

Project Fresh Light

Partnerships in Action

Monthly
Update
December
2006

Project Fresh Light

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Project Fresh Light

endeavors to bring new energy, emphasis and effectiveness to the treatment, services and supports received by Wisconsin's adolescents with substance abuse and co-occurring disorders and their families. We intend to do this by improving our provider network, integrating service administration, resolving funding and regulatory barriers and improving data management.

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From Susan's Cubicle

Readers 2007 Wish-List Poll



This is my New Year's Wish:

Project Fresh Light needs to hear from you irregardless of what capacity you're in. If you are following this Grant, you have some sort of interest in adolescent substance-use and mental-health issues.

Please send an e-mail to Mary with a response to the following two questions. The results will be analyzed and a summary will be included in the January issue. Your anonymity will be honored.

Question 1:

If the Grant could work toward resolving a barrier, it would be:

E-mail Mary with your response at
unmutmj@dhfs.state.wi.us
or fax her at 608-261-7800 by Jan 2, 2007.

Question 2:

This is an issue because:

E-mail Mary with your response at
unmutmj@dhfs.state.wi.us
or fax her at 608-261-7800 by Jan 2, 2007.

May the *Project Fresh Light* Force be with you.

Dr. Witkovsky

focuses on the psychiatric care of youth and the systems of care that provide that care. As a medical director of an inpatient facility, he works with some of the most severely ill children. Management of a university teaching service also involves collaboration with a variety of agencies, professionals, students and regions within the state. Recent interests have evolved to include planning within systems of care at all levels of need.

(mtwitkov@wisc.edu)

Michael Witkovsky, M.D., M.A.

**Associate Professor, Psychiatry and Pediatrics, University of Wisconsin,
Madison Medical Director, Child & Adolescent Psychiatry, Meriter Hospital**



Dr. Witkovsky and his son, Aidan

Anger and Apology

I Need to Discuss Anger . . .

In a recent state meeting, I found myself becoming unsettled with a dominant aspect of the discussion, and I worry that I entered into the conversation with some harshness. My instinct was to apologize for the anger that may have been in my voice, but I have rethought that instinct. Instead, I have come to realize that it is okay to get angry at aspects of what we confront in our dialogue about children who are drug using or drug dependent. The stories of parents who permit or encourage or profit from children's drug use should rile us. Confronting

political decisions that continually cut back resources for the treatment of childhood addictions, especially in our increasing intimate awareness of its extent, should irk us. Every death or disability from drug use or its associated wrongs, such as drunk driving, should enrage us.

Attention to our own emotional reactions is part of being effective when we explore these issues in these dialogues about drug use and abuse. We cannot serve our interests in caring for the youth of this state if we don't demonstrate the very skills we know will help our children reduce vulnerability to experimentation and addiction.

About That Apology; Let Me Explain . . .

In October, I was very fortunate to be invited to join a group of men who work with youth to brainstorm with staff from the Department of Health and Family Services. Under the stewardship of Flo Hilliard, we had several hours to discuss key concepts in the understanding of young men. This project was inspired by the growing legacy of Dr. Leonard Sax's book, *Why Gender Matters*, encouraging us to see the needs of, and the responses to, male and female youth as not monolithic but as individually tailored. One size still does not fit all.

As this session with Ms. Hilliard and the group of eloquent and dedicated men progressed, I found myself troubled by a lack of historical context in our discussion. The questions we explored centered on changes in the definitions of being a male, and on defining healthy behaviors in males. We explored men's failures to adapt to new expectations and our tendency to over-value aspects of culturally defined male values including strength, determination, success, single-mindedness of purpose, loyalty, protection of self and affiliates.

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Anger and Apology

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The troubled feeling I got was that the time frame for our review of change seemed to be limited to the personal experiences of the men at the table, the histories of their families, and the cultural narratives that shaped differences among us. For the most part, this meant that history started with the 1950s. My concern about this limited perspective was that there have been solutions to the problems men experience as boys that have been crafted over millennia. A deeper sense of history and a broader lens of cultural variations would inform our discussion of solutions to clarify the nature of our current problems and illuminate male creativity within history. The group was not averse to considering these perspectives. But, my energy around this was, I fear, somewhat urgent, maybe harsh.

Maybe it is a guy thing. Maybe it is an older guy thing. Missed opportunities to repair the fractures in this world, whether on a large scale or in the life of an individual, become less tolerable as our personal abilities or chances to do so fade. Regret and remorse can be the stimuli for sadness and anger.

