Ryther Voice

Spring 2012

Acknowledgments of Recent Significant Donations:

$61,500: Ryther League in unrestricted funds

$30,000: Connie & Steven Ballmer

$11,477: Microsoft Giving Campaign & Matching Gifts, including Margo Day, $2,418; Govind Maharaj, $1,000; Mary Snapp, $656; William & Patricia Dean, $262; Kim Saunders & Michelle Beebe, $250; & for volunteer hours: Anuj Bansal, $850; Arturo Garza Fernandez, $510; & Erik Steinfeld, $272

$11,649 through the Seattle Foundation's GiveBIG, including $1,000: Camilla Eckersley, Jesse Proebstel, Carol Radovich & Sylvia Wilks; $700: Sally & Wally Campbell; $500: Martin & Ann Dirks, Robert & Rebecca Hindman, Julie Stocker & Carol Valdrighi

$10,000: Elizabeth A. Lynn Foundation for Specific Assistance Fund

$10,000: Sonia O. Kemp Charitable Trust

$5,000: The Lauren Trust in memory of Ivan & Mary Lou Lauren

$5,000: Nordstrom for Specific Assistance Fund

$4,546: United Way of King County, including Kristina & Ross Heyl, $483; Steven Haluschak, $327

$2,535: Nintendo of America for Allan Crouch's vacation hours

$2,000: Trilogy for Kids for therapeutic tools, arts & crafts, gardening & sports programs

$1,845: Starbucks Coffee Company Partner Matching Program

$1,509: Combined Federal Campaign of King County

$1,500: American Express Employee Giving & Matching Program, including Aaron Snyder, $500

$1,000: Gerald K. & Virginia Family Foundation, William Francis, & Western National Insurance Company

$759: Washington State Employees Combined Fund Drive

$615: American Express PAC matching program

$572: Russell Investments employees for "Jeans Awearness Day"

$550: Denise Clark for Russell Investments "Jeans Awearness Day"

$500: Andrew & Marianna Price Jr. in memory of Mrs. Clifford Wiley

Barriers to Treatment

By Lee Grogg, Ryther CEO/Executive Director, MSW, MBA

Lee Grogg has over 37 years of experience in nonprofit management and behavioral healthcare. For 26 years, he was the first CEO of a community mental health center near Chicago that he built and developed. Mr. Grogg completed his undergraduate education at Wabash College and holds graduate degrees from Indiana University, MSW, and Notre Dame, MBA, with additional graduate work in Healthcare Financial Management at the Ohio State University.

What mental health care providers and the American public are up against.

For far too many health professionals, officials, policy makers and ordinary citizens, mental illness remains a topic to be avoided. This remains true despite the fact that the American Hospital Association considers mental illness to cause more disability than any other class of disease. Depression is the sixth leading cause for hospitalization in the United States. Twenty-six percent of the general population (excluding the homeless and institutionalized) reported symptoms sufficient for diagnosing a mental disorder in the past twelve months. Suicide is the third leading cause of death among American adolescents. And only a third of those who need treatment will ever receive it.

We know more now about how the human brain functions than at any time in the history of the world. And our array of effective treatment interventions is more extensive than ever before. We know enough that the recognition of mental illness as a treatable disease of the brain ought to be axiomatic, yet the policies and practices of many individuals and institutions reflect an attitude that communicates a kind of fear that cheats people out of appropriate treatment and support.

What are the barriers to treatment?

The barriers to treatment of mental health are many and staggering—as if the stigma we've allowed to continue isn't enough to overcome. Some barriers have been described as "structural." Historically, insurance coverage has been discriminatory against the mentally ill and, though progress is being made, it is progress only for those who can afford or be eligible for coverage. The availability of providers in many areas including child psychiatrists effectively keeps people out of treatment.

When it's all said and done, however, the big barriers are our misperceptions of the disease and its treatment. This is especially the case for children who are suffering from mental health and behavioral disorders. For the most part, children are at the mercy of their parents or guardians when it comes to seeking care. By the time the need for treatment may be acknowledged, families are suffering pain, disappointment, fear and guilt. People do not seek psychiatric care for their children with anything near the same enthusiasm they exhibit when seeking help for a broken arm or a twisted knee.

How do we remove barriers?

While we can only keep trying to educate the public about the biological truth of the illness and the science behind the treatments, we providers must make every effort to make sure we are not erecting or maintaining other barriers. Access to care must be as easy and as pleasant as possible. Facilities should be warm and welcoming. Promptness in making and keeping appointments is absolutely necessary and the paper work for the patient and family should be minimized. All of these things must be in place before we can begin to relieve the pain, soothe the disappointed feelings, erase the fear and assuage the guilt that accompanies mental illness.

From the Executive Director

Washington's Children's Administration periodically sends out reports with data about its activities. You might be interested in what some of that data is.

In the State's fiscal year 2011 (ending last July 1) there were 77,882 referrals received by CPS reporting alleged abuse or neglect. 37,992 were "screened in" for investigation while 35,772 were deemed for some reason not meeting a standard for further involvement of the agency. In short, about half of all reports made get investigated. If you total the "screened in" and "screened out" figures there is a gap of some 4,118 referrals that is unexplained.

On June 30, 2011, there were nearly 10,000 children in the care of the Children's Administration. This figure has remained surprisingly stable over the years. Of the 9,987 children in care, 90% (8,966) were in out-of-home care of some kind. A little over a thousand of the children were in State Dependent In-Home care. 3,174 of the children in out-of-home care were placed with relatives. This figure has increased via policy emphasis in recent years. 5,819 (65%) were in foster care or group homes.

