2ND ANNUAL

BEHAVIORAL HEALTH COMMUNITY FORUM

Monday, October 8, 2018

Normal Theater and Bloomington-Normal Marriott Hotel & Conference Center

"We're all in this together"

Presented in Partnership by:

McLean County

Bloomington Illinois

Town of Normal

Agenda for Adult Sessions

8:30—8:50 a.m. **Welcome and Opening Remarks — NORMAL THEATER**

8:50—9:50 a.m. **Keynote Speaker: Dr. Suzana Flores — NORMAL THEATER**
Facehooked: How social media affects our emotions, relationships and lives

10:00—10:55 a.m. **The Influence of Religion, Culture, Race & Ethnicity on Mental Health — MARRIOTT REDBIRD E**
A panel discussion on the significant roles that our other identifying factors have on our mental health.

Suicide Prevention: A Community Effort — MARRIOTT REDBIRD C/D
Suicide basics, stigma, and the role we all play.

Behavioral Health in Schools and Restorative Practice Conversations—MARRIOTT REDBIRD F
Learn strategies to build strong, healthy relationships.

Marijuana and Mental Health: Cause, Cure or It's Complicated — MARRIOTT REDBIRD G
Better understand the impact marijuana has on mental health, the research, and the legal aspect.

11:00—11:55 a.m. **Integrating Behavioral Health into Primary Care — MARRIOTT REDBIRD F**
What steps are physician groups taking to ensure the behavioral health needs of their patients are being met.

Safe Passage: Addiction is not a crime and asking for help shouldn't be either — MARRIOTT REDBIRD G
Understanding opioid addiction and the steps our County has taken to ensure people can get the help they need.

Techniques for addressing behavioral health — NORMAL THEATER
Learn techniques you can use in your daily life to help with mood fluctuations, stressors and anxiety.

12:00—1:15 p.m. ***LUNCH & LEARN SESSIONS***
Brain and Behavior: The effects of chronic illness on mental health — MARRIOTT REDBIRD C/D
Hear one family's experience with chronic illness and its impact on the individual, the family, and how they coped and moved forward

Can We Talk? Addressing behavioral health issues and understanding mental illness vs the average teenage mind — NORMAL THEATER
Learn how to navigate difficult conversations with your adolescent and better identify if what they're going through is typical for their age or something more to be concerned about.

Agenda continued on reverse

1:25—2:20 p.m.

NAMI Ending the Silence for Families — MARRIOTT REDBIRD C/D
Parents and families can gain factual information about statistics and learn warning signs.

What is self-harm? — MARRIOTT REDBIRD E
Better understand what self-harm is, how it is different from a suicide attempt, and how to help.

Pain Management: Getting help without getting hooked? — MARRIOTT REDBIRD F
Learn how pain can impact mental health and understand options beyond medication.

Aging: We All Do It; Preparing for Changing Times — MARRIOTT REDBIRD G
Understand what healthy aging looks like, signs of Alzheimers, how to help others, and prepare yourself for the future.

2:25—3:20 p.m.

Mental Health and the LGBTQIA Community — MARRIOTT REDBIRD E
A clinician speaks to a variety of aspects of working with the LGBTQIA community and raises awareness on mental health needs, microaggressions, and teaches inclusive language.

Panel — Mental health crisis: When to go to the emergency room — MARRIOTT REDBIRD F
Learn how to navigate our crisis system within McLean County and better understand the levels of resources and interventions.

Speak up for mental health: Be the voice — MARRIOTT REDBIRD C/D
Recognize how YOUR voice helps reduce the stigma.

Continuing Education Credits:

- **Teachers** — Please be sure you have registered through the Regional Office of Education #17 website for your CPDU credit. If you have questions, please contact the ROE office at 309-888-5120.
- **Speech Pathologists**—Please be sure you have registered through the Regional Office of Education #17 website, as they will be handling the credits for this licensure. If you have questions, please contact the ROE office at 309-888-5120.
- **LSW/LCSW, LPC/LCPC, CADC**—Please be sure to sign in for each session you attend. There will be a volunteer in each breakout session with a sign-in sheet to track attendance. Certificates will be mailed or emailed to you following the Forum. Please note that you will only receive credit for sessions attended and in which you signed-in.

Key points about the venue:

- **Restrooms** are located in the Lobby of the Normal Theater, on the North end of the Conference Center in the Marriott near the North Street exit and Redbird E, F & G, as well as the West side of the Conference Center in the Marriott outside of Redbird B and C/D.
- The **Resource Fair** exhibits will be located in the halls of the Conference Center.
- **Coffee, tea and water** will be available in the Conference Center in the Resource Fair space.
- **Lunches** purchased for the Lunch & Learn will be available on a table in the back of Redbird C/D at lunch. If attending **Brain & Behavior**, find your lunch and a seat in Redbird C/D. If attending **Can We Talk**, please find your lunch and then go to the Normal Theater.
- **Parking** is free for attendees in the parking garage attached to the Bloomington-Normal Marriott Hotel & Conference Center.

Agenda for Youth/Adolescents

8:30—8:50 a.m.	**Opening Remarks****
8:50—9:50 a.m.	**Keynote Speaker: Dr. Suzana Flores**** *Facehooked: How social media affects our emotions, relationships and lives*
9:50—10:00 a.m.	**Break/ Guided Body Scan Relaxation** Learn how a quick "scan" of your body can help calm your nerves when needed.
10:00—10:55 a.m.	**NAMI Ending the Silence** Better understand the warning signs, facts and ways to help with regard to mental illness.
10:55—11:00 a.m.	**Break / PRIZE GIVEAWAY**
11:00—11:55 a.m.	**Techniques for addressing behavioral health**** Hear from 3 professionals about how mindfulness and yoga, music, and more traditional therapy skills can all help improve mood and memory
11:55—12:00 p.m.	**Break / PRIZE GIVEAWAY**
12:00—1:15 p.m.	***LUNCH & LEARN SESSION*** **Can We Talk? Addressing difficult topics and understanding mental illness vs the average teenage mind**** Hear some tips for how to talk to your parents about difficult topics and also understand if what you're feeling is typical or something to tell someone about.
1:15—1:25 p.m.	**Mindful Movement** Have an opportunity to move after listening to other topics and also learn how some specific movements can help with mood, stress, and focus.
1:25—1:30 p.m.	**Break / PRIZE GIVEAWAY**
1:30—1:55 p.m.	**Bullying 101** What does bullying look like and what can you do?
1:55—2:30 p.m.	**Panel by the Youth Action Board from Project Oz** Hear from your peers about the impact of your choices.
2:30—2:35 p.m.	**Break / PRIZE GIVEAWAY**
2:25—3:30 p.m.	**"What can I do to make a difference?"** A group of local teens speak to what they're doing to make a difference and help you understand that YOUR voice does matter.

****Denotes sessions in Normal Theater with adolescents and adults**

Keynote Address: ***Facehooked: How Social Media Affects our Emotions, Relationships and Lives***

8:50 a.m. — 9:50 a.m.

Normal Theater

Suzanna Flores, PsyD is a licensed clinical psychologist, social media expert and commentator, keynote speaker and author of *Facehooked: How Facebook Affects Our Emotions, Relationships, and Lives* and *Untamed: The Psychology of Marvel's Wolverine*. Dr. Flores specializes in the psychological treatment of chronic pain and physical illness, the psychological effects of social media interaction and addiction, trauma therapy and applied behavior analysis.

Dr. Flores received her doctoral degree from the Illinois School of Professional Psychology in Chicago, IL. She has worked as the Director of Counseling at the Illinois Institute of Art, the Rehabilitation Institute of Chicago, has experience working within the Federal Bureau of Prisons and the VA Medical Center, and recently has worked with college students and athletes as a Senior Staff Psychologist and Clinical Coordinator of Athletics at Arizona State University. She is currently a psychologist on staff with Psychology Specialists in their Phoenix, Arizona location.

Dr. Flores will be available at a table at the Resource Fair following her keynote with books available for purchase.

Dr. Flores' keynote address has been sponsored in partnership by:

Advocate BroMenn Medical Center

Project OZ

PSYCHOLOGY SPECIALISTS

Acknowledgements

Presentation of the 2nd Annual Behavioral Health Community Forum would not be possible without the ongoing support and partnership of McLean County, Town of Normal and City of Bloomington. In addition, members of the Behavioral Health Coordinating Council, the below-named Forum Planning Committee, and various staff members of McLean County Administration and the McLean County Health Department, have spent countless hours of their personal and work-related time helping coordinate this day and promote it. Special thanks to community organizations and members of the media for their further promotion of the event. As our tagline indicates, ***we truly are all in this together!***

Members of the Behavioral Health Coordinating Council

John McIntyre, Chairman, McLean County Board
Stephanie Barisch, Services Coordinator, Center for Youth & Family Solutions
Tom Barr, Executive Director, Center for Human Services
Lynn Fulton, CEO, OSF St. Joseph's Hospital
Laura Furlong, CEO, MARC First
Mark Jontry, Regional Superintendent, Regional Office of Education #17
Colleen Kannady, President, Advocate BroMenn Medical Center
Tosha Maaks, NAMI McLean/Livingston Counties
Kevin McCarthy, Council Member, Town of Normal
Joni Painter, Council Member, City of Bloomington
Sonja Reece, Secretary, McLean County Board of Health
Judge Elizabeth Robb, Retired Chief Judge, 11th Judicial Circuit
Donna Schoenfeld, Asst. Director for Student Affairs, Illinois State University
Dianne Schultz, CEO, The Baby Fold
Dave Sharar, CEO, Chestnut Health Systems
Laurette Stiles, Vice President, State Farm
Laurie Wollrab, McLean County Board
Karen Zangerle, Executive Director, PATH

Members of the Forum Planning Committee, 2018

Alicia Allen, Advocate BroMenn Medical Center
Judy Buchanan, President, McLean County Board of Health
Joanne Glancy, Project Oz
Cheryl Goldberg, Center for Human Services
Joan Hartman, Chestnut Health Systems
Mark Jontry, Regional Office of Education #17
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Donna Schoenfeld, Illinois State University
Dianne Schultz, The Baby Fold
Susan Shafer, McLean County Board
Lisa Slater, Comm. Specialist, McLean County Health Department
Cory Tello, McLean County Board of Health
Bill Wasson, McLean County Administrator's Office
Laurie Wollrab, McLean County Board
Trisha Wood, State Farm

Presenters

Liz Acevedo, Western Avenue Community Center

BN Youth Activists

Kathleen Backus, OSF Healthcare

Melanie Baker, Project Oz

Dr. Blair Brown, Psychology Specialists

Meryl Brown, Developing Melodies

Dr. Kathy Davis, McLean County Coroner

Adam Denman, Community Member

Renee Donaldson, Advocate BroMenn Medical Center

Rabbi Rebecca Dubowe, Moses Montefiore Temple

Elizabeth Hagemann, Alzheimer's Association

Brian Hanson, Chestnut Health Systems

Dr. Seth Hatlelid, Psychology Specialists

Chris Hays, Advocate BroMenn Medical Center

Bryan Hinman, Chestnut Health Systems

Dr. Amyas Kabir, Kabir Center for Health

Don Knapp, McLean County State's Attorney

CIT Officer Greg Leipold, Normal Police Department

Abby Lyons, McLean County Unit District #5 and The Elephant Tree

Dr. Kenleigh McMinn, Psychology Specialists

Tosha Maaks, NAMI McLean/Livingston Counties

Mignon Montpetit, Illinois Wesleyan University

Meghan Moser, Center for Human Services

Dr. Leandra Parris, Illinois State University

Project Oz Youth Action Board

Sheriff Jon Sandage, McLean County Sheriff

Rose Stadel

Karen Stipp, Illinois State University

Katherine Van Horn, ABC Counseling & Family Services

Nona Waller, Center for Human Services

Emily Wenger, ABC Counseling & Family Services

Trisha Wood, Community Member & State Farm

Karen Zangerle, PATH

FACEHOOKED: HOW SOCIAL MEDIA AFFECTS OUR EMOTIONS, RELATIONSHIPS, AND LIVES

DR. SUZANA E. FLORES

FACEHOOKED—GLOBAL USE

1. India —270 million
2. United States —210 million
3. Brazil —130 million
4. Indonesia —130 million
5. Mexico — 85 million

FACEHOOKED—THE POWER OF SOCIAL MEDIA (SOURCE: ZEPHORIA)

- Worldwide, there are over 2.23 billion monthly active Facebook users—an 11% increase year over year (Source: Facebook 07/25/18)
- There are 1.15 billion mobile daily active users for December 2016, an increase of 23 percent year-over-year (Source: Facebook as of 2/01/17)
- Age 25 to 34, at 29.7% of users, is the most common age demographic
- Five new profiles are created every second
- There are 83 million fake profiles

FACEHOOKED—THE POWER OF SOCIAL MEDIA (SOURCE: ZEPHORIA)

- Photo uploads total 300 million per day
- Average time spent per Facebook visit is 20 minutes
- Every 60 seconds on Facebook: 510,000 comments are posted, 293,000 statuses are updated, and 136,000 photos are uploaded
- 50% of 18-24 year-olds go on Facebook when they wake up

FACEHOOKED—THE BIRTH OF SOCIAL MEDIA

- 1994 – More than 1500 Web servers are online. The Internet is called the "Information Highway"
- 1995 – Newsweek Article: *The Internet? Bah! Hype Alert: Why Cyberspace Isn't, and Will Never Be, Nirvana*

FACEHOOKED—THE BIRTH OF SOCIAL MEDIA

1997 – Is a big year!

- The Web has one million users
- AOL Instant Messaging Begins
- Blogging Begins

- 1998 – Goggle is born

FACEHOOKED—BIRTH OF SOCIAL MEDIA

2001

- Wikipedia is started
- Apple begins selling iPods
- Friendster opens in the U.S. and grows to 3 million users in 3 months

FACEHOOKED—BIRTH OF SOCIAL MEDIA

2003 – Another big year!

- My Space opens
- Second Life opens
- LinkedIn is launched
- The Web has over 3 billion active pages
- Apple introduces iTunes

FACEHOOKED—BIRTH OF SOCIAL MEDIA

- 2004 – Facebook is born as a way to connect Harvard Students
- 2009 – Facebook was ranked as the most used social media network worldwide

FACEHOOKED—AM I MY PROFILE PIC?

FACEHOOKED—AM I MY PROFILE PIC?

"I think I spend so much time on Facebook because my Facebook self is the person I always wanted to be: smarter, funnier, and more beautiful.

On Facebook, I present the person I was born to be. I can change things about my life and I can change who I really am.

And no one will ever have to know my mistakes or see my faults."

FACEHOOKED—VIRTUAL OR REALITY?

- Some feel their truest nature is expressed online
- Our interpretation about how and when to interact is changing
- We're spending more time in these dual realities
- The two worlds are slowly merging
- Substituting one world for the other

FACEHOOKED—AM I MY PROFILE PIC?

- Virtual or Reality?
- Without real-life social cues, can we be certain whether what we see reflects reality?
- Do our digital expressions give off more truth about ourselves?

FACEHOOKED—CONNECTING IN THE DIGITAL AGE

- Performing for the masses
- We are more "out there" than ever before
- We are a culture of online personas
- We need to be "followed" and observed

FACEHOOKED—CONNECTING IN THE DIGITAL AGE

Since the 2000s we now…

- Pay more attention to building and nurturing our social media relationships
- Are willing to be reachable and chainable to our Smartphones
- Choose to be quasi-present
- Feel obligated to respond to push notifications with lighting speed
- Texting, video chatting and IM are to be respected
- Differences between TV and social media

FACEHOOKED—PRIVACY

FACEHOOKED—PRIVACY

- How long is the Facebook's privacy clause?
- Facebook owns <u>everything</u> that you post…
  and delete

FACEHOOKED—PRIVACY

How much control do we really have?

- Employers/Colleges check Facebook accounts
- Policies on giving up your passwords
- YouTube and Teens
- "Mouse Hovering"
- GPS
- Checking-In

FACEHOOKED—THE NEW ADDICTION

FACEHOOKED—ADDICTIVE FACTORS

- FOMO
- Facebook Mobile App – GPS and Checking In
- Everyone's a photographer
- Intermittent Reinforcement, AKA…

FACEHOOKED—ADDICTIVE FACTORS

- Phantom Vibration
- AKA: Hypovibochondria or ring-xiety
- Brain triggered by push notifications
- Compulsive behavior is leading to obsession

FACEHOOKED—CYBERBULLYING

The Story of Amanda Todd

https://www.youtube.com/watch?v=vOHXGNx-E7E

FACEHOOKED—CYBERBULLYING

- Over half of adolescents and teens have been bullied online, and cyberbully
- More than 1 in 3 adolescents have experienced cyberthreats online
- Over 25 percent of adolescents have been bullied repeatedly through their smartphones or the Internet
- Well over half of teens do not tell their parents

FACEHOOKED—CYBERBULLYING

- Sending mean messages or threats to a person's email account or cell phone
- Posting hurtful or threatening messages on social networking sites or web pages
- Sexting, or circulating sexually suggestive pictures or messages about a person
- Spreading rumors online or through texts

FACEHOOKED—CYBERBULLYING

- Stealing a person's account information to break into their account and send damaging messages
- Pretending to be someone else online to hurt another person
- Taking unflattering pictures of a person and spreading them through smartphones or the Internet
- Know your state laws
- Know the school's policy on cyberbullying
- Teach teens about the benefits of privacy

FACEHOOKED—CLICKING IN WITHOUT CHECKING OUT

Some tips to be mindful of:

- Social media is a powerful communication tool
- Social media has led to psychological and physiological changes
- Social media doesn't impact people without our participation
- "With great power comes great responsibility" - Spiderman

QUESTIONS?