While I find some understanding of my anger by looking at my age, I believe that age and experience should be accompanied by wisdom. Wisdom is the necessary ingredient to temper anger and the animosity it can cause. I have been trying to find some wisdom in my reactions to the men's group meeting. My examination of my feelings led me to consider the following explanations:

- Getting angry because I felt I had a different, better (?) grasp on the problem than the other participants: **Pride.**
- Getting angry because I had to confront my own over-extension in projects and clinical work to a point where any involvement in this very desirable project might be cursory: **Limitations.**
- Getting angry because I am the father of four children and I feel a significant energy and obligation to modify the world in their interest: **Attachment.**
- Getting angry because my social consciousness comes from growing up in a socialist background, in a highly charged area of the south side of Chicago, during the riots after Dr. King was assassinated, the Democratic Convention, and Viet Nam; realizing how permanent certain political foibles (lack of historical sense, knee-jerk self interest) we Americans are prone to: **My failed acceptance of the world as it is.**
- Getting angry because we identified choices that parents make to serve their own interests, while their children suffer: **Confronting the selfishness of others.**
- Getting angry because heartfelt sentiments about the condition of young men were spoken, ideas to repair these conditions were offered, and the length of an ongoing process to consider these ideas was mentioned--the necessary insertion of a delay in the corrective process, the stark reality that change is a lengthy process and for some people it never happens: **Impatience.**



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Anger and Apology

(continued from Page Three)

I am uncertain which of the above was behind the energy I felt when considering the issue of history in our meeting. So, I apologize for any aspects of my anger that I brought to the meeting because of my own inadequacies. I do not, however, apologize for getting incensed: when we speak of children being maltreated; when we recognize our place in a system of government that seems to value incarceration over prevention; when we are forced to accept limited responses to limitless need; and, when our creativity is suppressed by the numbing effects of denial, delay and distancing from leaders, victims, communities, industry, and ourselves.

The above list of the sources and the dynamics that made me vulnerable to anger are the same dynamics that create this vulnerability in adolescents, in children. The vulnerability of impatience is a fact of life in being with youth of all ages. The nature of youth is also to feel limitless. A preschooler gets angry when told no, an adolescent gets angry when denied opportunities.

Giving praise to children can be tricky business. Mock praise is transparent to most children and they bristle with it. Over-exaggerated praise can give children a false sense of their ability, as can the lack of praise can give them uncertainty. Management of pride is clearly a skill for which there are no easy solutions.


Neither are there easy answers for the management of our attachments to physical possession, ideals, beliefs, or our relationships with others. How many of our difficulties when young come from these attachments and the negotiation with others about compromise and sharing? A sticking point for many children is the confrontation with an unwilling partner in these negotiations, the confrontation with the selfishness of others. And, lastly, is the perpetuation of disappointment and frustration by the failure to accept the world as it is. Sages in psychiatry have long admonished trainees to first embrace their own impotence in being able to effect a change in someone; only then can they begin the arduous task of facilitating change.

I am thankful for the opportunity to sit with the men who have gathered in this process. We will all ultimately benefit from this dialogue as it may shape the implementation of gender-specific interventions for some of our most recalcitrant and relapsing clients. ~~~



What's the Big Deal . . . About Prescription Medication?


By *Crystal Dalebroux, MS MFT RADCI*
Marriage and Family Therapist
Registered Alcohol and Drug Counselor
Connections Counseling



Prescription drug abuse has recently gained recognition as one of the most prevalent epidemics in today's society. The headlines around the nation, including those in Wisconsin, are filled with stories of new arrests, drug rings, accidental overdoses, and deaths resulting from combining prescription medications with other drugs or alcohol.

Prescription medications help millions of people lead more productive lives, freeing them from the symptoms of a myriad of medical conditions from attention deficit hyperactivity disorder (ADHD) to depression, from asthma to fibromyalgia. However, this benefit is only when the drugs are being used by the person for whom they were prescribed for the proper condition. Often, people do not realize that taking prescription medications improperly is as illegal as taking street drugs and can be lethal. The misconception exists that if these drugs are prescribed by a doctor and approved by the FDA, then they are safe. Furthermore, as prescription drugs are prevalent in many households and often not monitored, the availability and ease of access is much higher for young people than it is for illicit drugs. Once gaining access to these medications, adolescents are abusing these medications by various methods: swallowed, crushed and then snorted or injected. These behaviors are similar to those of street drugs and can lead to abusive behaviors and serious problems within the body.

There are three categories of commonly used prescription drugs. The first is stimulants. These drugs increase the activity of the nervous system and are used to treat conditions such as narcolepsy, ADHD, depression, obesity, and asthma. Common medications include Ritalin, Adderall, and Strattera. In the case of stimulant abuse, signs might include hyperactivity, shaking, sweating, dilated pupils, fast heartbeat, paranoia, loss of appetite, or unexplained weight loss.



