

The Spiraling Times



April 2009



WHAT CAN DBSA SOUTHERN NEVADA SUPPORT GROUPS DO FOR YOU?

“A FAMILY MEMBERS EXPERIENCE”

SUBMITTED BY PARENT ROBIN M.

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We Have Been There
We Care,
We Understand
We Can Help

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My daughter is 13. She was a great student and happy child, until...She started becoming angry, defiant, and “difficult.” She was initially diagnosed as depressed. At the age of 4, she had been sexually abused by her father as a child. He is an alcoholic—likely also bipolar as they ten to “self medicate” with alcohol or drugs which is then known as “dual diagnosis” - he’s been in and out of jail since we divorced in 1994. When she was 10 we began going to therapy. I thought perhaps she was having troubles dealing with living in a single parent or lower income household, or the combination; perhaps even having latent memories of the violent childhood she had. Her therapists agreed that early violence (seeing me repeatedly beaten), and then being sexually abused along with the separation from her father and brother, were causing her depression. They suggested we go to a Psychiatrist and get her some medication, as the combination of medication and therapy would be ideal. For her depression she was prescribed Zoloft—that was at the end of 2001.

Six weeks later, as the Zoloft reached therapeutic level, the 2002 New Year turned into a nightmare—she attacked me twice with a butcher knife that first week. It turns out the Zoloft had the effect of making her worse because she is bipolar—they caught on after the second attack on me. Anti-depressants can escalated the mania side of bipolar, which once progressed to a mania stage cannot be shut off, only regulated by medication. While I suffer from depression and Zoloft benefits me, for my little girl it was nothing short of disastrous. I found out that each medication reacts differently in each person due the individual levels of the chemical imbalance in their brain.

Soon she also had a record of shoplifting. I was getting to know our local policemen by name, as they would respond to altercations at our apartment regularly. (The arresting officer for her shoplifting was one of them, so he was familiar with her case.) Several times they transported her via ambulance to the ER for evaluation by mental health experts. Each time their opinion was that she needed treatment. But, our HMO refused to pay any bills for hospitals, etc.—said she was just being a “brat.” In January, the director of the HMO sat

on her bedside and told me that to my face—after she had ripped equipment off the walls of the ER, ran off and had to be run after by security, and attacked several of us after having been administered enough drugs to sedate an overweight adult! Fortunately she got a great judge here in Clark County, who forced a re-examination, after she attacked me with the butcher knife again and the policemen told me it was time for me to face facts and let them take her in. She tried to hang herself in jail.

At this point, our HMO had no choice in the matter, and referred us to an excellent specialist. Then we got the diagnosis of bipolar—I’d known very little about it to that point. She spent 5 weeks, including the last 4 weeks of school, in the juvenile detention center.

Later in the summer I almost lost her to a drug overdose—I’d locked up the knives, but not the meds. She’d threatened suicide numerous times, would rattle the bottles, dump pills down the drain, but she had never taken any of them.

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A Parents Letter—Continued

For eight hours, I sat beside my 12 year olds body, holding her hand, listening to the monitors while the doctors would not tell me if she'd see daylight. The HMO authorized her to be transferred to a local private psychiatric hospital that treated children. The would NOT however, pay for the ambulance transport, despite the fact that she had wrenched the steering wheel out of my hands on previous occasions and nearly caused accidents) where she spent less than a week in the psychiatric facility—again, the lovely HMO's decision.

She got suspended from school in November for having a knife at school (she "forgot" it was in her purse, lost the purse and they found it looking for ID—more sad, was that she had crept into the bathroom while I was showering and took the key to the lock box that the knives were kept in, unlocked it, took the Swiss army knife, locked it back up and crept back in and replaced the key unbeknownst to me). Fortunately for her, since she had an IEP for a speech impediment, she fell between Clark County School District administrative cracks that took them from Thanksgiving until late Jan to resolve—the whole time she was out of school (missing over FIVE weeks of education, yet still being required to take the exams in January and having the low grades). Then they put her in a detention school. From there, she got worse again, emotionally, although scholastically she excelled in the controlled environment. Incidentally, she was taken off her IEP for speech, having made significant progress, and was placed on Section 504 protection for her mental health diagnosis.