SUICIDE PREVENTION: A COMMUNITY EFFORT

COLLEEN O'CONNOR, CPS, CADC
NAMI ENDING THE SILENCE COORDINATOR

KEVIN RICHARDSON
CIRS CALL CENTER PROGRAM MANAGER

SUICIDE: THE BASICS

- Suicide is a public health problem that affects everyone
- Someone dies by suicide every 17 minutes in the USA
- People of all ages, genders, and races struggle with suicide
- Approximately 6 people are **dramatically** affected by each death
- Suicide is preventable and recovery is possible

SUICIDE IN ILLINOIS AND THE USA

- Suicide is the 4th leading cause of death for adults (18-65) and 2nd leading cause of death for young people (15-24)
- Approximately 45,000 Americans die by suicide yearly
- In Illinois, more than 1,000 people die yearly

SUICIDE IN MCLEAN COUNTY

- 25 reported deaths by suicide in 2016
- 17% of high school students in McLean County report seriously considering suicide in the past year
- 28% report feeling so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing usual activities

WHY WOULD SOMEONE END THEIR LIFE?

- Suicide is complex and usually caused by multiple factors
- Many people who die by suicide experience mental illness
- Living with depression increases risk for suicide by 50%
- Significant life stress (like financial difficulties, relationship problems, or bullying) increases risk for suicide

STIGMA AND SUICIDE

- **Stigma** prevents people from reaching out for help
- Average delay between starting to struggle and starting treatment is 8-10 years
- Without help, people may feel unable to cope, which increases their risk for suicide

STIGMA AND SUICIDE

- Stigma refers to negative, unfair beliefs about a group
- Stigma about mental health is widespread
  - Stereotypes and labels
  - Judgment
  - Bullying
  - Discrimination

STIGMATIZING SUICIDE MYTHS

- "People who commit suicide are weak and selfish."
- "Talking about suicide will make someone want to do it."
- "People who talk about suicide are just looking for attention. They won't actually do it."

STIGMATIZING SUICIDE MYTHS

- "It would be obvious if she was thinking about suicide."
- "If someone wants to die, there's nothing you can do."
- "No one saw it coming. It just came out of nowhere."
- "If someone starts to feel better, the crisis is over."

MENTAL ILLNESS WARNING SIGNS

- Feeling sad or withdrawn for more than 2 weeks
- Severe, out-of-control risk-taking behaviors that cause harm to self or others
- Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort, or fast breathing

MENTAL ILLNESS WARNING SIGNS

- Significant weight loss or gain; throwing up, using laxatives, or not eating to lose weight
- Drastic changes in mood, behavior, personality, or sleep
- Seeing, hearing, and believing things that aren't real
- Excessive use of drugs or alcohol

MENTAL ILLNESS WARNING SIGNS

- Extreme difficulty concentrating or staying still that causes physical danger or school failure
- Intense worries or fears that impact daily activities
- Trying or making plans to harm or kill oneself or others

SUICIDE WARNING SIGNS

- Talking, writing, or drawing about death
- Looking for ways to hurt or kill oneself
- Feeling alone, hopeless, helpless, empty, desperate, or trapped
- Feeling like a burden to others

SUICIDE WARNING SIGNS

- Increased use of drugs or alcohol
- Giving away possessions
- Sudden agitation or anger
- Dramatic change in mood

WHAT SHOULD YOU DO?

- Take warning signs seriously
- Don't keep warning signs a secret
- Ask the question: Are you thinking about suicide?
- Ask follow-up questions:
  - Have you thought about suicide recently/in the last two months?
  - Do you have a **plan** for how you would die?

WHAT SHOULD YOU DO?

- Call a resource like PATH Crisis Center
- Contact CHS's Crisis Team or the Crisis Stabilization Unit
- If possible, stay with the person until help arrives or they are safe
- Explore resources for treatment

WANT TO HELP?

- Reduce stigma by talking openly about mental health
- Pay attention to warning signs and share concerns with loved ones
- Get certified in Mental Health First Aid and/or Youth Mental Health First Aid
- Get involved in a NAMI support group or class

WANT TO HELP?

- Support agencies that improve mental health by donating or volunteering your time (i.e. PATH)
- Share information about resources with friends, family, and community members
- Make an effort to avoid stigmatizing language

Tips for Talking About Suicide

Consider saying	Instead of
Suicide attempt/ attempted suicide	Failed suicide or unsuccessful attempt
Died by suicide/ suicide death	Successful or completed suicide
Took their own life	Committed suicide
Died as the result of self-inflicted injury	Chose to kill him/herself
Disclosed	Threatened

QUESTIONS?

Colleen O'Connor, CPS, CADC
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Kevin Richardson, MA, LCPC
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BEHAVIORAL HEALTH IN SCHOOLS: RESTORATIVE PRACTICES CONVERSATION

MARK E. JONTRY, REGIONAL SUPERINTENDENT

REGIONAL OFFICE OF EDUCATION #17

DeWitt · Livingston · Logan · McLean Counties

2018 McLean County Behavioral Health Community Forum

BUILDING COMMUNITY WITH RESTORATIVE CONVERSATIONS

BY KEVIN JONES, MS
REGIONAL OFFICE EDUCATION #17

OVERVIEW OF RESTORATIVE PRACTICES: LEARN STRATEGIES TO BUILD STRONG HEALTHY RELATIONSHIPS

REGIONAL OFFICE OF EDUCATION #17

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FUNDAMENTAL HYPOTHESIS

The fundamental hypothesis of restorative practices is that human beings are happier, more cooperative and productive, and more likely to make positive changes in their behavior when those in positions of authority do things ***with*** them, rather than ***to*** them or ***for*** them.

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AIM OF RESTORATIVE PRACTICES

To develop community and to manage conflict and tensions by repairing harm and restoring relationships.

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EXPLICIT RESTORATIVE PRACTICES

For restorative practices to be explicit, it must actively integrate:

- Social Discipline Window
- Fair Process
- Restorative Practices Continuum
- Psychology of Affect

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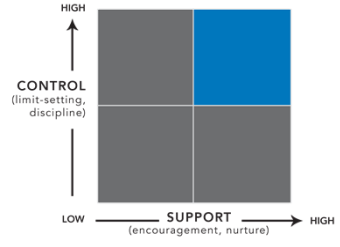
SOCIAL DISCIPLINE WINDOW



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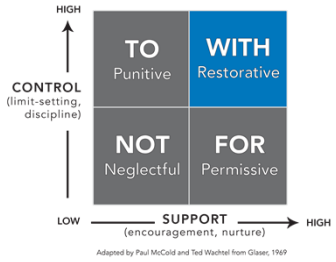
SOCIAL DISCIPLINE WINDOW



FAIR PROCESS: THE CENTRAL IDEA

"…individuals are most likely to trust and cooperate freely with systems – whether they themselves win or lose by those systems – when fair process is observed."

(W. Chan Kim & Renee Mauborgne, Harvard Business Review, January 2003)

THE THREE PRINCIPLES OF FAIR PROCESS

- Engagement
- Explanation
- Expectation Clarity

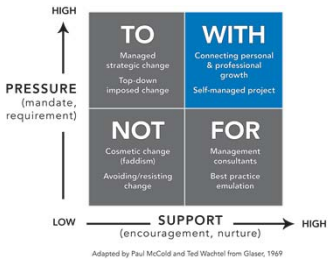
(W. Chan Kim & Renee Mauborgne, Harvard Business Review, January 2003)

WHAT FAIR PROCESS ISN'T

- Decision by consensus
- Does not set out to achieve harmony
- Does not set out to win people's support through compromises that accommodate every individual's opinions, needs or interests
- Democracy in your system
- Leaders forfeiting their responsibility to make decisions, establish policies and procedures

(W. Chan Kim & Renee Mauborgne, Harvard Business Review, January 2003)

ORGANIZATIONAL CHANGE WINDOW



PSYCHOLOGY OF AFFECT: AFFECT, FEELINGS, AND EMOTION

- Affects

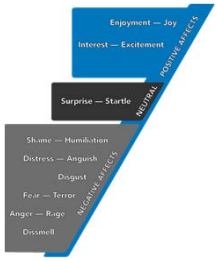
  Nine innate, biological programs triggered in response to specific stimulus conditions
- Feelings

  The awareness an affect is present
- Emotions

  Scripted responses learned over a lifetime of the triggering of affects by environmental forces that surround us

(Vernon Kelly & Margaret Thorsborne, The Psychology of Emotion in Restorative Practice, 2014)

THE NINE AFFECTS



COMPASS OF SHAME

Nathanson, 1992

RESPONDING TO SHAME

Respond to others experiencing shame by:

- Listening to what they have to say
- Being present with them without trying to problem solve
- Reflecting on what has caused the shame feeling
- Acknowledging their feelings
- Encouraging them to talk about their experience

Nathanson, 1992

TOMKIN'S BLUEPRINT

Individuals are at their best when they:

- Maximize positive affect
- Minimize negative affect
- Freely express emotion
- Do as much of the above three as possible

Nathanson, 1992

INTIMACY

Intimacy is when two people agree to:

- Maximize positive affect
- Minimize negative affect
- Freely express emotion
- Do as much of the above three as possible

Nathanson, 1992

COMMUNITY

Community is when multiple people agree to:

- Maximize positive affect
- Minimize negative affect
- Freely express emotion
- Do as much of the above three as possible

Nathanson, 1992

BRIATHWIATE'S HYPOTHESIS

Separating the 'deed from the doer'

Restorative Practices allow:

The act (unacceptable behavior) to be rejected because they failed to meet expectations or standards

While:

Acknowledging the intrinsic worth of the person and their potential contribution to society

STIGMATIZING SHAME VS. REINTEGRATIVE SHAME

Stigmatizing Shame:

Pushes the offender out of the community and labels them. The offender is now a bad person who committed a crime or harm. This label may follow them their whole lives. Since the offender is pushed out of the community, it encourages their participation in a criminal subculture.

Reintegrative Shame:

Expresses disapproval but does not push the offender out of the community. This type of shame rejects the act but not the person and allows for the person to be reintegrated back into the community.

RESTORATIVE PRACTICE CONTINUUM

informal				formal
affective statements	affective questions	small impromptu conversation	circle	formal conference

CONTACT US

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MARIJUANA AND MENTAL HEALTH: CAUSE, CURE, OR IT'S COMPLICATED

BRYAN HINMAN, CHESTNUT HEALTH SYSTEMS
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CURRENT TRENDS IN CANNABIS USAGE

- Cannabis is the most popular illicit drug in the United States.
- Estimated 8.3% of people 12 years and older have used it in the past month.
- Most prevalent among young people between 18 and 25 (~20%).
- Since 2002, its use has declined in ages 12-17 and increased sharply in the senior population (55+).
- Noticeable increased intensity of heavy users (smoking daily) equals about one third of active users.
- Public perception of cannabis has steadily shifted.
- Estimated market for legal cannabis is $7.1 billion as of 2016.

CHALLENGES IN CANNABIS RESEARCH

- Many issues prevent researchers from answering specific questions tied to the health effects of cannabis use.
- Lack of diversity in research funding creates a gap in understanding
  - In 2015, nearly 60% of all studies on cannabis through NIH were done by NIDA.
  - Less than 17% of NIDA's studies investigated potential therapeutic effects of cannabis.
- Methodological Issues
  - Administration (Smoking, edible, vaporization, etc.)
  - Placebo Issue
  - Over-reliance on self-report
- Case example
  - Colorado Researcher

COMORBIDITY...IT'S COMPLICATED...

- Common for those with mental health issues to use substances of abuse.
- Many who have substance use disorders also meet criteria for mental health disorders.
- Possible Explanations
  - Substance use as a risk factor for developing mental health issues
  - Mental health disorders as a risk factor for developing substance use disorders
  - Shared predisposing risk factors for both mental health issues and substance use disorders
- Explanation is still unclear.
- Comorbidity makes determining causality difficult.

MENTAL HEALTH ASSOCIATIONS WITH CANNABIS USE

- PTSD, depression, and anxiety do not appear to be more likely to *develop* in cannabis users.
- Compared to non-users, heavy cannabis users are more likely to have thoughts of suicide.
- Risk of developing social anxiety disorder is elevated with regular cannabis use.

- Bipolar Disorder
  - Limited evidence to suggest higher risk among cannabis users, greater risk among heavy users.
  - Moderate evidence suggest elevated symptoms of hypomania and mania, especially among heavy users.

MENTAL HEALTH AND CANNABIS USE (CONTINUED)

- Schizophrenia and other psychoses
  - Heavy users of cannabis likely have increased risk of developing these issues.
  - Higher the use, greater the *risk*.
  - Greater risk if heavy cannabis use begins in adolescence
  - Moderate evidence of better performance on learning and memory tasks with history of cannabis use.

THE "GATEWAY" THEORY

- Moderate evidence exists that suggests cannabis leads to the use of other illicit substances.
- Studies also show most users of illicit substances first experiment with alcohol or tobacco.
- Large majority of people who use cannabis do not go on to use other illicit substances.
- Cross-sensitization is not unique to cannabis.
- Rather recent research suggests the "Exit" Theory.
- Important to note other key factors that can influence development of substance use disorders.

IS CANNABIS ADDICTIVE?

- A recent survey in 2015 found that 22.2 million Americans identified as users of cannabis.
- Less than 19% reported having symptoms that would qualify as a substance use disorder.
- DSM-V substance use disorders are more of a spectrum (mild, moderate, severe).
- Lack of official distinction between "risky" or "problem" use of cannabis.
- Research suggests 9% of users will become "addicted" to cannabis.

RISK FACTORS FOR PROBLEM USE OF CANNABIS

- Moderate Risk Factors
  - Major depressive disorder
  - Male
  - Smoking cigarettes
  - Exposure to combined use of abused drugs
- Substantial Risk Factors
  - Male smokers
  - Beginning cannabis usage at an earlier age

SYNTHETIC CANNABINOIDS

- Illicit synthetic cannabis (K-2, fake weed, spice, etc.) has markedly different effects than cannabis and is much more potent (4-100 times).
- Usage of research chemicals can lead to an array of mental health effects, even after quitting.
- High usage rates among heavy cannabis users.
- Link between people who use spice exhibiting psychosis with no prior history of psychosis.
- Because the chemicals are relatively new the long-term effects of usage are relatively unknown.

THERAPEUTIC EFFECTS OF CANNABIS (MENTAL HEALTH)

- Mental health issues that medicinal cannabis is prescribed for include:
  - PTSD, Tourette's Syndrome, dementia, addiction, anxiety, depression, sleep disorders, psychotic disorders/schizophrenia
- Limited Evidence
  - THC capsules as an effective treatment for Tourette's Syndrome
  - Cannabinoids are ineffective treatment for dementia
  - Nabilone is effective in improving symptoms of PTSD
  - Cannabidiol is an effective treatment for social anxiety disorder
- Moderate Evidence
  - Cannabinoids, especially nabiximols, for sleep disorders

CANNABIS AND OPIOIDS

- Access to legal cannabis associated with lower rates of opioid related issues.
  - Use and abuse, hospitalizations, traffic fatalities, drug treatment admissions, and overdose deaths
- Chronic Pain
  - Chronic pain patients are less likely to abuse cannabis as compared to opioids.
  - Rates of depression are less in chronic pain patients using cannabis compared to opioids.
  - Cannabinoid-Opioid Synergy

CONCLUSIONS

- Cannabis' current federal status imposes considerable barriers to researchers striving to ascertain its harmful/beneficial effects.
- Comorbidity makes it imperative to address both substance use and mental health issues together instead of independent factors.
- Cannabis can be addictive and there are risk factors that predict problem use.
- Research exists that supports cannabis as a treatment for some mental health issues.
- In treating chronic pain issues cannabis may show promise, especially related to the dangers posed by the current opiate crisis.

COMPASSIONATE USE OF MEDICAL CANNABIS PILOT PROGRAM ACT

Effective 1/1/2014

Sunsets 7/1/2020

Legislative Findings:

* Medical Cannabis use is nearly 5,000 years old
* Research indicates cannabis alleviates pain and nausea symptoms

How does this Act relate to criminal statutes

CARDHOLDER UNDER THE ACT "SHALL NOT BE CONSIDERED AN UNLAWFUL USER" IF IN COMPLIANCE WITH THE ACT

WHAT IS A CARDHOLDER?

1.) Qualifying patient, or

2.) Designated Caregiver who

3.) Has been issued and possesses a valid registry identification card by

4.) The Illinois Department of Public Health

WHAT CAN A CARDHOLDER DO?

WITHIN THE PARAMETERS OF THE ACT

1.) Possess, use and transport

2.) Medical cannabis products

3.) Purchased by a qualifying patient from

4.) A licensed dispensing organization

HOW MUCH CAN BE POSSESSED?