The second major category of prescription drug is depressants. These are drugs that diminish the function or activity of a specific body part and are helpful for treating anxiety, tension, panic attacks, and sleep disorders. This category includes Valium, Xanax, and Nembutal. In incidences of abuse, symptoms of intake are loss of coordination, slowed reflexes, and slurred speech.

The final major category and generally the most publicized category in regard to abuse cases are the opioids. These are drugs that are primarily used to treat pain, relieve coughs, and for diarrhea. The commonly prescribed drugs in this group are OxyContin, Vicodin, and Demerol. Symptoms of illicit opioid intake could include sleep deprivation, droopy eyes, nausea, vomiting, constipation, dry skin, itching, skin infections, or flu-like symptoms.

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Prescription Medication

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Moreover, there are signs of a child abusing prescription drugs or other illicit drugs beyond the physical signs, and these include the following behavioral changes:

- Acting especially angry or abusive
- Engaging in reckless behavior
- Trouble at school and/or significantly lower grades
- Lying or acting secretive or deceptive
- Possessing unexplained valuables or cash
- Hanging around with different peers
- Acting withdrawn, depressed, or apathetic
- Neglecting appearance or hygiene

Should these signs start to appear, there are many different strategies that parents and other family members can use to help protect children from prescription drug abuse:

- Talk with your children about prescription drug abuse, particularly the dangers and concerns, and take time to listen to them speak.
- Lock up any medications and monitor them closely. Make sure medication is being consumed by the correct person and not taken to school or out of the home.
- Stay involved in your child's life. Show interest in their activities, get to know their friends, and make sure to schedule family time.

If you suspect that your child has a substance-abuse problem or may have been involved with any form of drug, GET HELP. ~~~

Resources for Parents

US Dept. of Health & Human Services

www.rx.samhsa.gov

National Institute on Drug Abuse

www.drugabuse.gov

Partnership for a Drug-Free America

www.drugfreeamerica.com

US Drug Enforcement Administration

www.usdoj.gov/dea/resources/parents.teachers.html

US Department of Justice

www.usdoj.gov/kidspage/index.html

Families Anonymous

Meets Wednesday evenings, 7:00 - 8:30pm

Connections Counseling

1334 Applegate Rd

Madison WI

(608)221-1500, Ext. 20

www.familiesanonymous.com

Connections Counseling LLC
1334 Applegate Rd, Suite 101
Madison, WI 53713

*Connections
Counseling*



As we continue our road trips all over Wisconsin, we are visiting counties and learning about their services to adolescents with substance-abuse challenges as well as substance-abuse and co-occurring mental-health conditions. We have learned a great deal about each individual system.

We are both establishing a baseline from which to gauge the impact of *Project Fresh Light*, and we are recording ideas within key-service categories that we hope will be useful to other counties as well.

We've been graciously received by juvenile justice personnel, by social services/human services staff and purchased service providers. We thank them heartily for their time, information and hospitality. In this process, we

On the Road

On the Road

is a monthly column. It will feature *Project Fresh Light* Strategic Consultants **Judy Adrian** and **Carol Lobes** as they make their travels through several Wisconsin counties that are partnering with *Project Fresh Light*. They are charged with identifying and defining a baseline of treatment services related to adolescent substance abuse and co-occurring mental health conditions in those counties.

are seeing responses that cut across counties, but we are also finding unique approaches in individual counties that we want to broadly share through this column.

The dynamic we want to highlight in this issue of *Update* is the relationship that the Fond du Lac County Juvenile Court Unit has developed with local schools. So often the relationships between service systems and the schools are strained or distant, resulting in youth and their families trying to find their way in both arenas.

In Fond du Lac County, the local school district administers the **TeenScreen Program** to all freshmen. The **TeenScreen** is an emotional health-screening program developed by Columbia University. It is designed to find risk factors that are associated with depression and other mental-health concerns. Youth who have risk factors are referred for further assessment.

While the local school district administers the **TeenScreen Program**, screens are completed in several schools and school districts throughout the county to include two private high schools. The screen is also being offered at two local medical clinics, and since August 1, 2006, through Juvenile Court Services. Each child referred to Juvenile Court Intake, age 13 or older, is offered the ability to participate in the screen. It is a completely voluntary program.

The schools have also begun piloting the screening of middle-school students for mental-health issues. The psychologist provides feedback to Social Services after the screening. There is also a defined team at the high school that will provide intervention for youth who are threatening suicide. Administration and clinical interviews are completed by licensed therapists that work specifically for the **TeenScreen Program**. (More information on the Columbia University **TeenScreen Program** is available at <http://www.teenscreen.org/> including available grants and awards for youth suicide prevention.)