In February I had to go searching for her each night when I got home from work. Her therapist recommended placement in a residential treatment center, which naturally insurance does NOT pay for (I had to even obtain a letter specifying that). However, the state facility she did qualify for was full. As an interim solution, her probation officer got her into a group home for juve-

niles. She spent two months there. Unfortunately, while there was one other child diagnosed with bipolar and one with schizophrenia, the rest of the girls were hard core, and I'm afraid my little girl got quite the street-wise education. She did however learn she had to take her meds and cope with people and situations. She was finally placed in Desert Willow. It has been estimated that she will spend eight months in this state run facility. During this stay she improved greatly, both in anger management and impulse control.

It's been a long, depressing disaster that has taken its toll on all of us. My parents are elderly and live 4 hours away. Each episode has taken a toll on them, financially, emotionally, and physically. My mother had recently undergone hip surgery when the first manic episode and hospitalization occurred. I can hear the anguish in their voices when I call, as they wonder if this call will bring good or bad news. For myself, my depression deepened, affecting not only my work, but also my ability to assist my daughter through her crises. Her brother lives 6 hours away; he, too, is diagnosed with bipolar disorder. The interpersonal relationship they have has been both strengthened by their mutual understanding, and strained by the emotional roller coaster ride as they go from manic event to manic event. The toll the HMO's inaction from January to May is incalculable—I will never know if, had they taken appropriate action at that time, would that have affected the outcome today?

One of the things her case manager at the hospital suggest to help my well-being was to call DBSA Southern Nevada. She said they had a program to help parents. I made the call and am very glad I did.

What did DBSA do for us? Well, to begin with, I should point out what it COULD have done for us. I did not find The group until May. Had I known of the group before this time, The group until May. Had I known of the group before this time, I would have

I would have had access to an advocate that could have accompanied me to the IEP meetings and would have had her IEP re-written to include her mental health diagnosis. I would have had an advocate assist me in battling my HMO in obtaining the necessary care she needed. I would have had the support for myself, so that I would not have reached the low depths that I did. And, most importantly, I would have been armed with the tools—education, the materials, the people, and the contacts—to help my little girl in the best way possible.

What does DBSA do for us now? Well, it's achieved a higher level of happiness for me, which makes for a happier Mommy for my daughter! I come out of meetings energized and, truthfully, relieved. To speak about our experiences, stumbling for the words and phrases to express my feelings, and look about the room and see other's nodding their head in sympathy because they UNDERSTAND without my having to get the words out, is a grateful and bonding feeling I just can't explain. I've felt the loneliness, the fear, the helplessness; I've cried alone, shouldered the burden alone. No one has to do that thanks to DBSA. The sustainable friendships I have made with other parents is incredible. DBSA provides support everyday to strangers and their members. They are there to help with dealing with suicides and attempted suicides, special education issues, court hearings, answering the phones 24 hours a day. They are there to support you and help educate you.

My hope for my daughter is she finds the same feelings of empathy, understanding and support at the adolescent support group meeting they conduct. How can anyone put into words what the importance of DBSA is? How can anyone put into words the value of a human life?

UPDATE: Robin's son committed suicide last summer. Her daughter graduated from high school the following month and is now married and expecting her first child. This article was written in 2003. Robin still attends meetings.

