NAMI Greater Des Moines

National Alliance on Mental Illness

This newsletter is not intended to be read in one sitting. Take your time. This is not "quick" reading.

December 2018

511 E. 6th St., Suite B, DM 50309
Website: www.namigdm.org
Executive Director- Michele Keenan
director@namigdm.org
Email: info@namigdm.org
Events: events@namigdm.org
Phone: 515-850-1467 (Michele)
Cell: 515-277-0672 (Gary)
rasmussen@namigdm.org

Mental Health Education, Support and Advocacy
Serving Polk, Dallas, Warren, and Madison counties

Mission Statement:
Empowering individuals, families and community by providing hope and education about brain disorders.

In this issue –

Help Our Membership Grow!!

You can join NAMI at the local local, state and national level in three different ways:

1. Join on-line by reaching the NAMI Greater Des Moines website **www.namigdm.org**. Click on the blue "donate" box and enter your payment information. **OR**
2. **Join on-line by reaching the National NAMI website at www.nami.org/JOIN** and complete the payment information.

OR

3. Please make your check payable to NAMI Greater Des Moines.
   Household membership $60 - Regular Membership $40
   Open Door Membership $5 (limited income)

Name_____
Address_____
_____
Email_____
Phone _____

Do you want to receive our monthly newsletter by _____mail or _____email? *If paying by check, please mail to NAMI Greater Des Moines, 511 E. 6th St., Suite B, DM, IA 50309*

My Stay at Rhonda's House – A Testimonial

To be totally honest I had no idea what to expect when I walked through these doors on Friday. I had just spent the last 5 days on the psych unit at the Hospital after collapsing in a bar.

My emergency contact (Gary Goings) was contacted and he informed the hospital that on June 28, 2018, my son Jaycob John, age 19, had died in my arms after a car accident on July 5, 2018, my wife of 22 years took her life, and I had literally crawled into a bottle until my collapse.

At the hospital, I signed a 72-hour voluntary stay form and was transferred upstairs. I was given a pair of sweatpants, a T-shirt, showed how to order meals, showed my room and the TV room and not spoken again to until I saw the doctor on a teleprompter for about 3 minutes the next morning. He placed me on medication. This went on for 4 days. It should be noted that the capacity of this unit was 7 and I was the only one there and the nurses couldn't take time even once to sit down and talk to me. By Friday, I had enough.

My friend Gary and one of the staff members asked me to consider going to Rhonda's House in DeWitt until Gary, who is truck driver, could come pick me up on Nov. 16, 2018. The concern being me at home by myself. I agreed and was brought by taxi to Rhonda's House.

I initially met with Todd, who instead of asking me a bunch of questions, shook my hand and told me his story; which did two things (1) helped me relax and (2) gave me a sense that I wasn't alone. After showing me to my room we sat down and did my intake paperwork. It dawned on me about halfway through that I was finally talking about my loss to a stranger. I knew I could trust him because of the way he was willing to share his problems with me. Kris, the other staff person working that night, shared with me her story and a little bit bigger chunk of my isolation wall I had built around me crumbled. I'm not going to say I slept great that first night, but I will say I was more relaxed than I had been for months.

Since that first night every staff member here has taken the time to tell me their story, which has allowed me to tear down the barriers I had built around my loss. They have helped me get set up with a grief counselor, AA, they have helped me learn the importance of journaling, talking and trusting again. In short, the love, care and compassion of this staff has helped save my life. I can get up at 2 a.m. and come out and talk to whichever staff is working about whatever is bothering me, and know it's coming from their heart. I went from the brink of death to facing life again because of the love and support of the staff in this house. I know very little about mental health, but I do know what love is and this house is filled with it. ------**Robert Lyle Littrel**, **Galesburg, Illinois**

Rhonda's House is a peer run respite house in Dewitt, Iowa.

NAMI National Alliance on Mental Illness

Mental Health Care gets my VOTE!

4.2% of Iowa's population has severe mental illness or approximately 132,300 people
(3.15 million (2017) X .042)

Acute Care Psychiatric Hospital Beds Available in the Des Moines Area

Location	Adult	Children & Youth	Geriatric	Total
Mercy	18	16		34
Iowa Lutheran	40	16	12	68
Broadlawns	44			44
VA Hospital	10			10
Total	112	32	12	156

The number of acute care psychiatric beds statewide

Mental Health Institutes (MHI)	Total # of beds		# adult beds	# child & youth beds	Geriatric beds
Independence	60		40	20	
Cherokee MHI	36		24	12	
Total MHI beds	**96**		64	32	
Staffed Hospital Beds Statewide	**654**		455	113	86
Total Staffed Beds	**750**		519	145	86
Total Licensed Beds	**802**				

Clarinda MHI closed by Governor in 2015
Mt. Pleasant MHI closed by Governor in 2015
Independence PMIC (children's) beds closed by Governor 2016
Both remaining MHI's have a waiting list for persons waiting for treatment

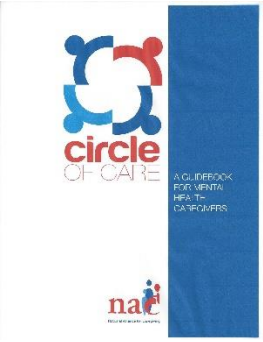
The entire Clarinda MHI campus is now controlled by Dept. of Corrections – they have a 795 bed prison and a 147 bed minimum security unit.

