the public's health status. But, the 1999 U.S. Surgeon General's report, *Mental Health: A Report of the Surgeon General* reported that racial and ethnic minorities have less access than their white counterparts do to mental health services. They are less likely to receive needed care and when they do receive care, it is more likely to be substandard. In addition, minorities are often underrepresented in research, perpetuating the cycle of poor quality of care. As mental health and public health systems begin to collaborate in planning and service delivery, every effort must be made to address and eliminate racial, ethnic, cultural, geographic and economic disparities in access and health outcomes.[12]

NACCHO's Role

As the evolution of the healthcare system occurs and opportunities emerge to transform how mental health and public health work together, NACCHO has sought to determine its role by hosting a consensus meeting involving local public health officials, mental health association executive directors, a state mental health commissioner and participants from the Association of State and Territorial Health Officials (ASTHO) and the National Mental Health Association (NMHA). Through this open forum, the participants addressed existing connections between public health and mental health and explored challenges and opportunities key players face in incorporating mental health into public health practice. The discussion resulted in the following recommended action steps.

NEXT STEPS

► UTILIZE NACCHO'S UNIQUE ROLE AS REPRESENTING LOCAL PUBLIC HEALTH AGENCIES (LPHAS) TO ENCOURAGE OTHER NATIONAL ORGANIZATIONS TO FACILITATE COLLABORATION AND COMMUNICATION BETWEEN FEDERAL, NATIONAL, STATE, LOCAL AND COMMUNITY PARTNERS.

► INTEGRATE THE CONCEPT OF MENTAL HEALTH AND PUBLIC HEALTH INTO PROGRAM PLANNING AND PRACTICE AND ADVOCATE FOR SIGNIFICANT AND SUSTAINED FUNDING TO SUPPORT THESE EFFORTS.

► IDENTIFY BEST PRACTICES OF MENTAL HEALTH AND PUBLIC HEALTH COMMUNITIES THAT ALREADY WORK TOGETHER.

► SHARE THE WORK NACCHO IS CURRENTLY ENGAGED IN WITH CONSTITUENTS AND STAKEHOLDERS.

► SUPPORT MORE COMPREHENSIVE INSURANCE COVERAGE FOR MENTAL HEALTH SERVICES.

► SHARE INFORMATION WITH MEMBERS ON FUNDING OPPORTUNITIES AND RESOURCES THAT EMPHASIZE MENTAL HEALTH.

In addition, the consensus meeting participants agreed on other action steps that require an increased time and effort, as well as advancement on the legislative front. Advocates at the local level should be aware of the priority issues on the legislative agenda and their potential repercussions in the mental health arena, such as legislative issues that could affect Medicaid, Medicare and screening, which promotes detection and access to appropriate services, especially for children.

"Our Health Department takes a holistic approach and includes school districts, nurses, doctors, bioterrorism, substance abuse, home health care and homeless shelters. There are lots of opportunities for partnerships to form."

Jacquelynn A. Meeks, former Director, St. Louis County (MO) Department of Health

On a local level, youth and other vulnerable populations can be impacted through bringing mental health and public health professionals together in maternal and child health Title V block grant planning, and public health can become involved in examining and addressing the mental health aspect of emergency/disaster situations.

Public health activities can complement mental health by enhancing the capacity of mental health systems. Mental health systems can be improved through an assessment of current surveillance and epidemiological infrastructure, which could lead to the development of a system that increases data and information collection. Public health's epidemiological methods can be developed to profile mental health systems, the results of which could promote program development and funding.

In addition, creating workforce and training development opportunities can strengthen the quality of the workforce, thus enhancing the capacity of health systems to serve the public's mental health needs.

Conclusion

A strong partnership between mental health and public health systems will enhance the individual goals of each profession while accomplishing the overarching mission of improving the public's health. The President's New Freedom Commission on Mental Health pointed out, "as future opportunities emerge to transform health care in America, mental health care must be considered part of the reform necessary to achieve the optimal health benefits for the American public."[11]

By incorporating the goals of public health into mental health practice through the particular action steps stated above, NACCHO and other national organizations can assist LPHAs and communities in providing accessible and quality mental health prevention and treatment services for all. Increasing access and enhancing quality of mental health services can improve the overall health of the community. Consumer knowledge regarding mental health has risen due to awareness and availability of new and effective treatments, and the demand for mental health services is subsequently increasing.[24]

LPHAs and other safety net providers must be able to respond to these challenges unhindered by an inadequately trained work force and financial constraints. In addition, the need to facilitate dialogue and strategic planning at the community, state and federal level cannot be overstated. NACCHO seeks to enhance LPHAs' ability to respond to these growing needs in their communities through the aforementioned action steps and further partnerships throughout the mental health and public health communities.