WEEKLY MEETING LIST

MONDAY EVENING

**ADOLESCENT DIAGNOSED
Ages 13-17**

6:30 PM TO 8:00 PM

**Rawson-Neal Psychiatric
Hospital**

**1650 Community College
Drive
Las Vegas, NV 89146**

Training Room 1

WEDSDAY EVENING

**ADULT DIAGNOSED
(18 & OVER)**

6:00 PM TO 7:30 PM

**Rawson-Neal Psychiatric
Hospital**

**1650 Community College
Drive
Las Vegas, NV 89146**

Training Room 1

THURSDAY EVENING

**DUAL DIAGNOSED
Addiction and Mood Disorder**

6:00 PM TO 7:30 PM

**Rawson-Neal Psychiatric
Hospital**

**1650 Community College Drive
Las Vegas, NV 89146**

Training Room 1

MONDAY EVENING

**PARENTS OF DIAGNOSED
ADOLESCENTS**

6:30 PM TO 8:00 PM

**Rawson-Neal Psychiatric
Hospital**

**1650 Community College
Drive
Las Vegas, NV 89146**

Training Room 2

WEDSDAY EVENING

**PARENTS, FAMILY &
FRIENDS**

6:00 PM TO 7:30 PM

**Rawson-Neal Psychiatric
Hospital**

**1650 Community College
Drive
Las Vegas, NV 89146**

Training Room 2

THURSDAY EVENING

**PTSD
Post Traumatic Stress
Disorder**

6:00 PM TO 7:30 PM

**Rawson-Neal Psychiatric
Hospital**

**1650 Community College
Drive
Las Vegas, NV 89146**

Training Room 2

CONSUMERS CORNER

The Road To Recovery By Arnold Wax MD

My story starts over 60 years ago, but rather than bore everyone with that much detail, I will tell my path from last year to the present.

On March 8, 2008, I made a suicide attempt. The attempt had been planned over a 6 week period of time and it was times so I would not wake up for my birthday. I took large amounts of numerous medications in the hopes that my organs would fail and that I would die. I had no fear of dying, only the fear of living. The reason for the suicide attempt was due to many factors, a broken marriage, at my doing, a broken subsequent relationship, a failing practice and mounting debts with no foreseeable way of satisfying the debts. I was so horribly depressed, in despair, lonely and alone as well as isolated that I felt I just needed to permanently sleep as the only time I didn't face these problems was when I was sleeping. So, I finally went ahead with my plans. However, much to my chagrin I didn't die, at least not then.

The next morning, my daughter called and invited me over for dinner, but I said I "didn't feel well." She called again later as did her sister and mother (my ex-wife) and asked me what I had taken. I told them to leave me alone, but they didn't. They called an ambulance, came to my home, broke in the back door and over my protests I was taken a hospital. I spent a month in the hospital as I suffered a perforated ulcer and had to have emergency surgery, followed by respiratory failure due to pneumonia. I could have and probably should have died those two times, but I didn't.

Once I got out of the acute care hospital, I was put on a mandatory legal 2000 hold as required by law due to my suicide attempt. What a waste of time that was. However, during this time my daughter had found a facility where my recovery could begin and ultimately did. She arranged for me to have a bed there and I left Las Vegas for

Houston, Texas and my recovery began.

When I arrived at the facility in Houston, I was met by and interviewed by a resident physician in psychiatry from Baylor University. We talked for well over an hour about what I hoped to gain for the future. I then was taken to the unit I was to be on. It was known as the PIC (Professionals in Crisis) Unity. I met the nurses, was assigned a primary nurse and a mental health coordinator and a "buddy" to show me around the unit and the facility. He was another member of the unit. I spent 9 weeks at this facility where I had an individual therapist, two psychiatrists (an attending and the resident) and a "primary clinician" who supervised my case and helped with family therapy.

I was in many groups, such as group psychotherapy, perfectionism, shame and resiliency, positive psychology, cognitive behavioral therapy and dialectic behavioral therapy as well as family therapy and vocational therapy groups. This was the stepping stones for me to recover.

After 9 weeks at the facility I was ready to go home. Prior to leaving I completed, as required, a rather intensive wellness plan describing my short and long term future goals. I arranged to see a psychiatrist, a psychotherapist and my regular physician and dentist for follow-up. You see part of recovery from a mental illness is to keep ones self well physically. I also arranged to see a physician to after my thyroid gland something for which I ultimately had surgery.