1.) An adequate supply, defined as:

a.) 2.5 ounces for 14 days, or

b.) petition the Department for more if that is inadequate

WHERE CAN A CARDHOLDER POSSESS MEDICAL MARIJUANA

Written in the negative, so where can a cardholder NOT possess it

1.) school busses

2.) on the grounds of any preschool, primary or secondary school

3.) in any correctional facility

4.) in a vehicle unless properly packaged under the Act

5.) in a private residence used for licensed child care

WHERE CAN A CARDHOLDER USE MEDICAL MARIJUANA?

Again, written in the negative so can NOT use

1.) in any vehicle or place in which it is illegal to possess marijuana (school bus, correction facility, etc.)

2.) while on duty as a law enforcement officer, correctional officer, fireman

3.) in a public place where an individual could reasonably be observed by others

a.) public place defined as all parts of buildings owned in whole or part by the state or a local unit of government

b.) public place does not include most residences or health care facilities

HOW DO YOU TRANSPORT MEDICAL MARIJUANA?

Can only be transported in a "medical package container"

- a sealed, traceable, food compliant, tamper resistant, container or package used for the purpose of containment of medical cannabis from a cultivation center to a dispensing organization

ADDITIONAL LIMITATIONS

- Any private business can prohibit use on its property
- Any university or college can prohibit use on its property
- Misrepresentations of medical conditions is an offense punishable by fine up to $1000 (petty offense)
- Must notify IDPH of change in circumstance within 10 days or face $150 fine
  - Failure to notify of change in circumstance does not automatically revoke a cardholder's ability to possess or use medical marijuana

QUALIFYING / DEBILITATING MEDICAL CONDITIONS

Expanding every day

- Residents may petition IDPH to add debilitating conditions to those recognized by the General Assembly
- Statutory Conditions include, but are not limited to,
  - cancer, glaucoma, HIV, acquired immune deficiency syndrome, Crohn's disease, Alzheimer's, muscular dystrophy, Rheumatoid arthritis, spinal cord injury, Multiple Sclerosis, Lupus, seizures & PTSD
  - Terminal illness with a diagnosis of 6 months or less

WHO CAN PRESCRIBE/PHYSICAIN REQUIREMENTS

- Physician must be:
  - Currently licensed under the Medical Practices Act of 1987 to practice medicine in all of its branches
  - In good standing and hold a controlled substance license under Article III of the Illinois Controlled Substances Act
  - Comply with generally accepted medical standards of medical practice
  - Complete a physical examination of the patient (no remote means)
  - Maintain records subject to review of IDPH

QUESTIONS?

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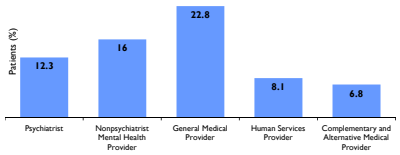
INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE

ADVOCATE BROMENN AND OSF HEALTHCARE

PRIMARY CARE IS THE LARGEST PROVIDER OF MENTAL HEALTH SERVICES

Proportion of mental health patients managed by different healthcare providers*†



*Percentages represent prevalence data obtained over a 12-month period from the National Comorbidity Survey Replication.
†Treatment could be received by more than one source.
Gaynes BN, et al. *J Fam Pract.* 2015;64(9):54-515.

MOVING FROM TRADITIONAL BEHAVIORAL HEALTHCARE TO A POPULATION HEALTH DRIVEN MODEL

- A realization that PCP's write over 1/3 of all behavioral health related prescriptions
- Clear evidence that screening helps identify symptoms earlier
- Research shows that social determinants of health (SDOH) have direct and lasting impact on overall health of an individual and a population and must be screened for and addressed regularly
- Evidence based integration models, such as collaborative care, show improvement in mental and physical symptoms, improved access to care, decreased unnecessary ED utilization, and overall cost of care reductions
- 2017 Data review showed population need for integration of BH into primary care

NATIONAL GUIDELINES RECOMMEND SCREENING FOR DEPRESSION

U.S. Preventive Services TASK FORCE

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that screening for depression in adults and is reasonable and necessary for the prevention or early detection of illness or disability and is appropriate for individuals

BEHAVIORAL HEALTH SCREENING: INPATIENT/OUTPATIENT INTEGRATION

- Screening **decreases clinical morbidity**
- Ideal screening ***interval*** and ***setting*** with highest potential yield are not well defined
  - Older adults with chronic medical illness at high risk for BH comorbidity (ED and In-patient medical floors)
  - Clinical integration incentive (out-patient)

JAMA 2016; 315 (4): 380-7

SOME RECOMMENDED SCREENING TOOLS

Table 1: Adult Symptom Rating Scales for Core Outcome Measures

MEASURE	DOMAIN	# OF ITEMS
PHQ-9	Depression	9
Altman Scale	Mania	5
GAD-7	Anxiety	7
PCL	PTSD	20
PDSS_SR	Panic attacks	7
Audit-C	Alcohol	3
DAST-10	Drug abuse	10
PHQ-15	Somatization	15

THE KENNEDY FORUM

Table 2: Adult Multi-Diagnostic Substance Abuse Outcomes Measurement

MEASURE	DOMAIN	# OF ITEMS
Substance Abuse Outcomes Module	Substance abuse	22
Brief Addiction Monitor (BAM)	Substance abuse	17

ISSUE BRIEF **A Core Set of Outcome Measures for Behavioral Health Across Service Settings,** www.thekennedyforum.org, **2017**

PRIMARY CARE: THE OPTIMAL SETTING FOR A POPULATION APPROACH TO BH

- The vast majority of people will not act on a referral to specialty BH offered by a PCP
- BH care delivered in primary care or none due to unwillingness to seek care in specialty BH clinic setting
- Cultural implications for who will seek out specialty BH treatment

Wang PS. Arch Gen Psychiatry. 2005;62: 629-40

KEY COMPONENTS OF INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE

Population based	• Identify and track patients
Measurement based	• Screening and severity assessment
Treatment to target	• Desired level vs. type/dose of drug or psychotherapy
Care management	• Psychoeducation, adherence, coordinated care
Psychiatric consultation	• Weekly meetings with BH provider • Consultative session with select patients
Brief psychological therapies	• Limited sessions • Simpler treatments

Kroenke. J Gen Int Med. 2017;32:404-10

DIGITAL HEALTH SOLUTIONS TO SUPPORT BH INTEGRATION

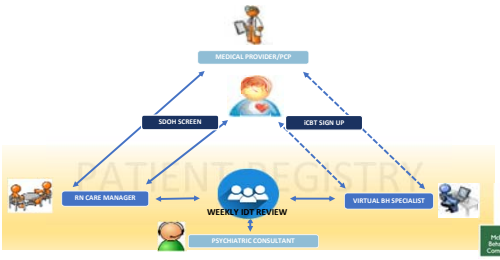
- **The central component of online interventions:**
  - Structured delivery of psycho-educational content, usually through text and explanatory videos
  - Self guided questionnaires
  - Consistent screening tools available
- **Immediate access and patient engagement:**
  - Efficient first point of care for patients presenting with mild mental health concerns
  - Patients presenting at PCP with BH concerns can be set up with access to care immediately
  - Can avoid PCP referral to higher intensity face-to-face care
  - A form of treatment which is more efficient in use of resources
  - Current evidence regarding engagement with online interventions suggests that a guided self-help model is most effective in improving adherence

CDC FIVE DOMAINS OF SDOH

Economic Stability	Education	Health and Health Care	Neighborhood and Built Environment	Social and Community Context
• Poverty • Employment • Food Security • Housing Stability	• High school graduation • Language and literacy • Early childhood education	• Access to health care • Access to primary care • Health literacy	• Access to healthy food • Quality of housing • Crime and violence • Environmental conditions	• Social cohesion • Civic participation • Incarceration • Discrimination

Centers for Disease Control and Prevention, Healthy People 2020 Midcourse Review, Chapter 39, page 39-2

VIRTUAL COLLABORATIVE CARE MODEL PILOT PROJECT



OSF MULTI-SPECIALTY SERVICES INTEGRATED BEHAVIORAL HEALTH

OBJECTIVES

At the end of this training, participants will be able to:

1.) Understand an overview of Integrated Behavioral Health within OSF's Multi-Specialty Services.

2.) Identify what a behavioral health provider (BHP) does and explain their role as part of the care team.

3.) Identify how a BHP can impact patient engagement and outcomes as it relates to the improvement of overall patient health and care.

OUR INTEGRATED BEHAVIORAL HEALTH TEAM

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- **Sonny Pickowitz, MSW, LCSW, Coordinator**
- **Becky Ala, MSW, LCSW, Morton Family Practice**
- **Kathleen Backus, MA, LCPC, College Ave IM and FP**
- **Mallory Hippler, MA, LCPC, Ft. Jesse, Normal, Family Medicine, SJD and Nord Farms**
- **Diana Mariani, MSW, LCSW, PRN for Bloomington**
- **Josh Young, MS, LCPC, Center for Health IM, Peoria**
- **Dennis Kurz, MSW, LCSW, Guilford Square, Parkview FP,**
- **Jody Ideran, MSW, LCSW, Rock Cut Primary Care, Spring Creek,**
- **Noelle Sliker, MSW, LCSW, Streator CFH and Family Practice, Wenona**
- **Roberta Pool, MA, LCPC, Galesburg Clinic and FP**
- **Joy Meachum, MSW, LCSW, Glen Park IM and IM/Pediatrics**
- **Andrea Bartlett, MSW, LCSW, Rt. 91 Pediatrics and Knoxville Pediatrics**
- **Loni Nolte, MSW, LCSW, Ottawa FP, Ottawa South, Marseilles and Starfire, Ottawa**
- **Heidi Colton, MSW, LCSW, Pekin CFH and Tremont**
- **Patricia Mortensen, MSW, LCSW, Pontiac, Chenoa, Clinton and Heyworth**
- **Elizabeth Case, MSW, LMSW, Escanaba Medical Group and Gladstone Clinic, Escanaba**

WHAT DOES THE BHP DO?

- Accepts warm hand-off/referrals from the provider.
- May conduct comprehensive psychosocial evaluations and diagnose and/or confirm behavioral health diagnoses.
- Identifies behavioral needs via:
  - provider assessment
  - coordination with care management and utilization of risk scores
  - self report
  - med/psych history
  - use of screening tools
    - PHQ2/9
    - Generalized Anxiety Disorder
    - Cage Aid

WHAT DOES THE BHP DO?

- Provides brief evidenced-based therapy and behavioral interventions to patients.
- Adjust treatment modality and intervention to fit individual patients' needs.
- Provides crisis intervention and de-escalation.
- Works in collaboration of the care team.
- Uses motivational interviewing to assist patients with goals.
- Offers expertise to care team on behavioral health concerns including:
  - readiness to change
  - psychotropic medication
  - overall management

PATIENTS WHO CAN BENEFIT FROM SERVICES

- All patients can benefit from working with the Behavioral Health Provider (BHP) throughout different times of their life span.
- Patients can be referred multiple times for different reasons or different "episodes" of care.
- If the patient requires more intensive or specialized care, the BHP can assist in referring that patient to more appropriate treatment.

PATIENTS WHO CAN BENEFIT FROM SERVICES

- We can treat a variety of issues including but not limited to depression, anxiety, adjustment disorders, grief and loss, stress management, substance abuse, sleep issues, chronic pain, etc.
- Also work on behavioral and healthy lifestyle changes. e.g., smoking cessation, weight loss, hypertension, COPD, and diabetes management.

THE WARM HAND OFF

- The "warm hand off" is a referral tool by which the Primary Care Provider directly introduces the patient to the BHP at the time of the patient's medical visit.
- It is used to establish an initial face-to-face contact between the BHP and the patient and transfer the trust and the rapport the client has developed with their PCP to the BHP.
- Many BHPs report that this face-to-face introduction helps ensure follow u

INVOLVING BHPS ROUTINELY WITH PATIENTS

If you suspect the "provider" term is not understood, you can use:

- Colleague
- Expert on stress
- Member on our care team, etc.

* Do **NOT** describe a referral reason as: "counseling," "therapy," or "psych issues" as this can prompt unwanted preconceived notions of traditional therapy.

https://www.youtube.com/watch?v=w4OdCOoGZL0&feature=youtu.be

WAYS TO SUPPORT THE BHP

- Collaboration!
- Remember we are all a part of the same team working together to provide the patient with the very best care. Let us know how best we can help **you** help the patient.
- We are here to treat the body and the mind together. This is our mission.

SHOW ME THE NUMBERS

- Patient Satisfaction
- Provider Satisfaction
- PHQ/GAD Improvement Scores

QUESTIONS?

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TECHNIQUES FOR ADDRESSING BEHAVIORAL HEALTH

ABBY LYONS, MCLEAN COUNTY UNIT DISTRICT #5 & THE ELEPHANT TREE MERYL BROWN, DEVELOPING MELODIES
KENLEIGH MCMINN, PSYCHOLOGY SPECIALISTS

MINDFULNESS FOR SOCIAL CHANGE: ALIGNING EDUCATION WITH MIND, BODY, AND PERSPECTIVE

Abby Lyons, McLean County Unit 5 & The Elephant Tree

Email: abby.lyons@theelephanttree.org

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UNDERSTANDING AND COPING WITH DIFFICULT EMOTIONS

Kenleigh McMinn, PhD

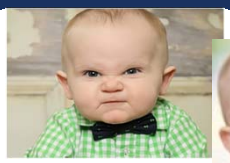
Postdoctoral Fellow, Psychology Specialists

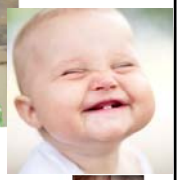
Credit to "DBT Skills Training Handouts and Worksheets, 2nd Edition" by Marsha Linehan; Google Images

UNDERSTANDING AND NAMING EMOTIONS

What do emotions do for us?

- Motivate us for action
  - Hard-wired "action urges"
- Communicate to *others*
  - Body language, facial expressions
- Communicate to *ourselves*
  - Signal that something important is happening



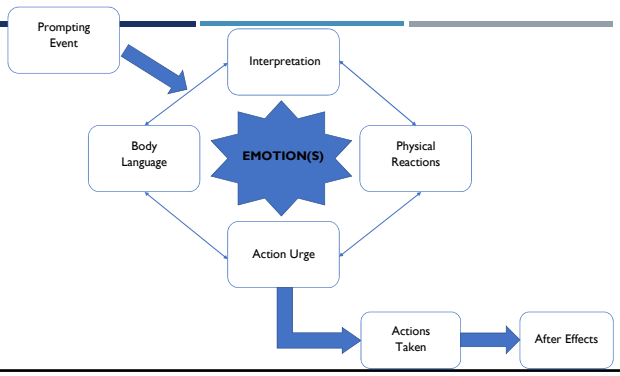


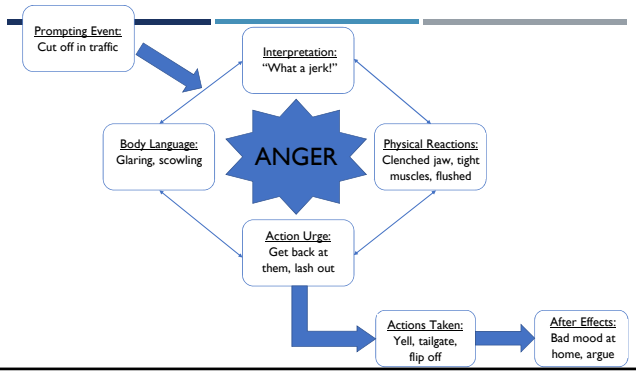
UNDERSTANDING AND NAMING EMOTIONS

Intensity of Feelings	HAPPY	SAD	ANGRY	AFRAID	ASHAMED
HIGH	Elated Excited Overjoyed Thrilled Exuberant Ecstatic Fired up Passionate	Depressed Agonized Alone Hurt Dejected Hopeless Sorrowful Miserable	Furious Enraged Outraged Boiling Irate Seething Loathsome Betrayed	Terrified Horrified Scared stiff Petrified Fearful Panicky Frantic Shocked	Sorrowful Remorseful Defamed Worthless Disgraced Dishonored Mortified Admonished
MEDIUM	Cheerful Gratified Good Relieved Satisfied Glowing	Heartbroken Somber Lost Distressed Let down Melancholy	Upset Mad Defended Frustrated Agitated Disgusted	Apprehensive Frightened Threatened Insecure Uneasy Intimidated	Apologetic Unworthy Sneaky Guilty Embarrassed Secretive
LOW	Glad Contented Pleasant Tender Pleased Mellow	Unhappy Moody Blue Upset Disappointed Dissatisfied	Perturbed Annoyed Uptight Resistant Irritated Touchy	Cautious Nervous Worried Timid Unsure Anxious	Bashful Ridiculous Regretful Uncomfortable Pitied Silly

The five core emotions run left to right across the top of the table. Manifestations of each emotion based upon the intensity felt are described down each of the columns in the table.

ADAPTED FROM AND REPRODUCED BY PERMISSION FROM JULIA WEST.