"We don't have knowledge about each other. At a meeting I attended about transitioning from a city to county health department, there wasn't familiarity with the mental health problems in the community. The two communities had worked together to discuss other types of issues but not directly on mental health collaboration."

Kristen Keech, Executive Director
Mental Health Association of York County (PA)

NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS

NACCHO is the national organization representing local public health agencies (including city, county, metro, district, and tribal agencies). NACCHO works to support efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, and supporting effective local public health practice and systems.

NMHA is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million people with mental disorders, through advocacy, education, research and service.

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The News-Gazette.com

Crisis Nursery program helps moms with perinatal woes

By Julie Wurth

Sunday March 8, 2009

Mykayla Thomas came into the world with an umbilical cord wrapped around her neck, survived on feeding tubes for several days and spent almost a week in neonatal intensive care.

Her mom had to wait two long days before she could hold her newborn.

Little wonder those days were stressful for April Browder, then an 18-year-old single mom. Too worried to eat or sleep, she lost her pregnancy weight – and then some – within a few weeks.

"It was very scary," says Browder, now 21.

As the birth of her second child, Clayton, approached last fall, Browder sought help from the Crisis Nursery of Champaign County. Family specialist Cherylanda Trice told her about a new program for moms at risk of perinatal depression.

Robert K. O'Daniell

April Browder plays with her daughter, Mykayla Thomas, 2, at her mother's house in Homer.

Browder said she was more anxious than depressed, but there were added stresses the second time around. She'd now be juggling two kids and would have to work to make ends meet. She and her boyfriend, Ben Thomas, planned to get their own place rather than continue living with Browder's mother.

So she joined a support group that met once a week. There she connected with other moms who had advice on how to calm a fussy baby or just get through the day.

Browder called Trice several times when she was stressed out; just talking to her for 15 minutes helped the young mom relax and "get my mind in the right place," Browder says.

"I actually am not as worried as I was before. I've figured out how to have more patience."

The "Beyond Blue" program started last July with $50,000 in grants from the Champaign County Board of Health and the Champaign County Mental Health Board, said Laura Swinford, program director at Crisis Nursery.

The idea was to target new mothers in rural areas who might not have easy access to support services. So far, 14 moms have signed up.

Swinford said Crisis Nursery already had a unique mix of programs available, offering 24-hour child care and support services to families in crisis, as well as Parent Child Interaction groups to help moms with parenting skills.

At the same time, a new federal mandate required hospitals and physicians to screen mothers for perinatal depression. It took effect in January 2008 but "we found that a lot of people weren't aware of this," Swinford said.

The nursery recruited women through its Parent Child Interaction groups and took referrals from Carle and Christie clinics.

Using the parenting groups as a model, the program offers support groups, parenting education from trained staff and home visits by Trice. The mothers also know they have a place to call or drop off their children 24 hours a day.

This particular population doesn't use Crisis Nursery as much as it could, Swinford said, and "our hope is to make it safer for them to reach out and ask for help."

The support group sessions have been held in Rantoul as well as Family Service of Champaign County and Frances Nelson Health Center in Champaign.

The idea is to "make it OK for those mothers to talk about their feelings and know that they're not alone," Swinford said. Being depressed or anxious during one of the happiest times of their lives is a "consuming and lonely feeling."

They should leave the program feeling they know whom to contact if they need help and that they're not alone, "so they can feel the joy they always dreamed of feeling of being parents," she said.

All the women have different stories, but depression, anxiety and high stress are common factors, along with a lack of family support, Trice said. Some women have struggled with depression before, a risk factor for perinatal depression.

Others never experienced it until pregnancy hormones kicked in.

Kelly Anderson, 32, of Tolono, said she was diagnosed with depression when she was 15.

She had a "blue period" after the birth of her first son, now 15, but it was easier to manage because she has a strong support network.

Her second son is due March 11, and "my support group has dwindled," she said.

She had an episode recently when "everything fell apart," and she's taking medication.