Lastly, I found support groups sponsored by DBSA Southern Nevada and NAMI and a DBT group online.

Back in Las Vegas, my recovery has continued on a steady pace. I go to support group meetings weekly, therapies and I take care of myself. I am now back at work and although it is part time I continue to look to increase my work hours as I am capable of working full time. My therapies have been decreased by half. I have not had any crises although there have been some difficult times both at work and

at home. Initially, when I came home I lived with my ex-wife and my daughter. Now, I have found my own place to live and I totally enjoy the independence. I remain on the one medication I have taken since the beginning of my event. It works for me and I tolerate it well. I practice the skills I have learned on a daily basis and now use them without even giving it a second thought. You see they work for me when I work on them. Now, I have even found a lovely woman to share my time with and I have been open enough with her to tell her my story. She didn't even bat an eye. Her comment was "you seem healthy to me."

So you see, there is a road to recovery. Everyone is capable of recovery, it is a personal choice. It's not a cure just like any and all chronic diseases. However, the appropriate therapies, medications, support systems (and I gave a great one stretching from California to England) and a special one here in Las Vegas,. Especially with hard work YOU can recover too, no matter what your personal circumstances are. I am living proof of that.

** Please note, Arnold is a DBSA Support Group facilitator, serves as Vice-president on our Board of Directors and heads up our facilitator training program.

DBSA Southern Nevada would like to thank Arnold for sharing his story with our readers, and wish him continued success in his Road To Recovery.

DID YOU KNOW?

DBSA Southern Nevada sponsors a free monthly community lecture series? Check out our website for scheduled dates, time, location and name of presenter.

www.dbsa-southernnevada.org

PARENT'S OF CHILDREN AND ADOLESCENTS CORNER

PSYCHIATRIC MEDICATION FOR CHILDREN AND ADOLESCENTS: WHAT TO ASK YOUR DOCTORS

Medication can be an important part of treatment for some psychiatric disorders in children and adolescents. Psychiatric medication should only be used as one part of a comprehensive treatment plan. Ongoing evaluation and monitoring by a physician is essential. Parents and guardians should be provided with complete information when psychiatric medication is recommended as part of their child's treatment plan. Children and adolescents should be included in the discussion about medications, using words they understand. By asking the following questions, children, adolescents, and their parents or guardians will gain a better understanding of psychiatric medications:

1. What is the name of the medication? Is it known by other names?
2. What is known about its helpfulness with other children who have a similar condition to my child?
3. How will the medication help my child? How long before I see improvement? When will it work?
4. What are the side effects which commonly occur with this medication?
5. Is this medication addictive? Can it be abused?
6. What is the recommended dosage? How often will the medication be taken?

DID YOU KNOW ?

- Nevada is second in the national for adolescent suicides?
- Adolescents with a Mood Disorder are more vulnerable to bullying incidents?
- Adolescents with a Mood Disorder are more vulnerable to sexual

7. Are there any laboratory tests (e.g. heart tests, blood test, etc.) before and/or during the time my child is on this medication?
8. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?
9. Are there any other medications or foods which my child should avoid while taking the medication?
10. Are there interactions between this medication and other prescription and /or over the counter my child is taking?
11. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities.
12. How long will my child need to take this medication? How will the decision be made to stop the medication?
13. What do I do if a problem develops (e.g.) child becomes ill, doses are missed, or side effects develop)?
14. What is the cost of the medication (generic vs. brand name? Will my insurance company cover the cost?
15. Does my child's school nurse and/or pediatrician, family doctor need to be informed about this medication?

Contributed by the American Academy of Child & Adolescent Psychiatry

ual abuse and rape.

- Neighborhood Care Centers in Las Vegas treat Severally Emotionally Disturbed children without insurance?
- Adolescents with a Mood Disorder have serious problems having healthy personal relationships and feel very isolated and alone.