ACCEPTS Skills:
When you need a new prompting event

Activities – TV, hobbies, exercise, clean, call a friend, music, read, go outside, play with pet

Contributing – volunteer, give a gift, help a friend/family, something thoughtful or surprising

Comparisons – think of a time you felt better, count blessings compared to less fortunate

Emotions – create different emotions (scary movie, comedy show, soothing music)

Pushing Away – mentally leave the situation, intentionally put it away for a while

Thoughts – think about other things (count to 100, recite a song, do puzzles)

Sensations – create new physical sensations (hold ice in hand, squeeze rubber ball, take hot or cold shower)

Opposite Action:
When acting on an emotion is not effective or helpful

Every emotion has an action urge – change the emotion by doing the OPPOSITE

Emotion	Action Urge	Opposite Action
Fear/Anxiety	Run away, avoid	Approach, don't avoid, face fears (within reason), act confident, use relaxation exercises
Anger	Attack, be mean	Gently avoid, be nice, take a time out, relax your body, take deep breaths
Sadness	Withdraw, isolate	Be active, avoid avoiding, increase pleasant events, do things to feel confident

IMPROVE the Moment:
To change any point in the emotion cycle

Imagery – imagine relaxing scene, everything going well, a happy time, your "happy place"

Meaning – find purpose or meaning in painful situation, focus on positive aspects

Prayer – turn things over to a higher being, ask for strength

Relaxation – hot bath or shower, self massage, stretch, deep breathing, meditation

One thing – focus entire attention on present moment, single sensation or object

Vacation – real or mental, take a break, unplug from devices, treat yourself

Encouragement – be your own cheerleader, give yourself encouragement

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WHAT'S MUSIC GOT TO DO WITH IT?
TECHNIQUES FOR ADDRESSING BEHAVIORAL HEALTH

MUSIC THERAPY

Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. It is an established health service similar to occupational therapy and physical therapy and consists of using music therapeutically to address physical, psychological, cognitive and/or social functioning for patients of all ages. Because music therapy is a powerful and non-invasive medium, unique outcomes are possible.

MUSIC THERAPY RESEARCH

- Outcomes noted in research
  - Reduced muscle tension and pain perception
  - Improved self-image/Increased self-esteem
  - Decreased anxiety/agitation
  - Increased verbalization
  - Enhanced interpersonal relationship
  - Improved group cohesiveness
  - Increased motivation
  - Successful and safe emotional release

MUSIC AND DOPAMINE

When we

1) anticipate and then

2) experience a pleasurable response while listening to music,

our brain reacts in distinct and specific ways to release the "feel-good" chemical dopamine.

MUSIC FOR YOU

- Active Music Listening
  - Create a Playlist of your trusted songs
- Play and Sing
  - Active Participation is more effective than Passive!!!!
- Songwriting
  - Find a song, change the words for you
  - Find a poem, add a melody

MUSIC THERAPY INTERVENTIONS

- Lyric Analysis
- Improvisation
- Songwriting
- Active Music Listening

WHERE TO FIND ME

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BRAIN & BEHAVIOR:

THE EFFECTS OF CHRONIC ILLNESS ON MENTAL HEALTH

Adam Denman

Trisha Wood

Dr. Amyas Kabir

MY STORY – ADAM

- Childhood cancer & addictive medications
  - Started chemotherapy & radiation at age four.
- Bone marrow transplant – fighting to live
  - Low survival rate meant no guarantees.
- Life after the hospital
  - Socialization with others was difficult.
  - Drugs and addiction

MY STORY – ADAM

- Finding a new normal
  - Healthy and employed, yet new health concerns
- Marriage, then losing it all
  - Divorce and lost custody of son was a trigger
- Hitting a new rock bottom
  - Ultimately received mental health care while in custody

MY STORY – ADAM

- Finding a new normal…again
  - With the help of family
- Present day fighting residual battles of the past
  - Congestive Heart Failure hospitalization
- Working towards wellness
  - Choosing happiness

WHAT HAS WORKED WELL?

- Finding medication(s) that works
  - Taking them as prescribed
- Counseling & psychiatric help
  - Attend even when things are going well
- Meaningful relationships
  - Quality time together

WHAT HAS WORKED WELL?

- Support Groups
  - Addiction recovery. Find one you like and go.
- Exercise
  - Self-esteem
- Family
  - Would not be here today without family support

WHAT CAN WE DO BETTER?

- Caring for "addicts"
  - Refrain from prescribing more drugs whenever possible
- Have a feedback process
  - Transparency
- Improve the consistency in care
  - Delays in getting care and turnover is a challenge
- Survey patients at Center for Human Services
  - Both present and past patients

MY STORY – TRISHA

- My brother has always been SPECIAL
  - Watching him fight illness my whole life
- Death or bone marrow transplant – or both?
  - Hoping to save him
- The health of the family depends on the health of him
  - My way of keeping it together caught up with me.

MY STORY – TRISHA

- His new rock bottom and my role
  - Searching for answers
- Calling 911
  - Jail was the last option
- Helping him when he couldn't help himself
  - Role-modeling wellness and self-care

WHAT HAS WORKED WELL?

- Education on the long-term effects of chronic illness
  - NAMI Family to Family class
- Support groups for all
- Find the helpers
  - Look for them in all situations, throughout our community
- Sustaining hope and a vision of what is possible
  - Realistic and optimistic

WHAT CAN WE DO BETTER?

- Proper preparation
  - Medical Power of Attorney enables you to advocate for your family member
- Family members are stakeholders
  - Identify and integrate these key players
- Acknowledge the mental connection to physical illnesses
  - Do not separate the brain from the body
- Humanize the struggle
  - We are all a work in progress – share what helps you overcome

MY STORY – DR. AMYAS KABIR

- My Dad
  - a Psychiatrist and opened a Mental/Behavioral health center (Centrec Care) in St. Louis in 1976 and it is still in operation today
- My paradigm of health
  - Shaped by my Dad's philosophy and perspective on the contributors of mental, physical, and emotional illness
- My mission and passion
  - Create a Culture of Wellness which focuses on maintaining a healthy bala within the autonomic nervous system

THE BRAIN & BEHAVIOR

- Chronic stress and "fight or flight"
- Treating the effects of stress versus mitigating the cause
- Physical, biochemical, mental/emotional stressors
- Survive OR Thrive
  - Neuroplasticity
- Fire department
  - Axes and hoses to rebuild a house?

THE BRAIN & BEHAVIOR

- Chronic stress impairs healing, growth, and repair
  - Can wreak havoc on your mind and body
- Parasympathetic nervous system and Vagal tone
  - The Vagus nerve is a fundamentally important component of this system
- Effects of chronic cortisol, epinephrine, insulin, sugar
  - Enemies to wellness

WHAT WORKS WELL?

- BE Proactive vs RE-active
- Lifestyle modifications include Eat Well, Move Well, Think Well
- Assessment of spine and nervous system
- Implementation of "Hour of Power"
  - Reprogramming of the brain

WHAT CAN WE DO BETTER?

- Action trumps awareness
  - If overwhelmed, pick *one* thing to work on.
- Doctor = Teacher
- Assess Wholistically
  - Consider the mind, body and the spirit

QUESTIONS FOR THE PANEL

Recovery is "a decision to meet the challenge of disability…people experience themselves as recovering a new sense of self and purpose within and beyond the limits of the disability." This is something only the self can do; it is a decision to lead a hopeful life and to make a contribution in spite of the limitations imposed by illness.

- Patricia Deegan

NAMI Family-to-Family Education Program: 2014

CONTACT

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UNDERSTANDING THE DIFFERENCES BETWEEN TYPICAL ADOLESCENCE AND MENTAL HEALTH CONCERNS

EMILY WENGER, MS, AND KATHERINE VAN HORN, MSW, ABC COUNSELING & FAMILY SERVICES

WHAT WE WILL DISCUSS

- Typical Adolescent Development
- Atypical Adolescent Development
- Adolescent Mental Health Concerns
- Special Topics
  - Electronics
  - Trauma
  - Suicide
  - Pornography
- How to talk about difficult topics

TYPICAL ADOLESCENT DEVELOPMENT

Physical Development

- Growth occurs in spurts
- Improved motor skills
- Primary and secondary sexual characteristics
- Increased perspiration and acne
- Variation in eating and sleeping habits

TYPICAL ADOLESCENT DEVELOPMENT

Cognitive Development

- Abstract thinking and choosing own values
- Egocentrism
- Sense of invincibility

Emotional Development

- Able to identify and consider own emotions and emotions of others
- Able to cope with and manage intense emotions
- Mood swings and tendency to exaggerate problems

TYPICAL ADOLESCENT DEVELOPMENT

Social Development

- Defining individual identity
- Building close relationships, with a focus on peer relationships
- Challenging authority and efforts to increase own independence

Sexual Development

- Interest in sexual and romantic relationships, including genital sexual behaviors
- Develop emotional attachments to romantic partners
- Interest in pornography
- Curious about sexual orientation

TYPICAL ADOLESCENT BEHAVIORS THAT ARE NOT OF CONCERN

- Talking back, swearing/cussing, having "attitude"
- Lying about homework
- Occasionally using electronics (phones, tablets, TV) outside of "permitted" hours
- Staying up later and sleeping in later
- Short (weeks to months) dating relationships
- Peer conflicts: intense but short-lived, typically able to be reconciled
- Wanting to be with friends rather than family

WHEN IS SOMETHING ACTUALLY A PROBLEM?

- It causes a problem for the adolescent
  - They feel shame, confusion, embarrassment, or other strong negative emotions; they experience consequences; physical or emotional harm
- It causes a problem for the family
  - Conflicts with family values, religion; confusion or discomfort; family shame
- It causes a problem for others
  - Disruptive to teachers; conflicts with peers; physical or emotional harm

ATYPICAL ADOLESCENT DEVELOPMENT: WHEN TO ACT

Cognitive Development

- Not keeping up with schoolwork (grades of D or lower)
- Not engaging in classes when asked
- Difficulty following conversation, expressing themselves, or understanding questions asked of them
- Difficulty thinking abstractly about larger concepts (politics, religion)

Emotional Development

- Cannot/will not label own emotions
- Self-harming behaviors (cutting, scratching, picking, pulling out hair)
- Unable to control or regulate strong emotions
- Lack of empathy for others
- Talking about death/dying

ATYPICAL ADOLESCENT DEVELOPMENT: WHEN TO ACT

Social Development

- Wanting to spend time with mostly younger children
- Persistently turning down opportunities to socialize with peers
- Does not enjoy family activities, routines or rituals
- Multiple friendships ending without resolution, discussion or compromise

Sexual Development

- Accesses pornography repeatedly by avoiding parental controls
- Knowledge of BDSM or deviant sexual activity
- Sexually touching with others more than two years younger or older
- Sexual activity with animals

COMMON MENTAL HEALTH DIAGNOSES THAT EMERGE IN ADOLESCENCE

- Mood Disorders
  - Depression
  - Anxiety
  - Bipolar Disorder
  - Disruptive Mood Dysregulation Disorder
- Behavioral Disorders
  - Conduct Disorder
  - Eating Disorders

IS IT MOODINESS OR MENTAL ILLNESS?

Typical

- Strong emotional responses to life events
- Seeks out peers for emotional support
- Wearing clothes that embarrass their parents
- Emotional outbursts

Of Clinical Concern

- No apparent reason for mood swings
- Unable or unwilling to seek out emotional support
- Neglecting hygiene
- Not resolving conflicts

WHAT TO DO IF YOU ARE STILL CONCERNED

- Read about it (see Additional Resources slide)
- Talk to a trusted friend, family member or counselor
  - In Illinois, minors over the age of 12 may receive up to 5 sessions, 45 minutes each, of outpatient mental health counseling without parents being informed or consenting.
  - Victims of sexual assault or sexual abuse may receive medical treatment without a parent's/guardian's consent

ELECTRONICS: TYPICAL VS CONCERNING

Typical

- Often using a phone or tablet during other activities, such as watching TV or a movie, or spending time with friends
- Updating social media accounts about activities of daily life
- Sharing emotions and discussing social relationships via text or direct messages
- Playing games for several hours at a time

Of Concern

- Deleting texts or messages before a parent will see them
- Refusing to allow a parent access to a phone or device
- Gaming or using an electronic device while neglecting homework
- Choosing to stay home and communicate via text instead of going to a social or extracurricular activity

ELECTRONICS: RECOMMENDATIONS FOR ADOLESCENTS

- Share your passwords to all devices and social media accounts with your parent.
- Communicate with friends in respectful, fun, friendly ways.
- Tell a parent or counselor if you are worried about a friend's posts or mental health.
- Remember that everything is PUBLIC and PERMANENT.
- Avoid taking, sharing, sending or receiving any sexual photos. (This is child pornography and it is a felony.)
- Only accept friend/follow requests from people you have met in real life.

ELECTRONICS: RECOMMENDATIONS FOR PARENTS

- Monitor all electronic devices, including phones, tablets, gaming systems, and computers. Check your teen's messages and recent posts regularly. Create your own social media accounts and connect with your teen by "friending" or "following" them.
- Be informed about all the apps on your teen's phone and what they do.
- Talk with your teen about online safety, protecting privacy, and how they are managing their relationships online.
- Use parental controls on Wi-Fi and data. Most cell phone and cable companies offer this service.
- Set reasonable limits on data use and daytime/nighttime use. Designate a place (not bedrooms) for all devices to remain overnight.

IMPACT OF TRAUMA

- Trauma: psychological, emotional response to an event or an experience that is deeply distressing or disturbing
  - EX. Witnessing abuse, experiencing abuse, car accident, death or loss
- Some trauma symptoms and concerns include:
  - Withdrawal
  - Regression in behavior
  - Intrusive thoughts related to the trauma or strong avoidance of trauma reminders
- It is important to consider any trauma-related issues when addressing the mental health needs and concerns of adolescents.

SUICIDE

- Suicide is the second leading cause of death among ages 10-24.
- What to look for:
  - Changes to eating or sleeping habits
  - Withdrawal, or lack of talk about the future
  - Frequent or pervasive sadness and despair
  - Preoccupation with death and dying
- It's okay (and often helpful) to talk about it and ask questions if you notice warning signs!

PORNOGRAPHY

- Average age for first exposure to pornography is 11 years old
  - Unsupervised access to the internet and social media platforms plays a role!
- Pornography can negatively impact your teen's understanding of healthy sexuality and relationships
- Parents should promote sexual responsibility and provide open communication about sexual development changes

RECOMMENDATIONS FOR PARENTS WITH ADOLESCENTS

- Don't be afraid to ask questions and answer questions as honestly as possible.
- Open door policy: let them know you are available, and let them come to you.
- Commit to regular quality time together.
- Validate, don't undermine or minimize, their feelings.
- Approach any concerns without stigma, shame, or blaming. Help teens get help for themselves.
- Model healthy coping skills, communication, and conflict resolution.
- Remember that early experiences and memories matter.

RECOMMENDATIONS FOR ADOLESCENTS WITH PARENTS

- Trust your gut. If something doesn't feel right, it probably isn't.
- Remember your parent probably experienced something similar when they were younger. Give their advice some thought.
- Your feelings matter. If it feels too hard to deal with on your own, don't be a hero.
- Getting help is more important than avoiding a consequence.
- If you can't or don't want to talk to your parent, talk to a school counselor, friend, teacher, or another trusted adult.
- The Internet is an amazing, wonderful place. It is also dangerous.

HOW TO TALK

- Find a place and time that works for you.
  - Schedule, commit, and follow through.
  - It's okay to be spontaneous. Car rides, doing chores together, or watching TV can be great opportunities for conversation.
- When you want to talk, use a code word or phrase if necessary ("I'm going to need ice cream tonight," or "Come listen to this song with me").
- Avoid being defensive or attacking. Listen, validate, and help problem-solve.
- Sometimes saying the words out loud is hard. Write messages, notes, or texts to each other. Use a white board or a journal.

ADDITIONAL RESOURCES

- Teens Health: Mental health resources for parents and teens (https://teenshealth.org/en/teens/)
- Fight the New Drug: Understand the effects of pornography (https://fightthenewdrug.org/)
- Planned Parenthood: Healthy sex education and reproductive healthcare (https://www.plannedparenthood.org/)
- Public and Permanent: Promoting responsible use of technology (https://www.publicandpermanent.com/)
- National Alliance on Mental Illness (NAMI) : Education, advocacy, support and awareness for mental health issues.

HOW TO CONTACT US

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705 E. Lincoln St., Ste 303
Normal, IL 61761

309-451-9495

www.abccounseling.org

For specific questions about today's presentation, you can email us at :

Emily@abccounseling.org
Katherine@abccounseling.org

MENTAL HEALTH and YOUTH

13% OF CHILDREN ages 8-15 experience a mental health condition

50% OF CHILDREN ages 8-15 experiencing a mental health condition don't receive treatment

13-20% OF CHILDREN living in the U.S.