The most common reasons for intakes were Negligence or Maltreatment (62.7%), Physical Abuse (27.3%) and Sexual Abuse (4.8%). Assuming that intakes equal the number of children in care in 2011, that means there were approximately 6,562 neglected children, 2,726 physically abused children and 479 sexually abused children in the system.

There were 18 child fatalities in open Children's Administration (CA) cases of which 11 were due to abuse. At this point the published report seems a bit obtuse. In breaking down the 18 fatalities of kids in open cases they report a line "the number related to child abuse" as being 11 while in the next line they report "abuse-related fatalities in open CA cases" being 7. The wording suggests that, in fact, all 18 fatalities in open CA cases were due to abuse.

Lee E. Grogg: Executive Director/CEO

"Children's Administration, 2011 Year in Review," Washington State Department of Social and Health Services, March 26, 2012. http://www.dshs.wa.gov/pdf/ca/year-in-review2011.pdf

Summertime: A not so carefree time for parents of teens

By Marie MacCoy, MSW, Ryther's Chemical Dependency Program Coordinator

Summer is almost here and teens will have lots of unstructured and unsupervised time on their hands. Unless your teen is working, volunteering, or going to school or camp, all those free summer hours could lead to first time experimental drug or alcohol use or deepen an already existing dependency.

If your teen is already using drugs or alcohol and is not responding to your concerns, see if he or she would be willing to come in for an assessment. Sometimes having a professional describe how serious their problem is can be effective. When an assessment is done, the teen will know what level of treatment he or she needs. The clinician will also be able to give teens a summary of their bio-psychosocial needs as well as three references for where they can seek these services.

I am often asked at what point inpatient drug and alcohol treatment for a teen should be considered. Generally, when the use of drugs or alcohol begin to take priority over other important aspects of the teen's life, that is when inpatient is needed. An example would be a teen who has always loved soccer starts to skip practice to smoke pot with some friends. A teen will need inpatient rather than outpatient treatment when his or her use has escalated from monthly recreational use to several times a week. Some good indications for the need for inpatient treatment is when a teen is using enough of the substance to the point where there are severe mood swings, blackouts or hangovers.

Ryther provides drug and alcohol assessments, outpatient Level I and co-occurring treatment as well as inpatient treatment for teen boys. Call us at 206.517.0234 to learn more or visit ryther.org/teen-drug-alcohol-treatment.

Save the date for the Ryther Annual Luncheon on Thursday, November 15, 2012 at the Grand Hyatt Seattle. To sponsor or host a table, contact Ryther at 206.517.0215.

An “Ollie” award from an 11 year old in classroom 5

Ryther League News

Spring was busy with a plethora of League happenings including Metropolitan Unit’s Annual Plant and Garden Sale, Sunrise Unit’s Cinco de Mayo Fiesta and the all-League Spring Luncheon. Six League members were recognized at the luncheon for their contributions to the League with an “Ollie,” a one of a kind framed piece of art from a child in Ryther’s Sub-Acute Residential Treatment program. This award has been named in honor of Mother Olive “Ollie” Ryther. Her tenacity and love are the same qualities that the League and recipients have demonstrated. If you are interested in joining or starting a Unit, please call 206.517.0215.

Thank you Ryther volunteers!

Once again, R-Salon volunteers from **Supercuts** and **Gene Juarez** delighted children and teens with new looks with a record 26 haircuts! Thanks to **Off Campus League Unit** for making this happen.

University Presbyterian Church cleared out and painted an old storage room that is now a bright new clothing room for our kids on campus.

UPS brought 20 volunteers to paint Cottage B’s new classroom while a few strong workers completed the dig to find a foundation leak.

Thank You to Our In-Kind Donors:

Cavalia: 55 show tickets, Seattle Aquarium: 100 passes, Blue Box Group: Smart Board, Fastline Publications: 12 new bicycles, Trilogy for Kids: 94 Regal movie passes, Ramola Lewis & Lynn Booth: 42” TV for Cottage C, Seattle Sounders: 29 Sounders tickets, Sage Studio: professional web development services.

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How children at Ryther grieve their losses

Losses for kids in Ryther's Sub-Acute Residential program can include termination of a parent's rights, separation from a sibling, loss of a foster family, or a death of a person or pet. To help process these events, select children participate in Ryther's Grief and Loss Group, having chosen one loss to focus on. The goal is not to have them think they will no longer be saddened by their loss. Rather, it is to help them understand that to alleviate grief, they have to talk about it and share it with caring people. They learn about the stages of grief, identifying feelings surrounding each, and then share these feelings with the group.

One of the most important topics is how to remember good memories without being flooded by negative ones. Using a picture of a brain, the group shows them how to separate their good, bad and sad memories. Good memories tend to be mundane like cooking together, yet also include events like birthdays. Sad memories are saying good-bye to the person they lost. Bad memories can recall being hit or abused. Distinguishing these enables them to move on without having to dig up the abuse, which is handled through therapy. Focusing on good memories with a loved one, they tell stories and show mementoes like photos. Other children create collages such as the one pictured here. Next, they write a letter to that person. Or they can pick a family member or a staff and write about their loss to them. At the end of the group they read their letters aloud at "graduation" where they also celebrate a new sense of healing. To learn more and how adults can help children deal with loss, visit the Ryther Voice blog at www.ryther.org/blog/grief-and-loss.