CHILD AND ADOLESCENT DRUG ABUSE STATISTICS

- An estimated 19.9 million Americans aged 12 or older were current users of an illicit drug in 2007. This estimate represents 8.0 percent of the population.
- An estimated 70.9 million Americans reported being current users of a tobacco product in 2007, a prevalence rate of 28.6% of the population 12 years and older.
- Marijuana is the most widely used illicit substance in the country. In 2007, 14.4 million people were current users of marijuana.
- Vicodin is one of the drugs most commonly abused by adolescents. In 2008, 15.4% of 12th graders reporting using a prescription drug for non-medical purposes in the last year.

Contributed by the American Academy of Child & Adolescent Psychiatry

RISK TAKING BEHAVIOR

Risk-Taking Behavior is any action that increases the likelihood of injury or death. 72% of all deaths among 10-24 year olds results from four causes:

1. Motor-vehicle crashes
 2. Other unintentional injuries such as self-mutilation, drinking, drug overdose etc.
 3. Homicide
 4. Suicide
- Verbal abuse, threats, and temper outbursts by children diagnosed have been reported by more than 50% of relatives?
 - A sign of suicidal ideology is giving away personal belongings?
 - Adolescents with a Mood Disorder tend to take more risks than those not diagnosed?

**YOUTH RISK BEHAVIOR
SURVEILLANCE (CDC)
UNITED STATES, 2007**

**Sadness and Suicide Ideation
and Attempts**

Felt Sad or Hopeless

- During the 12 months preceding the survey, 28.5% of students nationwide had felt so sad or hopeless almost every day for more than 2 weeks in a row that they stopped doing some usual activities. Overall, the prevalence of having felt sad or hopeless almost every day for more than 2 weeks was higher among female (35.8% than male (21.2%) students.

Seriously Considered Attempting Suicide

- During the 12 months preceding the survey, 14.5% of students has considered attempting suicide. Overall, the prevalence of having considered attempting suicide was higher among female (18.7%) than male (10.3%).

Made a Suicide Plan

- During the 12 months preceding the survey, 11.3% of students nationwide had made a specific plan to attempt suicide. Overall, the prevalence of having made a specific suicide plan was higher among female (13.4% than male (9.2%).

Attempted Suicide

- Nationwide, 6.9% of students had actually attempted suicide one or more times during the 12 months preceding the survey. Overall, the prevalence of having attempted suicide was higher among female (9.3%) than male (4.6%) students.

**YOUTH RISK BEHAVIOR
SURVEILLANCE (CDC)
NEVADA 2007**

**Sadness and Suicide Ideation
and Attempts**

Felt Sad or Hopeless

- ◆ During the 12 months preceding the survey, 26.1% of Nevada high school students had felt so sad or hopeless almost every day for more than 2 weeks in a row that they stopped doing some usual activities.

Seriously Considered Attempting Suicide

- ◆ During the 12 months preceding the survey, 14.3% of Nevada high school students had seriously considered attempting suicide.

Made A Suicide Plan

- ◆ During the 12 months preceding the survey, 14.2% of Nevada high school students had made a specific plan to attempt suicide.

Attempted Suicide

- ◆ Statewide, 8.9% of Nevada high school students had actually attempted suicide one or more times during the 12 months preceding the survey.
- ◆ Nevada ranks second in the nation with the most completed suicides by adolescents.

Information provided by the Nevada Office of Suicide Prevention.

**TEEN DEPRESSION
SIGNS AND SYMPTOMS
TIPS FOR PARENTS**

Symptoms

Teenagers face a host of pressures, from the changes of puberty to questions about who they are and where they fit in. The natural transition from child to adult can also bring parental conflict as teens start to assert their independence. With all this drama, it isn't always easy to differentiate between depression and normal teenage moodiness. Making things even more complicated, teens with depression do not necessarily appear sad, nor do they always withdraw from others. For some depressed teens, symptoms of irritability, aggression, and rage are more prominent.