(1 out of 5 children) experience a mental health condition in a given year

17% OF HIGH SCHOOL STUDENTS seriously consider suicide

1/2 OF ALL LIFETIME CASES of mental illness begin by age **14**

Despite effective treatments, there are long delays—sometimes decades—between onset of symptoms and treatment

Source of statistics: National Institute of Mental Health and Centers for Disease Control and Prevention

NAMI National Alliance on Mental Illness

Why it MATTERS

Approximately **50%** OF STUDENTS AGES 14 + with a mental health condition drop out of high school

50-75% OF YOUTH IN JUVENILE JUSTICE SYSTEMS experience a mental health condition

Over **90%** OF YOUTH WHO DIE BY SUICIDE had one or more mental health conditions

SUICIDE IS THE 2ND LEADING CAUSE of death for people ages **15-24**

Source of statistics: Centers for Disease Control and Prevention, National Institute of Mental Health and U.S. Department of Education

NAMI National Alliance on Mental Illness

When we say MENTAL HEALTH CONDITIONS...

Some of the most common conditions we see in youth are:

Attention Deficit Hyperactivity Disorder (ADHD)
Conduct Disorder
Bipolar Disorder
OBSESSIVE COMPULSIVE DISORDER
ANXIETY DISORDERS
EATING DISORDERS
DEPRESSION
Oppositional Defiant Disorder
Disruptive Mood Dysregulation Disorder

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FOUR STEPS to early intervention

STEP 01	STEP 02	STEP 03	STEP 04
Know the warning signs	Reach out & respond	Work with school staff & your child	Provide resources & support

NAMI National Alliance on Mental Illness

WARNING SIGNS

- Feeling very sad or withdrawn for more than 2 weeks
- Severe, out-of-control, risk-taking behaviors that cause harm to self or others
- Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or fast breathing
- Seeing, hearing or believing things that aren't real
- Drastic changes in mood, behavior, personality or sleeping habits

NAMI National Alliance on Mental Illness

WARNING SIGNS

- Extreme difficulty concentrating or staying still that puts a person in physical danger or causes school failure
- Intense worries or fears that get in the way of daily activities
- Throwing up, using laxatives or not eating to lose weight; significant weight loss or weight gain
- Using alcohol or drugs excessively
- Trying to harm oneself, attempt suicide or making plans to do so

NAMI

Be aware of **BULLYING**

Signs of being bullied

- **Recognize the warning signs:**
  - Unexplainable injuries
  - Lost or destroyed clothing, books, electronics or jewelry
  - Feeling sick or faking illness
  - Difficulty sleeping or frequent nightmares
  - Declining grades, loss of interest in schoolwork, or not wanting to go to school
- **Learn what bullying IS and what it IS NOT**
- **Cyberbullying**
  - Learn how to prevent it and how to address it if it occurs

Source: The Relationship Between Bullying and Suicide: What we know and what it means for school, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

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Be aware of **BULLYING**

Signs of bullying others

- Get into physical or verbal fights
- Have friends who bully others
- Are increasingly aggressive
- Get sent to the principal's office or to detention frequently
- Have unexplained extra money or new belongings
- Blame others for their problems
- Don't accept responsibility for their actions
- Are competitive and worry about their reputation or popularity

Source: The Relationship Between Bullying and Suicide: What we know and what it means for school, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

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STEP 01 Know the **WARNING SIGNS**

Intensity

How severe are the symptoms?

Duration

How long do they last?

Level of distress

How much do they impair daily functioning?

NAMI

What teachers may see **IN CLASS**

- Misses class frequently
- Misses assignments and tests
- Quality of work gets worse
- Extremely disorganized
- In schoolwork, expresses violence, thoughts of death, hopelessness, social isolation or confusion
- Frequently seeks special conditions
- Shows patterns of perfectionism
- Responds very emotionally to grades

NAMI

What you may see **AT HOME**

Adolescents:

- Constantly runs late, unexpectedly rude, misplaces belongings
- Is isolated, doesn't participate in social situations
- Uses alcohol and/or drugs excessively, behaves hyper sexually
- Feels sad, hopeless, empty
- Overreacts to disappointment or failure, highly reactive to rejection and criticism
- Has difficulty sleeping, experiences high activity level at night
- Lies and makes up stories

NAMI

Younger children **AT HOME**

- Never slows down, is demanding or unable to focus
- Nothing pleases them, difficult to manage at home but not at school
- Has severe separation anxiety, doesn't want to go to school, unwarranted worrying, is severely shy
- Has excessive, non-stop energy, is impulsive
- Has low frustration tolerance, making it difficult to participate in family activities
- Has disrupted sleep cycles or night terrors
- Is irritable and aggressive, has abrupt mood changes, imagines body pains

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Common warning signs of **SUICIDE**

- Talking, writing or drawing about death
- Talking about:
  - Having no reason to live
  - Being a burden to others
  - Not being here tomorrow
- Feeling hopeless, desperate or trapped
- Looking for ways to attempt suicide
- Giving away possessions
- Loss of interest in the things they care about
- Behaving recklessly

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Common warning signs of **SUICIDE** younger children

- Change in usual behavior
- Preoccupation with death
  - Think, dream, fear and worry more about death than other children
- Risky behavior
  - Running into a busy street, trying to get out of a moving car
- Talking about or threatening suicide
- Anger, irritability, violence

NAMI

STEP 02 **REACH OUT** and **RESPOND**

If you believe a young person is considering suicide:

Take Action Immediately!

- Ask the question, "Are you thinking about suicide?"
- Don't leave them alone
- Share relevant information with the mental health contact
- Determine who will contact their family

NAMI

TALK with your child

- Choose a time to talk when your child feels safe and comfortable
- Communicate in a calm and straightforward way
- Speak at a level that's appropriate to your child's age and development level (preschool children need fewer details than teenagers)
- Watch your child's reactions and slow down or back up if your child becomes confused or upset
- Listen openly and let your child tell you about their feelings and worries

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Start the **CONVERSATION**

Can you tell me more about what's happening? How you are feeling?

Have you had feelings like this in the past?

Sometimes you need to talk to an adult about your feelings. I'm here to listen. Would you like to talk with me?

Do you feel like you want to talk to someone else about how you're feeling?

NAMI

What **NOT** to say

- Don't dismiss how they're feeling as routine or as something that will get better on its own
  - "We all go through times like these. You'll be fine"
- Don't ask questions that will only give you a yes/no answer
  - "Are you OK?"
  - "Are you having any problems?"
- Don't ask in a way that indicates you want "no" as an answer
  - "You're not feeling anxious about going to school, are you?"
- Don't promise confidentiality

NAMI

Talk with **SCHOOL STAFF**

Share your concerns
- Ask what teachers see in school
- Refer to academic indicators

Establish communication channels
- Email, folder, phone/text

Ask about classroom adjustments
- Preferential seating
- Flexible homework assignments
- Special education and accommodations (Individualized Education Program (IEP) 504 Plan)

NAMI

Talk with **HEALTH CARE PROFESSIONALS**

Share your concerns
include reports from school staff and what you've seen at home

Ask for referrals
Reach out to family, friends and school community

Ask if an evaluation is needed
Preferably by a specialist with experience in children's mental health

Educate yourself
Build your confidence so you can ask questions and advocate

REMEMBER that you have a voice in your child's mental health care

NAMI

Advocate for your child

Talk with your pediatrician
Keep a record of concerns

Work with the school
- Maintain regular communication
- Help teachers understand your child's challenges

Get a referral to a mental health specialist

Connect with other families
NAMI Basics, NAMI Family Support Groups

NAMI

Promote resilience and well-being

Teach your child how to:	Make sure your child:	Help them see:
• Make friends, connections and have empathy • Set goals and work on them at a reasonable pace	• Maintains a routine • Takes a break and has unstructured time • Learns how to have a positive self view	• The good things in life to help them through rougher times • That change is a part of living • How good it feels to help others

NAMI

Colleen O'Connor, CPS, CADC

NAMI Ending the Silence Coordinator

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WHAT IS SELF HARM?

MEGHAN MOSER, LCPC AND NONA WALLER, LCPC

LEARNING OBJECTIVES

- Understand the difference between non suicidal self-injury and suicide attempts
- Identify reasons youth engage in self-harm
- Understand how to approach youth who may be engaging in self-harm

WHAT IS SELF-HARM? DEFINITION

- Intentional destruction of one's own body tissue without suicidal intent and for purposes not socially sanctioned
- Non Suicidal Self Injury (NSSI)
- Common symptom found in a variety of disorders as well as in adolescents without a specific psychiatric diagnosis
- Not a diagnosis in itself

WHAT IS NSSI? CHARACTERISTICS

- Typically begins in mid-adolescence
- Often impulsive
- Can seem to acquire addictive characteristics and be quite difficult for a person to discontinue

WHAT IS NSSI? EXAMPLES

- Cutting
- Burning
- Hitting
- Pinching
- Banging or punching walls and other objects to induce pain
- Breaking bones
- Ingesting toxic substances
- Interfering with healing of wounds
- Women are more likely to use cutting
- Men are more likely to use hitting or burning
- Most people who self-injure have used multiple methods

WHAT IS NSSI? RISK FACTORS

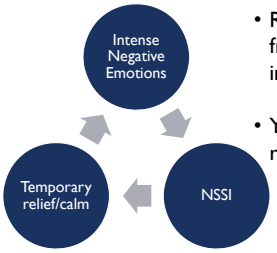
- Highest among psychiatric populations
- People who report characteristics associated with emotional distress
  - E.g. negative emotionality, depression, anxiety, and emotion dysregulation
- Especially common in people prone to self-directed negative emotions and self-criticism
- More common among people who report non-heterosexual orientations
- More common among Caucasians than non-Caucasians

WHAT IS THE DIFFERENCE BETWEEN NSSI AND SUICIDE ATTEMPTS?

NSSI
- Non lethal intent
- Lower severity
  - E.g. Cutting, burning
- Higher frequency

SUICIDE
- Lethal intent
- Higher severity
  - E.g. Firearms, hanging, self-poisoning
- Lower frequency

WHY DO YOUTH ENGAGE IN NSSI?



- Remember: NSSI generally stems from emotional pain, not malevolent intentions
- Youth need more effective skills to replace self injury

WHY DO YOUTH ENGAGE IN NSSI?

- To stop suicidal ideation or to stop themselves from actually attempting suicide
- Affect regulation and management of distressing thoughts
  - Gain a sense of control, to feel excitement, or to stop dissociative experiences
  - Give the adolescent the experience of being "real."
- Elicit positive reinforcement in the form of attention from others
- Help the teen to avoid difficult situations
  - Cause adults or peers to decrease interpersonal pressure
- Form of self-directed anger or self-punishment

TYPICAL REACTIONS TO NSSI

- Shock/horror and denial
- Anger and frustration
- Empathy, sympathy and sadness
- Guilt
  - Wondering what you may have done to make them do this
  - Guilt for feeling anger about the self-injury
- Confusion and worry
- Thoughts that the youth is doing it to get attention or to manipulate those around them.

HOW TO APPROACH YOUTH ENGAGING IN NSSI: DOS

- Recognize own reactions and emotions
- Address the issue as soon as possible.
  - Have difficult conversations when there is ample time and privacy
- Help the youth realize the impact of his/her self-injury on themselves and others
- Validate the youth's feelings
  - This is different from validating the behavior
  - Use a supportive and calm tone to acknowledge concern and challenges
- Offer reassurance
  - Use active listening and pay attention to the youth's emotional needs
  - Use respectful curiosity and open-ended questions to understand NSSI from the youth's perspective

HOW TO APPROACH YOUTH ENGAGING IN NSSI: DOS

- If the youth does not want to talk, do not pressure him/her
  - Be patient
  - Leave the door open for future conversation
- Focus first on helping the youth to acknowledge the problem and the need for help
  - "How do you feel before you self-injure? How do you feel after you self-injure?"
  - "How does self-injury help you feel better?"
  - "What is it like for you to talk with me about hurting yourself?"
  - "Is there anything that is really stressing you out right now that I can help you with?"
  - "Is there anything missing in our relationship, that if it were present, would make a difference?"
  - "If you don't wish to talk to me about this now, I understand. I just want you to know that I am here for you when you decide you are ready to talk. Is it okay if I check in with you about this or would you prefer to come to me?"

HOW TO APPROACH YOUTH ENGAGING IN NSSI: DON'TS

- Yelling
- Lecturing
- Put downs
- Harsh and lengthy punishments
- Invasions of privacy (i.e., going through a youth's bedroom without his/her presence)
- Ultimatums
- Threats
- Avoid power struggles
- Trivialize/Guilt
  - "I know how you feel."
  - "How can you be so crazy to do this to yourself?"
  - "You are doing this to make me feel guilty."
- Avoid jumping in with solutions

RESOURCES

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695720/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4244874/
- http://www.selfinjury.bctr.cornell.edu/perch/resources/parenting-2.pdf
- https://www.cmho.org/images/2017%20Conference%20Presentations/Tuesday%20Worskshops/TA%20Sessions/TA7%20Supporting%20Youth%20Who%20Self%20Injure.pdf
- http://sioutreach.org/learn-self-injury/parents-and-families/#ffs-tabbed-15

QUESTIONS?

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PAIN MANAGEMENT:
GETTING HELP WITHOUT GETTING HOOKED

DR. SETH HATLELID, PSYCHOLOGY SPECIALISTS

2018 McLean County Behavioral Health Community Forum

WHAT IS PAIN?

Pain hurts!

Pain is the sensory and emotional experience of discomfort, which is usually associated with actual or threatened tissue damage or irritation (Sanders, 1985).

Pain is the most common medical complaint and is the single most compelling force underlying a person's choice to seek or avoid medical care (Karoly, 1985). Chronic pain affects more people than diabetes, heart disease, and cancer combined.

Pain can be organic (caused by tissue damage) or psychogenic (medical examinations fail to find an organic basis for the pain), but is more often both. Psychogenic pain is still real pain.

Pain is whatever hurts and whatever the patient says that it is!

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COSTS OF PAIN: EMOTIONAL INTERFERENCE WITH PAIN (TEATER, 2018)

- Pain is worse after surgery with people who:
  - catastrophize their pain (10 out of 10 pain)
  - Ruminate about their pain
  - Feel helpless in managing their pain
  - Magnify their pain before surgery
  - Experience depression before surgery
- Having a partner touch you with empathy REDUCES pain!
- Just imagining back-straining movement triggers pain. This can be seen on an MRI!

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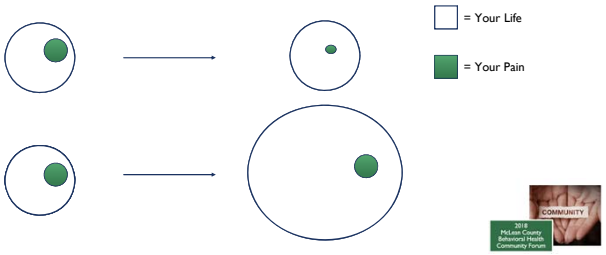
PAIN TREATMENT (THE TWO CIRCLES)



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TYPES OF TREATMENT FOR PAIN

- Physical interventions: Surgery, physical therapy, diet, exercise, injections, treatments.
- Pharmacological interventions: Pain medications, antidepressants, sleep aids, and anxiolytics.
- Psychological/behavioral interventions: Therapy, relaxation skills, exercise, enjoyable experiences, social connections, biofeedback.

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OPIOIDS

- Opioids are narcotic drugs that act on opioid receptors to block pain in the brain.
- They mimic the body's own pain-blocking endorphins.
- They can be quite effective at blocking pain, at least in the short term.
- They can be quite addictive.
- The side effects can be dangerous or deadly.

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OPIOIDS: THE SOLUTION AND THE PROBLEM (FRANK, 2015)

- 3-4% of the US population on long-term opioids.
- 5-8 million people use opioids daily!
- 2 million of those people are addicted (opioid crisis).
- 420,000 annual ER visits due to opioid misuse.
- $504 billion in annual costs. This is 2.8% of the GDP!
- 64,000 people die per year from opioids. (175 per day). Twice as much as car crashes!
- The drop is life expectancy from opioid use is greater than all other medical advances since 1993!

OPIOIDS

- The 5% of the world's population in the United States uses 80% of the world's opioids!
- We use 99% of the world's hydrocodone.
- 83% of the world has NO access to opioid pain killers.
- In 1997, there was enough morphine for 96 mg of morphine per person. In 2015, it was 640 mg per person.

APPROPRIATE USES OF OPIOIDS

- Very short term pain relief (< 1 week)
- End of life issues.

THE PAINKILLER MYTH

- Opioids do not necessarily provide long-term pain relief.
- In 2016, the CDC recommended behavioral treatment BEFORE any opioid prescription.
- 1 extra strength Tylenol (500 mg) + 200 mg ibuprofen, when taken at the same time, provides MORE pain relief than 10 mg of Percocet or 15 mg of Oxycodone (Teater, 2018).
- Opioids can increase perceived pain over time!
- Other side effects can make a person's life much worse or even end.
  - Cruise ship story.
- 30 days of opioid use can lead to reduced brain volume in the amygdala; the effect is permanent!

ADDICTION AND DEPENDENCE

- Addiction involves both physical and psychological dependence.
- *Physical dependence* exists when the body has adjusted to a substance and incorporated it into the normal functioning of the body's tissues.
- *Psychological dependence* is a state in which persons feel compelled to use a substance for the pleasant effects that it produces, without necessarily being physically dependent on it.