"Anybody would be a little concerned in my situation, although I am very happy that he's coming," she said. "I'm more prepared for it than I was last time. ... I imagine I'm going to have some difficulty at first. It won't come as a nasty shock."

She attended her first support group recently and expects that to be a "huge help."

Just providing support services brings some women out of their depressive mode, Trice said. Others are referred to counselors or psych- iatrists.

Swinford and Trice believe the program is making a difference. They see women more engaged in the parent-child groups and more eager to schedule home visits or just get out of the house.

A formal evaluation of the program will be done next summer, with help from the University of Illinois School of Social Work.

Michael Trout, director of the Infant-Parent Institute in Champaign, is also a program consultant.

Browder plans to move out of her mom's house this month, and she's nervous about being on her own with the kids for the first time.

But now she knows things she can do to calm her children, like giving them a bath or having 2-year-old Mykayla run around the room to entertain 5-month-old Clayton. She also knows she can call Trice in a pinch.

Without the Beyond Blue program, "I think I'd still be sitting at home, stressed," she says. "It's nice to know there are places you can turn to in an emergency."

Some facts about perinatal depression

— Experts say 10 to 15 percent of women develop major depression while pregnant, and more than 20 percent do after giving birth. 'Perinatal' refers to the time from conception to one year after childbirth.

— Symptoms of major depression include nearly constant feelings of sadness or emptiness; feelings of hopelessness, guilt or negative self-worth; difficulty sleeping even while exhausted; weight gain or loss; difficulty concentrating or making everyday decisions; very low energy levels; or even thoughts of harming themselves or the baby.

— About half of women develop normal mood changes called "postpartum blues" after giving birth, but that tends to be

temporary.

— Untreated depression may increase the risk that babies will be born prematurely or underweight. Perinatal depression can also interfere with mother-infant bonding and increase the risk of emotional and intellectual problems in the child. At its most severe, it can be life-threatening.

— Screening is recommended because women may not recognize their symptoms, assuming they are just experiencing normal stresses of new motherhood. Or they may not seek help because of the stigma of mental illness.

Sources: University of Illinois-Chicago Perinatal Mental Health Project, Perinatal Foundation.

Find this article at:
http://www.newsgazette.com/news/2009/03/08/crisis_nursery_program_helps_moms_with_perinatal_woes

Comments

The News-Gazette.com

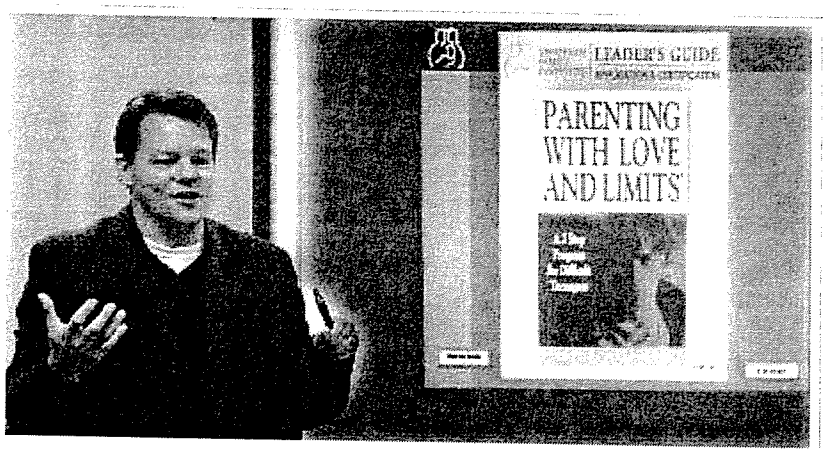
Champaign County starts program on family-based therapy

By Mary Schenk

Sunday March 1, 2009

URBANA – Unhappy with the results of previous programs aimed at preventing juvenile delinquency in Champaign County, officials charged with that responsibility are going to try something new.

They've chosen a program with a track record of getting a whole family not only to start therapy but also to finish it. In mental health jargon, it's referred to as an "evidence-based practice."



Vanda Bidwell

Scott Sells delivers a presentation on his program for helping troubled teens, 'Parenting With Love and Limits,' to a group of probation officers, police, prosecutors and social workers.

"We have funded a variety of different programs through the quarter-cent (public safety) sales tax and the Mental Health Board," said Peter Tracy, executive director of the Champaign County Mental Health Board. Five percent – about $220,000 – of the annual amount collected for public safety is earmarked for serving juveniles who come into contact with the criminal justice system.