Signs

- ◇ Sadness or hopelessness
- ◇ Irritability, anger, or hostility
- ◇ Tearfulness or frequent crying
- ◇ Withdrawal from friends and family
- ◇ Isolating in room
- ◇ Loss of interest in activities
- ◇ Changes in eating and sleeping habits
- ◇ Restlessness and agitation
- ◇ Feelings of worthlessness and guilt
- ◇ Lack of enthusiasm and motivation
- ◇ Fatigue or lack of energy
- ◇ Difficulty concentrating
- ◇ Thoughts of death or suicide
- ◇ Risk taking more than usual
- ◇ Problems in school.
- ◇ Listening to sad or music about death
- ◇ Frequent web sites that talk about death
- ◇ Unexplained aches and pains
- ◇ Extreme sensitivity to criticism

TEEN DEPRESSION SIGNS –CONTINUED FROM PAGE –6-

SIGNS CONTINUED

- ◇ Talking or joking about committing suicide
- ◇ Withdrawing from some, but not all people.
- ◇ Saying things like, “I’d be better off dead,” “I wish I could disappear forever,” or “There’s no way out.”
- ◇ Speaking positively about death or romanticizing dying (“If I died, people might love me more”).
- ◇ Writing stories and poems about death, dying, or suicide.
- ◇ Engaging in reckless behavior or having a lot of accidents resulting in injury, or an increase in speeding tickets or driving infractions.
- ◇ Giving away prized possessions.
- ◇ Saying goodbye to friends and family as if for good
- ◇ Seeking out weapons, pills, or other ways to kill themselves.

Seek Help Immediately if you think your adolescent might be considering suicide.

National Suicide Hotline
1-800-784-2433

Untreated Depression can lead to:

- ◆ Problems at school
- ◆ Running Away
- ◆ Substance abuse
- ◆ Low self-esteem
- ◆ Eating disorders
- ◆ Internet addiction
- ◆ Self-injury
- ◆ Reckless behavior
- ◆ Violence
- ◆ Suicide

TIPS FOR PARENTS

Tips For Talking To A Depressed Teen:

- ◆ Offer Support—Let them know that you’re there for them, fully and unconditionally.
- ◆ Be gentle but persistent Don’t give up talking to your teen if he/she shuts you out at first. Be respectful of your child’s comfort level while still emphasizing your concern and willingness to listen.
- ◆ Listen without lecturing Resist any urge to criticize or pass judgment once your teenager begins to talk. The important thing is that your child is communicating. Avoid offering unsolicited advice or ultimatums as well.
- ◆ Validate Feelings Don’t try to talk teens out of their depression, even if their feelings or concerns appear silly or irrational to you. Simply acknowledge the pain and sadness they are feeling. If you don’t, they will feel like you don’t take their emotions seriously.

WHAT PARENTS NEED TO DO

- VISIT YOUR FAMILY DR. Make an immediate appointment for your teen to see the family physician for a depression screening.
- SEEK OUT A SPECIALIST If there are no health problems that are causing your teenager’s depression, ask your doctor to refer you to a psychologist or psychiatrist who specializes in children and adolescents.
- EXPLORE TREATMENT OPTIONS. Discuss with the specialist about treatment possibilities. There are a number of treatment options, including medication, one-on-one talk therapy, group or family therapy and the possibility of a short term hospitalization program.

SUPPORTING A TEEN THROUGH TREATMENT

As your depressed teenager in your life goes through treatment, the most important thing you can do is to let him/her know that you’re there to listen and offer support. Now more than ever, your teenager needs to know that he/she is valued, accepted, cared for and loved unconditionally.

SUPPORTING YOURSELF THROUGH TREATMENT

- ◆ TAKE CARE OF SELF - In order to help your teen, don’t ignore your own needs. Eat right, get enough sleep personal time.
- ◆ REACH OUT FOR SUPPORT Get the emotional support you need. Reach out to friends, join a support group, or see a therapist of your own. It’s okay to feel overwhelmed, frustrated, helpless, or angry. The important thing is to talk about how your teen’s depression is affecting you, rather than bottling up your emotions.
- ◆ BE OPEN WITH FAMILY AND FRIENDS Don’t tiptoe around the issue of teen depression in an attempt to “protect” other family members. Be open about what is going on and invite your children, family members and friends to ask questions and share their feelings.
- ◆ REMBER THE SIBLINGS Depression in one child can cause stress or anxiety in siblings. Make sure “healthy” children are not ignored, they too might need individual counseling to deal with their feelings.
- ◆ AVOID THE BLAME GAME It can be easy to blame yourself or another family member for your teen’s depression, but that only adds to an already stressful situation. Depression is caused by a number of factors, so it is unlikely, except in the case of abuse, neglect or other trauma that any loved one is “responsible”.