PROBLEMS WITH PAIN MEDICATIONS

People on opioids have LOWER pain tolerances due to opioid hyperalgesia.

People with headaches tend to use maladaptive coping strategies more often then non-headache sufferers (Mosley, 1990).

Arthritis sufferers who feel helpless before beginning medication have poorer outcomes regarding pain and disability than do comparable patients who don't feel helpless (Nicassio, 1993).

Placebo drugs (and sham treatments) often work. At least in the short term.

WIND UP/CENTRAL SENSITIZATION TO PAIN

In chronic pain, the nervous system (and pain gate) can be conditioned to transmit certain pain messages more easily. This makes the pain you already have WORSE over time.

Effectively, long-term potentiation allows a person in pain to stay in pain longer and to feel pain more intensely.

Pain can get worse over time, just by having chronic pain. Opioid pain medications actually make this problem WORSE.

Cold war between opioid pain medications and pain receptors!

Therapy is the only thing that helps unscramble these mixed messages in the brain.

LOW BACK PAIN (TEATER)

- Low back pain is the most common and costly chronic pain (14-45% of people per year and 23% become chronic).
- All of the risk factors for chronic back pain are psychological NOT physical!
  - Negative attitudes and beliefs about chronic back pain.
  - Belief that passive treatments (not moving) are the best solution.
  - Fear and avoidance of pain. (I can't possibly go swimming, I might hurt my back!)
  - Reduced activity levels (I fight about this ALL the time).
  - Work-related and emotional difficulties.

WHY IS REDUCING STRESS IMPORTANT IN PAIN PATIENTS?

Pain is stressful… and stressed people:

Smoke more often than non-stressed people.
Eat a less healthy diet, because stress leads to carbohydrate (sugar) cravings.
Abuse more substances, such as drugs and alcohol.
Experience increased family problems, including domestic violence.
Experience more physical illnesses.
Have increased conflict with coworkers.
Report being less motivated to care for themselves.
Actually heal 26% more slowly after a surgery!

THERAPIES THAT ARE USEFUL FOR PAIN

Cognitive therapy is a structured and educative form of psychotherapy. . . patients are taught skills for identifying, evaluating, and responding to their dysfunctional thoughts and beliefs. (Eimer & Freeman, 1998).

Experience - Thought - Feeling - Behavior - Whole New Experience

Behavior Therapy focuses on replacing people's maladaptive behaviors with new adaptive behaviors (Kaplan & Saddock, 1998).

Don't use pain words or grimace against the pain. Encourage exercise.

Acceptance and Commitment Therapy (ACT)

Face the things that cause you fear or discomfort and learn to beat them!

CBT AND PAIN

Because of the brain's downward influence on the gate in gain control theory, pain can be moderated by motivational and cognitive processes.

The goals are to help patients cope more effectively with their pain and other stressors and to reduce their reliance on pain medication to be able to effectively control their experienced pain.

We want to increase active coping and decrease passive coping (sleeping, hiding, curtailing activities).

WHAT PAIN PSYCHOLOGISTS DO

Evaluate and assess the person.

Diagnose co-morbid psychological conditions.

Provide useful recommendations for the person, their physicians, and their other providers.

Educate the person about pain and their role in their own pain treatment.

Intervene with the person psychology and physiology.

Communicate with other providers and physicians.

ASSESS FOR CHRONIC PAIN SYNDROME

Associated tissue damage.

Persistent pain complaints and behaviors.

Disrupted daily living patterns (typically decreased).

Disrupted social, marital, employment, and recreation.

Excessive use of drugs, medication, or repeated use of medical treatments/surgeries.

Disturbed sleep patterns.

Increased anxiety and depression.

TWO MODELS OF BEHAVIORAL TREATMENT (TEATER, 2018)

- Pain Education
- Breathing
- PMR and Imagery
- Automatic Negative Thoughts
- Cognitive Restructuring
- Stress
- Pacing
- Pleasant Activities
- Anger
- Sleep
- Relapse

- John Otis

- Assessment
- Treatment Orientation
- Goal Setting
- Exercise and Pacing
- Relaxation
- Pleasant Activities 1
- Pleasant Activities 2
- Cognitive Coping 1
- Cognitive Coping 2
- Sleep
- Discharge Planning

- The VA CBT Plan for Chronic Pain

CBT TECHNIQUES AND INTERVENTIONS

Health Habit Training

Education and Psychoeducation

Cognitive Restructuring

Automatic thoughts

Realistic limits

Pain related anxiety & fear

"Where the focus goes the energy flows"

WHERE TO INTERVENE?

Change the stressor: behavioral interventions can sometimes cure or at least manage disease.

Change the physiological response to the stressor: Educate the patient about the disease, treatments, side effects of treatments, and the likely outcome of the treated disease.

Change the interpretation of the stressor: Use cognitive restructuring and/or reality testing techniques to reframe the impact of the stressor on the patient's life.

Change the physical response to the stressor: Use relaxation techniques, biofeedback, and awareness techniques. Help people people realize that they have some control over the psychological response as well as allow them to understand that they are responding to a stressor.

DECREASE NEGATIVE THINKING

Negative thinking opens the pain gate, which lets pain move from the spinal cord to the brain, where it is perceived as the ouchy stuff.

Avoid: blaming, should statements, polarized thinking, catastrophizing, control fallacies, emotional reasoning, filtering, and the fallacy of entitlement.

We teach the patient to stop these thoughts, replace the faulty beliefs, and to reevaluate the new consequences of their beliefs.

GOAL SETTING

- Shift the focus to concrete milestones versus talking about the pain.
  - How many steps did you walk?
  - How long did you work in your garden?
  - How many times did you meet your friends for lunch?
  - How many times did you think about taking your breakthrough medication, and tried a relaxation technique instead?
  - How did you shift the focus to living your life and getting away from obsessing on your pain?

CHANGE BEHAVIOR TO RELIEVE SUFFERING

- Suffering = Pain/Resistance
- Suffering leads to
  - grimacing and clinching
  - wincing
  - bracing
  - aversive thoughts
  - wishes for relief
  - self-punishment
  - anger, fear, and depression
  - moaning, sighing
  - limping

DECATASTROPHIZING

- Pain grabs our attention. FIRE! DANGER! SNAKE!
- This leads pain to be seen as very important on which our brain to focus. Perhaps over focus.
- When you focus on pain, the pain increases. We can make it seem like the end of the world. This is catastrophizing and is almost universal with chronic pain.
  - Overestimates the pain and threat.
  - Underestimates coping skills and resources.
- Key Features of Catastrophizing
  - Magnification
  - Rumination
  - Helplessness

CATASTROPHIZING

- Leads to increased hospital stay duration.
- Greater pain intensity.
- Worse outcomes after surgery.
- Increased depression.
- Can actually be a larger problem than the illness/injury itself!

- You beat it by facing the very thing that you are afraid of!

MINDFULNESS

- Focus on the here and now vs the terrifying future that may never come (anxiety) or the awful past that cannot be changed (depression).
- Mindfulness consists of:
  - A non-judgmental stance, even towards pain.
  - Kindness towards oneself, and even the injury.
  - Accept the present experience.
  - Pain begins to fade into the background.
  - We become less anxious of anticipatory pain.
  - Moving to cognitive change. (Maybe it's not so bad, maybe I can move my life forward).
  - Increased symptom tolerance.
  - Calming the reactivity of the mind and body.

ABDOMINAL BREATHING

One of the easiest ways to decrease stress and distract yourself from pain.

4-8 breaths per minute from the diaphragm.

Decreases stress hormones and can affect blood pH, preventing hyperventilation and ischemia.

Even breathing and meditator's breath.

GUIDED IMAGERY

- Create a "special place" in your mind where pain cannot touch you.
- Build this place using all of your five senses in as much detail as possible.
- Go to this plan during pain or discomfort.
- Reset the body.
- Come back refreshed and ready to confront the fear/pain.

PROGRESSIVE MUSCLE RELAXATION

Many people are unaware of their muscle tension, which can lead to muscle fatigue, poor circulation, cramping, and stiffness.

Tighten and relax the muscle fibers in a systematic fashion to release sympathetic hyper-arousal and increase relaxation.

Be careful! If it hurts, do it lighter!

EXERCISE

Exercise decreases pain over time by strengthening injured muscles as well as releasing pain-killing endorphins.

We encourage the patient to exercise and stretch properly to increase muscle tone and range of motion.

We address motivation with operant conditioning and internal motivation.

We can use behavioral contracts when necessary.

Using pacing to prevent overdoing it and the "push-crash-burn" cycle. Start with a few minutes of a task and work up to more time.

BIOFEEDBACK

- Biofeedback uses a computer and special sensors that allow a person to see how their body reacts to their thoughts and experiences.
- You can see that pain causes your heart to race, your muscles to tighten, your skin to sweat, and your skin temperature to fall.
- You can learn to control these physical aspects of your body that we don't tend to think we have control over, and then make changes to relieve or relax through the pain.
- Not a magic cure, but it can bridge the gap between the mind and the body and teach people how their pain affects them, and how they in turn, have some degree of control over their own pain.

SETH HATLELID, PSYD BCB

THANK YOU FOR LISTENING?

You can reach me by calling Psychology Specialists at 309-706-3190.

You can also email me at shatlelid@psychologyspecialists.com.

ANY QUESTIONS? COMMENTS? THROWN TOMATOES?

AGING: WE ALL DO IT
PREPARING FOR CHANGING TIMES

ROSE STADEL, BS, CHS, LPN, CDP
ELIZABETH HAGEMANN, MA ALZHEIMER'S ASSOCIATION ILLINOIS CHAPTER

LEARNING OBJECTIVES

1. Review growth in the aging population
2. Distinguish between signs of normal & abnormal aging
3. Discuss Alzheimer's disease and dementia
4. Identify the "Sandwich Generation" and provide strategies and interventions to address current and future challenges
5. Understand need to prepare and plan for Healthy Aging

AGING BY THE NUMBERS

- US population age 65+ = 49.2 million in 2016 (US Census Bureau)
- 85+ group = 6.4 million…Expected to double by 2040
- 1 in 6 Americans working full or part time assist with care of an elderly or disabled family member.
- Some stats say adults will spend more time caring for their parents than their children.
- 34.2 million Americans provided unpaid care to an adult over 50 in the last 12 months. (Family Caregiving Alliance/AARP)

AGING IS CHANGING

Best if
"Use By Date"

Or

Like a Fine Wine-
"Better with Age"

NO TWO PEOPLE AGE THE SAME!

85 years/nursing home

85 years/pole vaulter

AS WE AGE
SOME CHANGES CAN OCCUR

- Body processes can slow down
- Senses diminish-degree & onset vary
- Impaired vision
- Hearing loss
- Touch: Unable to sense pain or pressure
- Taste: Poor appetite-Complaints of taste
- Joints stiffen & muscles weaken

CHANGES CAN IMPACT FUNCTIONING & BEHAVIOR

- Processing what is heard, seen and read takes longer. May seem like confusion.
- Lack of appetite/Weight Loss
- Injury/Balance and Reaction Time
- Fear of Falling/Limited Range of Motion
- Digestion of food/Absorption of medication
- Decreased Heart and lung capacity

NOW WHAT DID I COME IN HERE FOR???

MEMORY LOSS WITH AGING

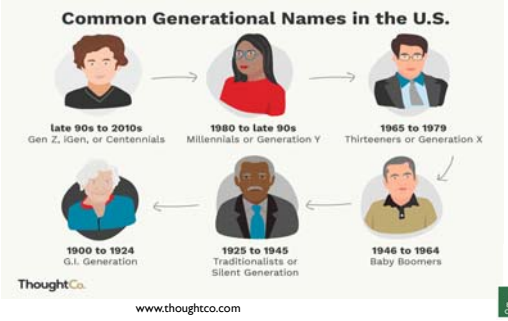
- Some change in memory is normal.
- Things that can affect memory and cause confusion:
- Medication interaction; Poor Nutrition
  - Infection; Disease
  - Depression; Stress
  - Vitamin Deficiency; Lack of Sleep
  - Pain; Fever
- Processing what is heard, seen and read may take longer. Seems like confusion.

Know the 10 Signs

1. Memory loss that disrupts daily life
2. Challenges in planning or solving problems
3. Difficulty completing familiar tasks at home, at work or at leisure
4. Confusion with time or place
5. Trouble understanding visual images and spatial relationships
6. New problems with words in speaking or writing
7. Misplacing things and losing the ability to retrace steps
8. Decreased or poor judgement
9. Withdrawal from work or social activities
10. Changes in mood or personality

Dementia and Alzheimer's Disease

- Dementia is a general term used to describe a decline in cognitive functioning.
- Alzheimer's is a progressive disease of the brain that destroys brain cells, causing problems with memory, thinking and behavior.
- Alzheimer's disease is the most common form of dementia.
- Though some treatments are available to help with symptoms, Alzheimer's is a disease that is eventually fatal.

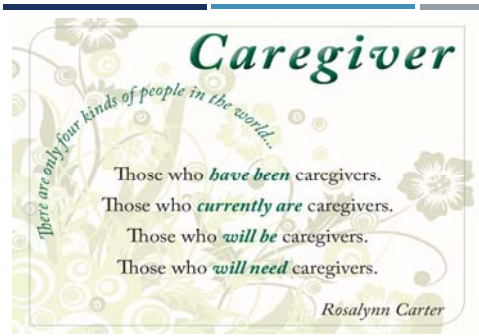


www.thoughtco.com

THE SANDWICH GENERATION
CLUTTERED NEST OR EMPTY NEST

- Traditional
  - Those sandwiched between aging parents who need care/help & other children (1981-Dorothy Miller)
- Club Sandwich
  - Age 50s & 60s sandwiched between aging parents, adult children & grandchildren. Those in 30s/40s with young children & aging parents (Carol Abaya)
- Open Faced
  - Anyone else involved in elder care. (Carol Abaya)

http://www.sandwichgeneration.com/



CAREGIVER ROLES DIFFER

- General oversight of meals, meds, transportation, housing and medical care
- Assistance with bathing, dressing, grooming, household chores and financial support
- Safety issues: fall risk, wandering, monitoring
- Needs 24 hour hands on care
- Long Distance Caregiving/No family support

CAREGIVER SYNDROME

A Condition Brought on by Caring for a Person with a Chronic Illness or Dementia
(Andree LeRoy, MD (CNN)

- Symptoms-depression, anxiety, anger declining health, guilt, stress
- Leads to high B/P, diabetes, compromised immune system, exhaustion
- Result of elevated stress hormones
- Can take on symptoms of care-receiver
- Caregivers often neglect their own care

CAREGIVER STRESS
EMOTIONAL ROLLER COASTER

Happy	Angry
Appreciated	Overwhelmed
Blessed	Frustrated
Satisfied	Resentful
Grateful	Unappreciated
Content	Guilty
Calm	Anxious
Rested	Exhausted
Relaxed	Stressed
Understanding	Intolerant
Involved	Isolated

COMMON THREADS AMONG CAREGIVERS

- Feel helpless; Have difficulty asking for help
- Feel alone; Feel guilty for expressing frustration
- Feel overwhelmed balancing work caregiving responsibilities
- Feel bad about feeling good
- Put their own health second

PREPARE FOR THE EVENT

- Explore Options Before You Need Them!
  - Home Care; Assisted Living; Nursing Home
  - Meals; Transportation; Financial information
- Prepare a List of Meds; Emergency Contacts; Healthcare Provider; Health conditions; Current Photo; Pet information
- Early Notification Registration Program
  - Call your local law enforcement agency
- Advance Directive— "A Personal Decision"; Illinois State Medical Society (www.isms.org)

HOW TO KNOW WHEN TO GET HELP

- Your own health is compromised
- Your care receiver's needs are too complex
- It is no longer safe
- You are reaching the breaking point
- Your relationship with the care receiver has become adversarial

BE PROACTIVE

- Ask for and accept help
- Make home/safety/security modifications
- Medical Alert; Cell phone; video technology
- Work with your Health Care Provider
- Join a support group

Know yourself. Know your limit.

FOR ME

In order to take better care of myself, I will:

1._____
2._____
3._____

AGE DOES NOT DIMINISH THE SUPREME DISAPPOINTMENT OF HAVING A SCOOP OF ICE CREAM FALL FROM THE CONE.
(JIM FIEBIG)

CAREGIVER RESOURCES

- Community Care Systems, Inc.
  - Caregiver advisory and other support services
  - Call (309) 661-6400
- AARP
  - aarp.org/caregiving
- American Red Cross Family Caregiving Program
  - www.programsforelderly.com

Alzheimer's Association Resources

- **24/7 Helpline 800-272-3900 or alz.org/illinois**
  We're here all day or night with information, emotional support, caregiving tools and referrals to healthcare, financial and legal resources.

- **Care Navigation**
  Individual sessions in person or by phone help individuals with memory loss and their families plan and cope with the disease

- **Community Resource Finder**
  Get easy access to resources, community programs and services.
  www.communityresourcefinder.org

Alzheimer's Association Resources

- **Education Programs**
  A variety of programs for people with dementia, their families, the public and continuing education for professionals. We also host conferences for families
  - Programs by Phone
  - Live Webinars

- **Get Involved!**
  Our volunteers are passionate, inspired, and making a difference in the fight to end Alzheimer's disease. Whether you can spare a few hours a month or can make a more significant time commitment, please consider becoming an Alzheimer's Association volunteer.