This level of cooperation and interaction can result in early identification and response by both systems in using the resources of each to achieve better outcomes for adolescents, their families and the community.

If you would like more information about this relationship and how it developed, contact Jamie Sigafus, Social Work Supervisor, Juvenile Court Unit for Fond du Lac County, Jamie.Sigafus@fdlco.wi.gov, (920) 929-3080.~~~

Project Fresh Light

April 25 - 27, 2007

2007 Joint Meeting on Adolescent Treatment Effectiveness (JMATE)

The Grand Hyatt Washington
1000 H Street, NW
Washington D.C. 20001
Phone: 202-582-1234
Toll Free: 1-800-233-1234

Coming in June 2007

2nd Annual Boys-at-Risk Summit

Olympia Resort & Spa
Oconomowoc, WI
cdunleavy@des.wisc.edu

February 2007						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
						Feb 3 <i>Wisconsin Family Ties Parent Involvement Meeting</i>
4	5	6	7	8	9	10
			Feb 7 <i>PFL Leadership Team Meeting</i>			
11	12	13	14	15	16	17
	Feb 12, 13 <i>PFL Biannual Report</i>			Feb 15 <i>GAIN Consortium Meeting WI Dells (tentative)</i>		
18	19	20	21	22	23	24
		Feb 20, 21, 22 <i>PFL Biannual Report</i>				
25	26	27	28	March 1		
February 25 - March 1 <i>Neurobiology of Addiction</i> Eldorado Hotel & Spa Santa Fe, New Mexico 800-253-0685 www.keystonesymposia.org						

March 2007						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10
			March 7 <i>PFL Leadership Team Meeting</i>			
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

How Young Adults Obtain Prescription Pain Relievers for Non-medical Use

Project Fresh Light Update

is published monthly from the Bureau of Mental Health and Substance Abuse Services. It is our hope that these *Updates* will keep conversation flowing between and among the wonderful people presently involved in the *Project*. They are working towards the common goal of supporting and providing services to one of the most under served populations in the state--adolescents. Send comments or topic suggestions to Mary at unmutmj@dhfs.state.wi.us or 608-266-9612.

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Table 1. Percentages of Youths Aged 12 to 17 Who Were Classified as Needing Substance Use Treatment in the Past Year, by Demographic Characteristics: 2003 and 2004

Demographic Characteristics	Alcohol Use Treatment Need (percent)	Illicit Drug Use Treatment Need (percent)
Gender		
Male	6.0	5.5
Female	6.3	5.3
Age Group		
12 or 13	1.2	1.4
14 or 15	5.3	5.4
16 or 17	12.0	9.5
Race/Ethnicity*		
White, non-Hispanic	6.9	5.8
Black or African American, non-Hispanic	2.8	3.8
American Indian or Alaska Native, non-Hispanic	14.1	11.8
Native Hawaiian or Other Pacific Islander, non-Hispanic	5.4	**
Asian, non-Hispanic	2.9	2.3
Two or More Races, non-Hispanic	9.7	9.5
Hispanic or Latino	6.1	5.6
Family Income		
Less Than \$20,000	6.0	6.2
\$20,000-\$49,000	6.0	5.8
\$50,000-\$74,999	6.3	5.2
\$75,000 or Higher	6.2	4.7

Source: SAMHSA, 2003 & 2004 NSDUHs

Table 2. Percentages of Youths Aged 12 to 17 Receiving Substance Use Treatment in the Past Year Among Those Who Were Classified as Needing Substance Treatment in the Past Year, by Demographic Characteristics: 2003 and 2004

Demographic Characteristics	Alcohol Use Treatment Need (percent)	Illicit Drug Use Treatment Need (percent)
Gender		
Male	8.8	10.2
Female	5.7	7.9
Age Group		
12 or 13	4.0	3.5
14 or 15	6.5	8.3
16 or 17	7.9	10.4
Race/Ethnicity*		
White, non-Hispanic	8.0	10.5
Black or African American, non-Hispanic	7.8	7.2
American Indian or Alaska Native, non-Hispanic	**	**
Native Hawaiian or Other Pacific Islander, non-Hispanic	**	**
Asian, non-Hispanic	**	**
Two or More Races, non-Hispanic	**	**
Hispanic or Latino	4.0	6.1
Family Income		
Less Than \$20,000	9.7	9.6
\$20,000-\$49,000	8.2	11.0
\$50,000-\$74,999	5.4	6.2
\$75,000 or Higher	5.7	7.9

Source: SAMHSA, 2003 & 2004 NSDUHs