A PUBLIC HEALTH CRISIS CHILDREN AND ADOLESCENTS WITH MENTAL DISORDERS

Reports by the U.S. Surgeon General and President Bush's New Freedom Commission on Mental Health offer hope to the millions of children and adolescents living with mental disorders and their families. Through appropriate identification, evaluation, and treatment, children and adolescents with mental disorders can lead productive lives. They can achieve success in school, work, and family life. Unfortunately, the majority of children with mental disorders fail to be identified, lack access to treatment or supports, and needlessly suffer throughout their lives. Stigma persists and millions of young people in the U.S. are left behind.

The following are the consequences of untreated mental disorders in children and adolescent:

SUICIDE

- Suicide is the third leading cause of death in youth aged 15 to 24. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined. Over 90% of children and adolescents who commit suicide have a mental disorder.

DID YOU KNOW ?

- Nevada is second in the national for adolescent suicides?
- Adolescents with a Mood Disorder are more vulnerable to bullying incidents?
- Adolescents with a Mood Disorder are more vulnerable to sexual abuse and rape.

- In 2002, almost 4,300 young people ages 10 to 24 died in this country by suicide. with completed suicides and suicide attempts by youth up to 20 years of age.

SCHOOL FAILURE

- Approximately 50% of students with a mental disorder age 14 and older drop out of high school; this is the highest dropout rate of any disability group.

JUVENILE/CRIMINAL JUSTICE INVOLVEMENT

- Youth with unidentified and untreated mental disorders also tragically end up in jails and prisons. According to an NIMH funded study, an alarming 65% of boys and 75% of girls in juvenile detention have at least one mental disorder. We are incarcerating youth some as young as 8 years old, rather than identifying their disorders early and intervening with appropriate treatment.

HIGHER HEALTH CARE UTILIZATION

- When children with untreated mental disorders become adults, they use more health care services and incur higher health care costs than other adults.
- Left untreated, childhood disorders are likely to persist and lead to a downward spiral of school failure, limited or non-existent employment opportunities, and poverty in adulthood.

- No other illnesses harm so many

- **Neighborhood Care Centers in Las Vegas treat Severally Emotionally Disturbed children without insurance?**
- **Adolescents with a Mood Disorder have serious problems having healthy personal relationships and feel very isolated and alone.**
- **Verbal abuse, threats, and temper outbursts by children diagnosed have been**

EARLY IDENTIFICATION, EVALUATION, AND TREATMENT ARE ESSENTIAL TO RECOVERY AND RESILIENCY

- Research shows that early identification and intervention can minimize the long term disability of mental disorders.
- Mental disorders in children and adolescents are real and can be effectively treated, especially when identified and treated early.

Disclosure

An individual has the right to review and obtain a copy of his/her PHI. Covered entities must provide PHI to the individual who is the subject of the medical record.

Restrictions

There are a few exceptions to this rule. An individual does not have the right to review or obtain psychotherapy notes, information compiled for legal proceedings, or medical records from correctional centers.