Questions?

MENTAL HEALTH AND THE LGBTQIA COMMUNITY

DR. BLAIR M. BROWN, LICENSED CLINICAL PSYCHOLOGIST

WHAT DOES IT ALL MEAN???

LGBTQQIP2SAA

Lesbian
Bisexual
Intersex
Allies
Gay
Queer
Pansexual
Transgender
Questioning
2-Spirit
Asexual

SEX VS. GENDER

- **Sex**
  - A person's physical or biological assignment of male, female, intersex at birth by medical professionals
  - Based on chromosomes, genitalia, gonads
- **Gender**
  - A social construct fabricated by society and culture
  - Traditionally defined as man/masculine and woman/feminine
  - Society suggests behavioral or characteristic traits for each
- A person's biological sex will not predict their gender or sexual orientation

GENDER AND COLOR

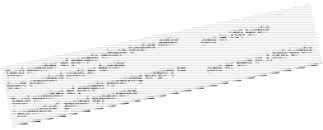
THE GENDER BINARY

- The societal classification and assumption of gender into two disconnected and opposite concepts.
  - i.e., Male OR female only.

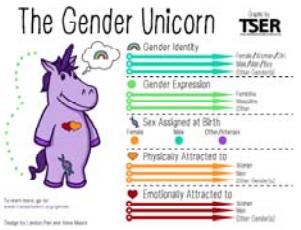
PREVALENCE OF INTERSEX CONDITIONS

HTTP://WWW.ISNA.ORG/FAQ/CONDITIONS

Not XX and not XY	one in 1,666 births
Klinefelter (XXY)	one in 1,000 births
Androgen insensitivity syndrome	one in 13,000 births
Partial androgen insensitivity syndrome	one in 130,000 births
Classical congenital adrenal hyperplasia	one in 13,000 births
Late onset adrenal hyperplasia	one in 66 individuals
Vaginal agenesis	one in 6,000 births
Ovotestes	one in 83,000 births
Idiopathic (no discernable medical cause)	one in 110,000 births
Iatrogenic (caused by medical treatment, for instance progestin administered to pregnant mother)	no estimate
5 alpha reductase deficiency	no estimate
Mixed gonadal dysgenesis	no estimate
Complete gonadal dysgenesis	one in 150,000 births
Hypospadias (urethral opening in perineum or along penile shaft)	one in 2,000 births
Hypospadias (urethral opening between corona and tip of glans penis)	one in 770 births



THE GENDER UNICORN!



RESEARCH TO SUPPORT THE CLAIM

Transgender Population Size in the United States: a Meta-Regression of Population-Based Probability Samples

Ester L. Meerwijk, PhD and Jae M. Sevelius, PhD

Published: February 2017

"We used data from national surveys to estimate the population size of transgender people in the United States. Estimates of the number of transgender adults significantly increased over the past decade, with a current best estimate of 390 per 100 000 adults. That is about 1 in every 250 adults, or almost 1 million Americans."

(Response: 99.6% ☺)

DISCRIMINATION

- LGBTQIA people are vulnerable to vast experiences of discrimination in many areas of life.
  - Employment
  - Housing
  - Public Accommodations
  - Health Care
  - Religious Facilities
- There are no federal protections for transgender people in the United States.

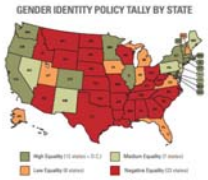
GENDER IDENTITY POLICY TALLY BY STATE

This image shows the quality of transgender protections in the United States. Policies are judged on the following major categories:

- Marriage and Relationship Recognition
- Adoption and Parenting
- Non-Discrimination
- LGBT Youth
- Health and Safety
- Ability for Transgender People to Correct the Name and Gender Marker on Identity Documents

For the states in RED, trans folks:

- Are not protected from bullying and/or discrimination in schools
- Cannot access medically necessary healthcare
- Often cannot change name & gender marker on ID's
- Can be unfairly fired, evicted, and/or kicked out of public places



MICROAGGRESSIONS

"Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership." –Psychology Today

Examples:

- Giggles in an audience during a same-sex love scene
- People staring at same-sex hand-holding
- Being told "you don't look trans" (as if it is an accomplishment)
- "You're only bi because you haven't found the right man yet"
- "Oh you're gay?! John is gay too!!!"
- Not reacting to "straight" PDA, but eye-rolling at "gay" PDA
- Asking a gay man for shopping advice
- "How do you know you're gay if you haven't had sex?"
- "How can you attend church if you're gay?"
- "Your outfit is so gay."
- Seeing every billboard with a straight couple out to dinner

LGBTQIA MENTAL HEALTH STATS (NAMI)

- LGBTQIA folks are 3 times more likely to experience a mental health condition
- Fear of coming out or discrimination can lead to depression, PTSD, substance use, and suicide
- For LGBTQ people aged 10–24, suicide is one of the leading causes of death
- LGBTQ youth are 4 times more likely to attempt suicide
- Questioning youth are 3 times more likely to attempt suicide, experience suicidal thoughts, or engage in self-harm than straight youth
- 38-65% of transgender individuals experience suicidal ideation
- Familial rejection after coming out increases likelihood of attempted suicide by 8 times
- 20-30% of LGBTQ people abuse substances (general population = 9%)
- 25% of LGBT people abuse alcohol (general population = 5-10%)

LGBTQ AND PEOPLE OF COLOR (NPR)

Discrimination *compounds* by intersecting identities:

TREATMENT ISSUES

HTTP://WWW.MENTALHEALTHAMERICA.NET/LGBT-MENTAL-HEALTH

- 1 in 5 LGBT individuals reported withholding information about their sexual practices from their health care professional
- 30 percent of transgender individuals reported postponing or avoiding medical care when they were sick or injured, due to discrimination and disrespect
- Approximately 8 percent of LGB individuals and nearly 27 percent of transgender individuals report being denied needed health care outright
- In mental health care, stigma, lack of cultural sensitivity, and unconscious and conscious reluctance to address sexuality may hamper effectiveness of care
- Evidence suggests that implicit preferences for heterosexual people versus lesbian and gay people are pervasive among heterosexual health care providers
- LGBT individuals that keep their sexuality hidden are at an increased risk of psychological distress
  - Also prevents them from accessing group-based coping resources that buffer against stigma

GENDER DYSPHORIA (AMERICAN PSYCHIATRIC ASSOCIATION)

- Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender.
- Gender conflict affects people in different ways:
  - Expression
  - Behavior
  - Dress
  - Self-image
- People may:
  - Cross-dress
  - Medically transition with hormones
  - Medically transition with sex-change surgery
  - Use affirmed gender's pronouns and bathrooms

MORE ON GENDER DYSPHORIA

- Gender dysphoria is not the same as gender nonconformity, which refers to behaviors not matching the gender norms or stereotypes of the gender assigned at birth.
- Examples of gender nonconformity include:
  - Girls behaving and dressing in ways more socially expected of boys
  - Adult men occasional cross-dressing
- Gender nonconformity is not a mental disorder
- Gender dysphoria is also not the same being gay/lesbian

- Some children express dysphoria at 4 years or younger
- Some adolescents do not start to feel uncomfortable in their own bodies until puberty
- Some children find that they are unable to shower, wear swimsuits, or undertake self-harming behaviors

HELPING SOMEONE "COME OUT" (TEEN VOGUE ☺)

- Understand that coming out is a process
- Don't put pressure on your person
- Realize that not everyone is as accepting as you are
- Don't deindividualize the person with your reaction
- Fully embrace, not just accept, their identity
- Trying to help can sometimes feel insensitive;
  - don't make assumptions about what you think the person wants or needs

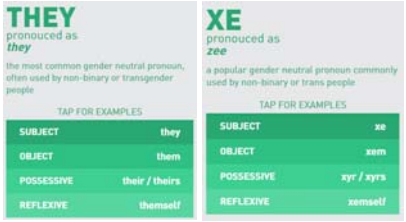
CONSIDERATIONS FOR YOUR PRACTICE

- Actively avoid making assumptions about a person's relationship status, gender, or pronouns
- Don't try to label your clients, unless it would be helpful to them
- Always make an effort to use inclusive language
- Speak up and report any harassment or discrimination
- Recognize that disclosure of layered and intersectional identities is complicated
- Ensure clear and implicit anti-discriminatory statements in all policies
  - Must be clearly included and posted for all to see
- Review inclusive policies on a yearly basis
- Change intake forms to include gender and sexuality options
- Post "safe ally" images
- Leave LGBTQIA themed magazines in the waiting room
- Indicate that people can use whatever bathroom makes them feel comfortable

PERSONAL GENDER PRONOUNS

- Asking for and reinforcing a person's pronouns is a most basic way of showing respect.
- How to ask what a person's pronouns are: What are your pronouns? Mine are she, her, hers.
- There are websites out there to help people practice using pronouns other than she or he.
  - https://minus18.org.au/pronouns-app/
  - www.practicewithpronouns.com

COMMON GENDER NEUTRAL PRONOUNS



- List of pronouns:
  - Xe, Ze, Ey, Hir, Fae, Hu, They, He, and She

EXAMPLES OF INCLUSIVE LANGUAGE

PROBLEMATIC TERMINOLOGY

- **Gay/Straight**: "in proper order or condition, conventional or respectable" "live an honest life", i.e. it has right or wrong connotations. Still used for efficiency-sake, however.
- **Homo/Heterosexual**: denigrating term that emphasizes a sexual act versus identity. It is also tied to the historic pathologization of LGBT identities (until 1973 in the DSM).
- **Transsexual/Hermaphrodite/Transvestite**: generally post-operative/Intersex is more accurate, historically denigrating/focused more on cross-dressing. Unless you know specifically, Transgender is a broader more inclusive term.
- **Transgendered**: (unless used by the individual to describe themselves) implies that something has been done to the person (follows in line with: neutered, castrated, etc.)

ADDITIONAL RESOURCES

- Human Rights Campaign (HRC)
  http://www.hrc.org
- Gay, Lesbian and Straight Education Network (GLSEN)
  http://www.glsen.org/
- Substance Abuse and Mental Health Services Administration Behavioral Health Resources (SAMHSA)
  https://www.samhsa.gov/behavioral-health-equity/lgbt
- American Psychological Association Lesbian, Gay, Bisexual and Transgender Concerns Office
  http://www.apa.org/pi/lgbt/index.aspx
- Association of Gay and Lesbian Psychiatrists
  http://www.aglp.org/
- Family Acceptance Project
  http://familyproject.sfsu.edu/
- The Trevor Project
  https://www.thetrevorproject.org/#sm.000189buxtm4bf0tsp71zj30revpo

THE END ☺

Please feel welcome to contact me with any questions, comments, or concerns!

bbrown@psychologyspecialists.com

SPEAK UP FOR MENTAL HEALTH: BE THE VOICE

TOSHA MAAKS, RECOVERY SUPPORT PROVIDER AT INTEGRITY COUNSELING AND NAMI COMMUNICATIONS SPECIALIST

LEARNING OBJECTIVES

- What is a CRSS
- Recovery
- Self-Care
- Self Advocacy
- Be the voice for Mental Illness

WHAT IS A CERTIFIED RECOVERY SUPPORT SPECIALIST

A person with lived experience in mental health recovery who helps others with psychiatric conditions on their recovery journeys in a formal manner and is paid for his or her services.

The basic concept for this is that it is peer based. Meaning that the person delivering the service also has a mental health condition. There for the connection between the person served and the person delivering the service is more mutual and common ground.

WHAT DOES A CERTIFIED RECOVERY SUPPORT SPECIALIST DO?

- The recovery support specialist meets an individual on a mutual level to teach life skills to promote, **Recovery, Self-Care**, and **Self-Advocacy.**
- They can also connect individuals served with community resources that are available to them. Which would be Mental Health Community Partners, or other Social Service Agencies.

PARTNERS IN MENTAL HEALTH

- Person receiving services
- Community mental health agencies
- Primary care professionals
- DHS
- Advocacy organizations like NAMI
- Employers
- The community we live in

RECOVERY

Refers to the process in which people are able to live, work, learn, and, participate fully in their communities.

For some individuals recovery is the ability to live a fulfilling and productive life despite a disability.

For others, recovery implies the reduction or complete remission of symptoms.

Science has shown that having hope plays an integral role in an individual's recovery.

–President's New Freedom Commission, 2003

HOW I RELATE TO RECOVERY

I prefer - Recovery is remembering who you are, and using you strengths to become all that you were meant to be.

-Recovery Innovations

SELF-CARE

- Many individuals do not factor in self-care to their daily routine. Teaching what Self-care is and how positive coping strategies can improve our over all health is a very important.
- Positive coping strategies are taught in order to teach individuals to cope with mental illness however they are important for even those individuals without mental illness to practice on a daily basis.

TOOL-BOX

We talk about our self-care as being things in our tool-box. All the items we enjoy doing we tuck away as an item in our tool-box. When we are having a hard day we can go to our tool-box and take out what it is we enjoy doing. We can do something we enjoy and then we can cope with the problem that has come up by using the item in our self-care tool-box. Next are some ideas of self-care!

SELF-CARE TOOL-BOX

I have in my self-care tool-box

dancing
listening to music
coloring or drawing
painting
cleaning
writing
decorating
shopping
baking
flower arrangement
gardening
going to lunch with friends
getting my nails done
getting a pedicure
getting my hair done
going to the gym
cooking

CRSS TEACHES SELF-ADVOCACY

Self-advocacy is a key concept in recovery!

FINDING SUPPORT

CRSS assists individuals in finding supports outside of their medical staff within their community. They assist them in finding new friends within their church, support groups, families and coworkers. They help them build their relationships and remove obstacles to form healthy bonds.

PROMOTING INDIVIDUAL CHOICE AND SELF-DETERMINATION

A CRSS supports individual choice and encourages self-determination on everything from treatment options to housing to employment choices. They can discuss the options provided by the individual and encourage them to weigh the pros and cons and set priorities. The individual must ultimately have ownership in the process in order for it to have a lasting effect.

ADVANCE DIRECTIVES

An Advance directive is a legal document that is created when a person is well that describes what kind of mental health treatment the individual prefers. It gives the individual the opportunity to have a say in their care if they are no longer able to make decisions about their care due to illness. Only the induvial can decide if they want to make an advance directive and what it contains. There are two types of advance directives.

1. A DECLARATION FOR MENTAL HEALTH TREATMENT

Includes personal preferences about:

- Medication
- Hospitalization
- Electro Shock Therapy
- An attorney in fact, chosen by the individual, who can view their mental health records and make decisions about the individual's care, on their behalf.

2. A POWER OF ATTORNEY FOR HEALTH CARE

- Is a person chosen by the individual in advance.
- Can direct both the individual's mental health treatment and other medical care.

Psychiatric Advance Directives are Voluntary!

WEBSITES FOR ADVANCE DIRECTIVE HELP AND ASSISTANCE

Equip for Equality
www.EquipForEquality.com

Illinois Guardianship and Advocacy Commission
www.GAC.State.IL.US

For sample Advance Directives
Illinois Department of Public Health
www.idph.state.il.us/public/books/advin.htm

BE THE VOICE FOR THOSE WITH MENTAL HEALTH CONDITIONS

We want to use person first language making sure to refer to people as people, instead of using labels like a bipolar or a schizophrenic. The goal of person centered language is ultimately to change attitudes and practices, not simply rename them.

PERSON 1ST LANGUAGE EXAMPLES

Say:	Instead of:
He/She has bipolar illness (or a diagnosis of…)	He/She is bipolar
He/She has schizophrenia (or a diagnosis of…)	He/She is schizophrenic
He/She has a mental health condition	He/She is emotionally disturbed
He/She has a mental illness	He/She is mentally ill
Person (singular) with a mental illness (singular) or	The Mentally Ill (plural)

THINK BEFORE YOU SPEAK

Don't use stigmatizing language!

What is Stigma?

Unfair, negative stereotypes, or beliefs that are normally untrue about something!

STIGMA AROUND MENTAL HEALTH

People with mental illness are violent.

People with bipolar can't be in relationships.

People with schizophrenia wear tin foil hats.

All people with mental illness smell.

Everyone with mental illness are lazy.

They are all crazy, nuts, psycho.

SOCIAL MEDIA

Social Media is a very important outlet. Share your hashtags. #okaytotalk #okay2talk #okaytonotbeokay #okay2notbeokay #mentalhealth #mentalhealthmatters you should never have a post without a hashtag.

You can follow your congressmen and advocate that way. You can follow NAMI National and know what is going on with legislation that way as well.

If you get on NAMI.org's mailing list they will email you when important legislation is out and even give you a simple way to advocate on your area's behalf. All with a click of a few buttons.

CALL YOUR LEGISLATORS

NAMI
National Alliance on Mental Illness

Once NAMI alerts you of legislation being voted on, Call your legislators. I have been told that even one call can make the difference. Many times that they will vote because of one vote. Call your legislators! Please!

However, if you are interested in more advocacy work within mental health you could reach out to individuals who work with Peoples Action of Bloomington Normal and get to work and make some trips to Springfield.