"In looking at the results of trying to link kids to services, we were very disappointed with family engagement. Families were not showing up, not participating. The ones that were, we were concerned that a lot didn't ever finish a program," he said.

About a year ago, Tracy went to a conference in St. Louis where several exhibitors were selling programs to help at-risk adolescents. One that caught his attention was "Parenting with Love and Limits."

Designed by Scott Sells of Savannah, Ga., who has a doctorate in marriage and family counseling and a master's in social work, the program integrates group and family therapy into one system aimed at helping families who have a child between 10 and 16 with extreme emotional or behavioral problems.

After a lot of research by Tracy, Court Services Director Joe Gordon and State's Attorney Julia Rietz, the county decided to buy Sells' program for $150,000 for the first year. That includes training of therapists, the manuals for the program, and evaluation and supervision of the therapists by Sells.

They aim to serve 228 families between April of this year and June 2010. Depending on its success – the program will be closely monitored – they may spend more to serve more, Tracy said.

The Mental Health Board will contract with community agencies to deliver the program. So far, Prairie Center Health Systems and the Champaign County Mental Health Center have expressed an interest. The salaries of the four people hired initially will be in addition to the $150,000 Sells is charging.

Sells will approve those hired, train them and evaluate them to make sure they're delivering the product the way it should be.

Late last month, Sells described the program for prosecutors, police, public defenders, juvenile probation officers and mental health workers at the Champaign County Courthouse.

The idea behind Parenting with Love and Limits is to help parents rebuild emotional attachments with their child, improve communications and set consistent limits. If parents aren't changed, then their children won't be either, he said.

"If you can't get the parents involved, you are not going to be successful," Sells said.

Using the right motivation to get parents to the counseling table is critical to the success of the program. Once there, therapists get the parents, child and siblings involved in changing.

"We're showing a 70 percent or higher parent graduation without court order," Sells said.

Ross Edmunds, the children's mental health specialist for the Idaho Department of Health and Welfare, said the state has been using Parenting with Love and Limits since July.

"About 75 percent of our mental health cases had (bad) behavior as a primary or contributing symptom," he said. "In areas where we've had a strong therapist, it's been among the most successful treatment service we've probably ever delivered. I have had several families communicate with me how much they appreciate this model."

Sells said the program will be offered on nights and weekends to meet the schedules of working parents. It includes six multifamily sessions where parents learn skills like how to de-escalate an explosive situation and get back to nurturing their children.

"If you've spent five to eight years arguing, there's no time left over for nurturance, laughter, playfulness," Sells said, adding that the parents coach each other during those sessions. "A lot of parents don't have a village. They don't have access to neighbors and relatives. They have access to probation officers and police. That creates learned helplessness."

John Burek, deputy director of the Bay Area Youth Services in Tampa, Fla., said his agency has been delivering the program in Hillsborough County for nearly two years, serving about 170 families.

"For us, the feedback has been all positive. We've worked with diversion and probation kids and now are using it with kids who are coming out of residential commitment programs to aftercare," Burek said.

"In the beginning, the families have to travel to do the six family group sessions. The biggest hurdle was the travel. What we found was if we can get them to first group, they end up staying. Over 78 percent stayed. That's phenomenal. We can see the change," Burek said.

Along with group therapy are individual family therapy sessions: two or three sessions for low- to moderate-risk adolescents, up to 20 sessions for those with more severe problems.

Tracy said in Champaign County, the plan in the first year is to offer the program to 128 "front-end" children – minor offenders who have received police station adjustments or been offered diversion instead of being criminally charged – and 100 "deep-end" children. Those would be children who have spent time in detention for a serious crime and may be on probation.

The details of how a family gets referred to the program are still being worked out. Rietz said the program will not automatically be ordered for every child sentenced to probation.

She's counting on police, probation officers and attorneys to recommend families who could benefit and are willing to try.

"If you think they're a good candidate, let us get them to want to do it. That's our job," Sells told the people at the recent meeting.

But he stressed that it's best to get them into the program as soon as possible – for instance, when a child is still in detention.

"When parents are in crisis, they're open to suggestions. What happens now is you engage families way too late in the process," Sells said. "Parents buy in because they think they're fixing the kid. But it's fixing their issues, too."

For more information on the program, check on the Web: www.gopll.com.

Comments