A health care professional can

- Research has yielded important advances in the development of effective treatment for children and adolescents living with mental disorders.
- Early identification and treatment prevents the loss of critical developmental years that cannot be recovered and helps youth avoid years of unnecessary suffering.
- Early and effective mental health treatment can prevent a significant proportion of delinquent and violent youth
- **diagnosed have been reported by more than 50% of relatives?**
- **A sign of suicidal ideology is giving away personal belongings?**
- **Adolescents with a Mood Disorder tend to take more risks than those not diagnosed?**

UNDERSTANDING AND NAVIGATING THE HIPAA PRIVACY RULE

Family members are often called on to provide care for a loved one with a mental illness. To function in this capacity, family members need to understand what kind of information they can get regarding their relative's diagnosis, treatment plan, medications, etc. The following describes the law and outlines some creative legal ways to get needed information.

What does HIPAA stand for ?

HIPAA stands for Health Insurance Portability and Accountability Act better known as HIPAA. The act was passed in 1996. It created a national standard for the protection of certain types of health care information. The Privacy Rule limits the circumstances in which individually identifiable health information can be used and disclosed by health care insurers, providers, and clearinghouses. The Privacy Rule refers to this type of information as "protected health information (PHI).

The Privacy Rule limits the use and disclosure of PHI by "covered entities." It does not affect other organizations or individuals. Covered entities can use and disclose PHI with no restriction only for treatment, payment, and health care operations. All other uses and disclosures must be authorized by the individual or be authorized under a section of the Privacy Rule.

Covered Entities Include:

- Health Plans. These are individual and group plans that provide for the cost of medical care, like Insurance Companies, HMO's, Medicare, Medicaid, and Employer-sponsored group health plans.
- Health Care Providers. All health care providers that use electronic technology in connection with a standard transaction are covered entities.
- Health Care Clearinghouses. These are entities that process PHI received from other covered entities.

Disclosure

An individual has the right to review and obtain a copy of his/her PHI. Covered entities must provide PHI to the individual who is the subject of the medical record.

Restrictions

There are a few exceptions to this rule. An individual does not have the right to review or obtain psychotherapy notes, information compiled for legal proceedings, or medical records from correctional centers.

A health care professional can deny an individual access to their own records if they believe access could cause harm to the individual or another.

Also, some state laws limit the rights of mentally ill individuals to act on their own behalf. In some states, a mentally ill individual may not be given free access to his/her PHI.

Disclosure to a Personal Representative

A personal representative is someone legally authorized to make health care decisions on behalf of another individual. A personal rep can be the health power of attorney or guardian for the person with a mental illness. Health care providers are required to treat personal representatives the same as they treat the patient. This means, that personal representatives are entitled to full access to the individual's medical records.

Restrictions

An exception is when the treating physician suspects the personal representative of abusing or neglecting the person with a mental illness. Disclosure is also limited when a personal representative only has authority to act on behalf of the person in limited or specific health care decisions. In this situation, the personal rep only has access to the PHI that is relevant to their area of authority. Also, a covered entity may refuse to share PHI with

a personal rep if the person with mental illness objects to the disclosure and the disclosure is permitted but not required under the Privacy Rule. Conversely, entities must make disclosures to personal reps that are required under the Privacy Rule, even if the individual objects.

Minor's Parent/Guardian Disclosure

In, most situations, parents/guardians are considered the personal representatives of their minor children (under age 18). This means that parents/guardians can access medical records on behalf of their children. Even in situations where a parent/guardian does not consent to their minor child's treatment due to an emergency, a health care provider is able to discuss all health related information with the parent/guardian.

Restrictions

In several situations, parents/guardians are not considered personal representatives of their minor children: Where a state law does not require the consent of the parent/guardian before the minor can receive a health care service, when a court or law authorizes someone other than the parent/guardian to make treatment decisions for the minor, or where the parent/guardian agrees to a confidential relationship between the minor and treating health care provider. In all these situations, the parent/guardian does not control the minor's health care decisions, or the minor's PHI.

Formal Authorization

A covered entity must obtain the written permission of the person with mental illness for any use or disclosure of PHI that is not for treatment, payment, or health care operations, or otherwise authorized by the rule. This written permission constitutes the authorization for disclosure. It must be written in specific terms and state what information is to be used or disclosed, specify the person disclosing and receiving the information, specify the purpose of the disclosure and have an expiration date.