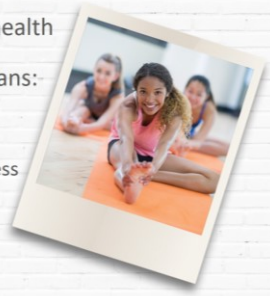
PEOPLE'S ACTION

QUESTIONS?

Tosha Maaks
Recovery Support Provider Integrity Counseling
NAMI Communications Specialist
309-242-7705
tosha@maaks.com
www.facebook.com/inbipolarfashion

What is MENTAL HEALTH?

- We all experience mental health
- Being mentally healthy means:
  - Being able to enjoy life and feel good
  - Dealing with emotions, stress in positive ways
- Mental health can be maintained with good habits



#OKTOTALK NAMI

What are MENTAL HEALTH CONDITIONS?

Mental health conditions ARE:	Mental health conditions ARE NOT:
• Medical conditions, like physical conditions • Conditions that change the way people think, feel and act • Common and treatable	• Anyone's fault • Something to be ashamed of • Limiting – you can achieve your goals

#OKTOTALK NAMI

FACTS

1 in 5 youth in the U.S. are experiencing or will experience a mental health condition at some point in their lives

50% of youth ages 8-15 with a mental health condition don't receive treatment

STIGMA is the biggest reason people don't seek help

Source: National Institute of Mental Health (NIMH)

NAMI

What is STIGMA?

STEREOTYPING
LABELS
BULLYING
DISCRIMINATION

#OKTOTALK NAMI

Know the WARNING SIGNS

- Feeling very sad or withdrawn for more than 2 weeks
- Severe out-of-control, risk-taking behaviors that cause harm to self or others
- Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or fast breathing
- Seeing, hearing or believing things that aren't real
- Drastic changes in mood, behavior, personality or sleeping habits

#OKTOTALK NAMI

Know the **WARNING SIGNS**

- Extreme difficulty concentrating or staying still that puts a person in physical danger or causes school failure
- Intense worries or fears that get in the way of daily activities
- Throwing up, using laxatives or not eating to lose weight; significant weight loss or weight gain
- Using alcohol or drugs excessively
- Trying to harm oneself, attempting suicide or making plans to do so

#OKTOTALK NAMI

What **YOU** can do

- Talk to a trusted adult (more than one if necessary)
- Talk to a friend
- Send a message to someone who cares about you
- Use resources on card
- Call NAMI

#OKTOTALK NAMI

Know the **WARNING SIGNS** of suicide

Someone needs **IMMEDIATE** attention if they are:

- Talking, writing or drawing about death
- Talking about:
  - Having no reason to live
  - Being a burden to others
  - Not being here tomorrow
- Looking for ways to attempt suicide
- Feeling hopeless, desperate or trapped
- Giving away possessions
- Behaving recklessly

#OKTOTALK NAMI

What **YOU** can do

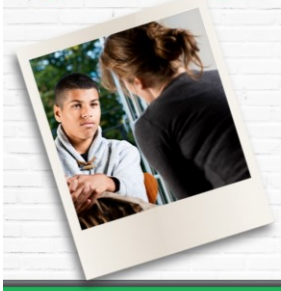
Take warning signs seriously.
Take action **IMMEDIATELY:**

- Ask the question, "Are you thinking about suicide?"
- Don't leave them alone
- Tell an adult you trust
- Call the National Suicide Lifeline at 1-800-273-TALK
- Go to an emergency room or call 911
- Don't keep suicide warning signs a secret

#OKTOTALK NAMI

Making symptoms **BETTER**

Treatment

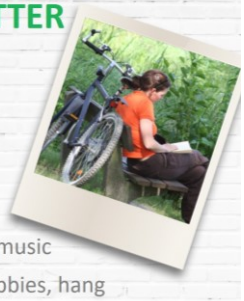


- Therapy
  - Cognitive behavioral
  - Group
  - Art or pet
  - Non-traditional
- Medication
- **The earlier, the better**

#OKTOTALK NAMI

Making symptoms **BETTER**

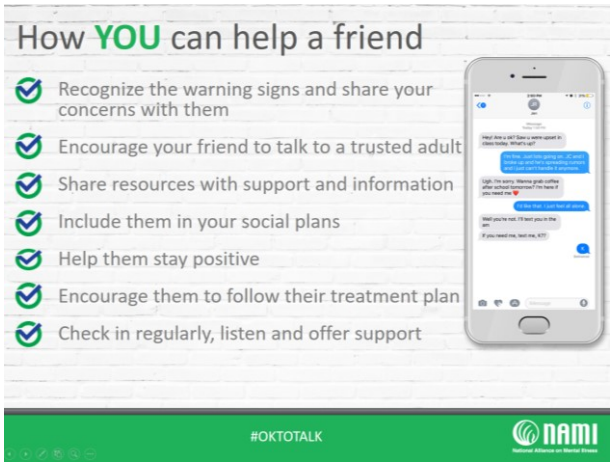
Positive coping strategies



- Get enough sleep
- Exercise and eat healthy
- Write (journal/blog) or listen to music
- Be active: Join a club, sports, hobbies, hang out with friends

These strategies are key to improving and maintaining mental health

#OKTOTALK NAMI



Colleen O'Connor, CPS, CADC

NAMI Ending the Silence Coordinator

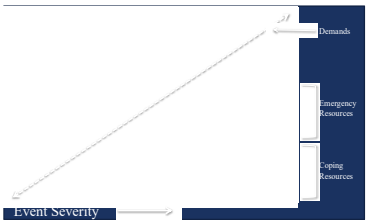
coconnor@projectoz.org

TAKING BACK THE POWER:
ADDRESSING BULLYING AND CYBERBULLYING

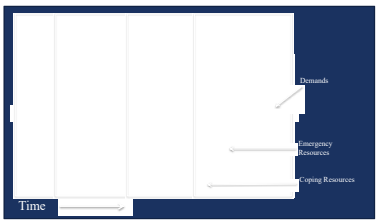
LEANDRA PARRIS, ILLINOIS STATE UNIVERSITY

FIRST, LET'S TALK ABOUT STRESS…

WHY WE FEEL STRESSED



WHY WE FEEL STRESSED



WHAT REALLY STRESSES US OUT

WHAT IS BULLYING?

CONSIDERATIONS

- Physical
- Verbal
- Relational
- Gender Differences

THOSE AT RISK

- Victimization
  - Being "different"
  - Avoiding Conflict
  - Has Trouble with Managing their Emotions
  - Lower Social Status
- Perpetration
  - Is a Victim
  - Wants Control or Power
  - Has Trouble with Managing their Emotions

WHAT IS CYBERBULLYING?

CONSIDERATIONS

- Intention
- Audience
- Technology Usage
- Gender Differences

THOSE AT RISK

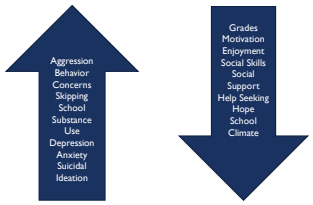
- Victimization
  - Being "different"
  - Puts a lot of information online
  - Reacts to Incidents
  - Cannot detect tone or sarcasm
- Perpetration
  - A victim of bullying
  - Has Trouble Managing the Emotions
  - Uses technology too much

BULLYING, CYBERBULLYING, OR BOTH?

VS

ROLES WITHIN BULLYING

IMPACT OF PEER AGGRESSION



HOW DO WE REACT TO BULLYING?

	Problem-Focused	Emotion-Focused
Approach	Problem-Solving • Make/implement a plan • Conflict resolution Seek Help/Advice • Ask an adult to intervene • Ask a friend for advice	Orientation: Self Cognitive Restructuring • Focus on the positive • Reframing incidents Self-Soothing • Count to 10 • Go to a quiet place Seek Encouragement • Vent feelings to an adult • Vent feelings to a friend Self-Blame • Think you could have stopped it • Think it was your fault Orientation: Situation Externalizing • Yelling/hitting someone • Retaliation
Avoidant	Physical Distancing • Avoiding areas bullying typically happens • Walking away	Cognitive Distancing • Pretending it didn't happen • Not thinking about it

WHY WE REACT THE WAY WE DO

- Control
- Confidence
- Knowledge, Skills
- Gender Differences
- POWER

BYSTANDER REACTIONS

WHY DO BYSTANDERS REACT THE WAY THEY DO?

- How the victim reacts
- How they feel about the victim or bully
- Gender Differences
- School Climate
- POWER

REAL QUESTION IS…

POWER:
Who has it?

AN EXAMPLE

ANOTHER EXAMPLE

HOW TO HELP

- Promote Positive Environment
- Recognize Levels of Friendships
- First, attend to emotions, then the problem
- Stand Up, Speak Out
- Listen, Validate

RESOURCES

Stand Up to Bullying: http://www.standuptobullying.org/
PACER'S: http://www.pacer.org/bullying/
Cyberbullying Research Center: https://cyberbullying.org/resources
StopBullying: https://www.stopbullying.gov/

Contact Information:
Leandra Parris
lnparri@ilstu.edu
309-438-5851

WHAT YOU CAN DO TO MAKE A DIFFERENCE

KIM H, ARI W, ELLIE D | BN YOUTH ACTIVISTS

WHO ARE WE?

- BN Youth Activists
- A group of students working for change
- 100% youth run

WHAT MATTERS TO YOU?

What are the issues you are personally passionate about?

HOW TO MAKE A DIFFERENCE: SCHOOL

- Speak up for those who can't speak up for themselves
- Embrace your identity with those like you
- Join clubs like Not in Our School
- Reach out to those in need
- Look for solutions and seek them out

NIOS - JR HIGH

- Many issues at middle schools
- Fights, bullying, petty drama, etc.
- NIOS: creates inclusive and accepting spaces
- *Students* got involved and helped bring NIOS to Kingsley!

MENTAL HEALTH IN A SCHOOL SETTING

- Can create an added barrier in speaking out
  - Anxiety, feelings of isolation
- Can be an issue in itself
  - Schools lack in providing connections for students in need
  - Students need more than a suicide hotline

HOW TO MAKE A DIFFERENCE: LOCAL COMMUNITY

- Get involved with local groups
- Educate yourself on community issues
- Volunteer
- Rally behind the issues you support

INVOLVEMENT IN THE LOCAL COMMUNITY

- Local students organized a March For Our Lives Rally in March to spread the word about school safety
- Illinois People's Action is working to ensure **PEOPLE** are a priority in the state budget

MCLEAN COUNTY
ILLINOIS

HOW TO MAKE A DIFFERENCE: STATE

- Contact your representatives
- Vote as soon as you can so your voice is heard
- Be informed and inform others about candidates and the importance of voting
- Tackle the issues you see in the world that are handled at a state level

INVOLVEMENT ON A STATE LEVEL

- Two years ago students from NCHS created a potential budget for the state of Illinois and took it to the capital to propose it
- Jason Barickman holds student conferences twice a year to get student input on IL politics
  - Students from U High, NCWHS & NCHS attended this past year.

HOW TO MAKE A DIFFERENCE: WORLD

- Vote in presidential elections
- Speak up about international issues
- Seek out information
- Look at the root of issues

2020 ELECTION

INVOLVEMENT WORLDWIDE

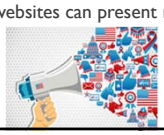
- Parkland students took gun safety issues to Washington D.C. and held protests in front of the White House
- Service groups at local schools raise money for disaster relief across the globe

HOW TO MAKE A DIFFERENCE: ONLINE

- Research topics you're interested in
- Share your beliefs
- Promote what you believe in
- Bring awareness to the online community
  - Adults and adolescents

ONLINE INVOLVEMENT

- Most candidates and representatives have Facebook pages that are frequently updated with relevant information
- Many activist groups use Twitter or Instagram to spread the word about events and movements
- Social media and news websites can present news worth spreading



SOCIAL MEDIA: EFFECTS ON THE MIND

- Can add to feelings of personal failure, isolation and self doubt
- Can foster negativity in an "untouchable" space
- Allows students to freely express themselves in a safe space
- Can foster positive communities and communication

WHERE TO START

- Get informed
- Spread the word
- Organize
- Seek out solutions

Every movement starts somewhere, with a vision for a better world.

QUESTIONS?

All in all, **get involved**. Youth behavior truly has an impact. If you need any help with starting projects or ideas, or just want to join a group to help get your gears turning, feel free to contact us on our website or any of our social media.

bnyouthactivists.com
BN Youth Activists
@bnactivists
@bnyouthactivists

Please visit these and other community organizations at our Resource Fair in the Bloomington-Normal Marriott Hotel & Conference Center

INtegRIty counseling
Do. Be. Heal.

502 S Morris, Ste D
Bloomington, IL 61701
309.827.9100
Email: Info@integrityhelps.org
www.integrityhelps.org

INtegRIty Counseling's qualified volunteers provide donation-based mental health counseling, education, and outreach services for those in need of all ages.

Contact us for information about our services, to volunteer, or to donate.

Community Care Systems, Inc.

"Care is our middle name"

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- Suicide Assessment and Intervention

PSYCHOLOGY SPECIALISTS
888.706.3190
www.psychologyspecialists.com

NAMI
National Alliance on Mental Illness
Mid Central Illinois

Connect with others in the community at our support groups!

Get in touch at namilivingstonmclean.org

The Baby Fold

Addressing the wellness of family and community

Healthy Start
Community Schools
Adoption Support Services
Hammitt School Special Education
Vocational Education Training
Autism Programs
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108 E. Willow Street
Normal, IL
(309) 451-7202

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Bloomington, IL 61701
Phone: 309-827-5351
Behavioral Health Services
www.mcchs.org

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- School-based Substance Abuse Prevention, Mental Health Awareness, & Suicide Prevention Education
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- Youth Workforce Development

1105 W. Front St.
Bloomington, IL 61701
www.projectoz.org
309-827-0377

REGIONAL OFFICE OF EDUCATION #17
DeWitt · Livingston · Logan · McLean Counties

Mark E. Jontry
Regional Superintendent

Advocate BroMenn Medical Center

McLean County Community Crisis Services

Description of Agencies:

PATH - 2-1-1

PATH (Providing Access to Help) assists community members 24/7 via a hotline that is manned by trained paraprofessionals. Trained paraprofessionals are skilled at assessing suicidal risk and linking callers with necessary services, including, but not limited to the Crisis Team through the Center for Human Services. In addition, PATH provides crisis services for the homeless and services for older adults, including Adult Protective Services. PATH is also the designated answering service for many social service agencies.

McLean County Center for Human Services Mobile Crisis Unit - (309) 827-5351

The Mobile Crisis Team is available 24/7 to assess crisis risk and other mental health crisis in person or over the phone. The team consists of members who specialize in mental health and risk assessment. The Crisis Team can provide services such as de-escalation, linkage to other services, suicide and/or risk assessment, and in the moment counseling.

CARES Hotline - 1-800-345-9049 - Statewide hotline which dispatches the appropriate SASS provider.

Center for Youth and Family Solutions - SASS Program - (309) 820-7616

CYFS operates the SASS program which serves as the crisis intervention program for youth ages 20 and under who have state funded health insurance, such as Medicaid. CYFS staff is trained in suicidal assessment and can link youth to necessary services. Services are provided in the least restrictive manner.

Chestnut Health Systems - (309) 827-6026 - Crisis Stabilization Unit (CSU)

Chestnut provides 24 hour short term supervised care for persons aged 18 years and older who are experiencing an acute psychiatric crisis that does not require acute psychiatric hospitalization. The CSU also provides medically monitored detox services. Please note this is a voluntary, 14 bed unit.

In many instances, individuals are better served in the least restrictive environment within their community. If an individual is at imminent risk of harm, please go to your nearest hospital or call 9-1-1.

Area Hospitals within McLean County:

Advocate BroMenn Medical Center

1304 Franklin Avenue, Normal, IL 61761
(309) 454-1400
Advocate also operates a 17 bed, adult inpatient mental health unit for those experiencing emotional trauma or psychiatric emergencies. For more information call 309-268-5747.

OSF St. Joseph Medical Center

2200 East Washington Street, Bloomington, IL 61701
(309) 662-3311

Sometimes, first aid isn't

a bandage,

or CPR,

or the Heimlich,

or calling 911.

Sometimes, first aid is YOU!

You are more likely to encounter someone in an emotional or mental crisis than someone having a heart attach. The Mental Health First Aid class teaches a 5-step action plan to offer initial help to people with the signs and symptoms of a mental illness or in a crisis, and connect them with the appropriate care. Mental Health First Aid is for anyone—parents, neighbors, students, first responders, teachers, leaders of faith communities, human resources professionals, and caring citizens.

Are you interested in learning to be a part of the solution?

Date	Time	Event 8-hour Course	Location	To Register
10/22/2018	**8:00 a.m.**	**Mental Health First Aid**	**Heartland Head Start**	**309-664-4880**
11/5/2018	**8:00 a.m.**	**Mental Health First Aid (Content covers ages 12-18)**	**OSF St. Joseph Medical Center**	**309-661-5151**

For more dates and locations for Mental Health First Aid, visit:

https://health.mcleancountyil.gov/606/Mental-Health-First-Aid

https://www.mentalhealthfirstaid.org/take-a-course/find-a-course/

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