100 bed Civil Commitment Unit for Sexual Offenders-Cherokee MHI

The entire Mt. Pleasant MHI campus is now controlled by the Dept. of Corrections – they have a 914 bed prison at the Mt. Pleasant MHI.

See **Psychiatric Bed Supply** **Need Per Capita**.
Iowa beds needed 31 X 50 = 1550 (50 beds per 100,000 pop.)
Iowa sits at 24 beds per 100,000.

654 hospital beds + 96 Mental Health Institute beds =
750 total hospital and MHI acute care beds
Add 10 VA beds = 760 total acute care beds in Iowa
Add 86 crisis residential beds developed by the 14 regions
Add 72 bed new psychiatric hospital approved via Cert. of Need for southeast Iowa
Add 12 beds proposed to be built in Mason City.
Add proposed 100 bed hospital by Mercy Des Moines in Clive
Equals a proposed new total of 1030.
Beds needed in Iowa 31 X 50 = 1550 minus 1030 = 520 needed



Circle of Care: A Guidebook for Mental Health Caregivers – go to www.namigdm.org
Click on "Get Help",
Click on Guidebook for MH Caregivers

In the nation, Iowa is:

- **50th for # of mental health institute beds**
- **45th for mental health workforce availability** (2018)
- **47th for # of psychiatrists**
- **46th for # of psychologists**

Regions are serving 30,161 unduplicated individuals FY 2017. The 14 regions are serving 27,234 with mental illness, 2810 with intellectual disabilities, 879 with other developmental disabilities and 80 with brain injury. The regions pay for services for some people with disabilities who do not qualify for Medicaid. See information on regions at: **https://dhs.iowa.gov/mhds-providers/providers-regions/regions**

Some of the Services Built in the Regions as of 6-30-18		In development	
Jail Diversion (# of counties)	66	25	
Mobile Crisis Response (# of counties)	40	32	
Residential Crisis Beds	86	30	
24 hour crisis line	11	1	
ACT teams	12 teams	30 counties	

Crisis residential beds are residential settings that de-escalate and stabilize an individual experiencing a mental health crisis. Stays can be for 3 to 5 days.

Residential beds who have stays longer than 3 to 5 days are called **transitional** beds.

An **ACT team** is a program for persons with serious mental illness (primarily schizophrenia, schizoaffective, bipolar and major depressive disorders. The program is targeted toward the highest utilizers of health care resources – whether through institutionalization, acute hospitalization, jail or homeless. The key features are:

- Multidisciplinary staff
- Team approach
- Locus of care in the community
- Favorable ratio (8 clients:1 staff or less if very rural/high need)
- Assertive outreach
- 24/7 availability for crisis intervention
- Fixed point of responsibility for service
- Time unlimited services

ACT is a service delivery model not a case management model.

Other types of beds available

8 residential care facilities (RCF) for persons w/MI – 135 beds
3 intermediate care facilities (ICF) for persons w/MI – 109 beds
8% of our population has Substance Abuse Disorder or around 248,000 people
23 of 120 substance abuse providers programs contract with Iowa Dept. of Public Health. There are 425 treatment beds.
Co-occurring Services – there are **292** adult residential treatment beds identified as dual substance abuse treatment beds.

A complete list of substance abuse providers can be found at: **https://idph.iowa.gov/substance-abuse/treatment**

In 1955 – we had 4 mental health institutes and 5300 beds
In 2018 – we have 2 mental health institutes and 96 beds
In 1955 – we had 3 prisons with around 2200 inmates
In 2018 – we have 9 prisons with around 8300 inmates, and over 30,000 in community corrections
A direct result of a historical lack of access to care.

Home and Community Based Waivers (HCBS)

Clients receive services in their home rather than an institution. **http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers**

Home and Community Based Waivers	Approved Nov 2018	In Process	# on waiting list
Aids/HIV	31	13	0
Brain Injury	1402	252	1275
Children's Mental Health	1014	555	981
Elderly	7786	2416	0
Intellectual Disability	12,129	1314	2272
Health and Disability	2298	811	2813
Physical Disability	1038	671	1048
Total	**25,698**	6032	**8389**

In 2016, when HCBS services were covered through the Fee for Service program, it was possible to determine the average actual cost per person for each of the waivers. Today, in 2018, that information is not available.

The Fee for Service program is no longer being used. MCO's (Amerigroup & United Health Care) are paid "up front" 98% of a Per Capita Payment for a person's entire health care costs. The MCO's are not required to report what the actual cost of HCBS waivers are. They are, however, required to reveal whether or not they have met performance standards (set by DHS) to receive the remainder (2%) of their per capita payment.

Polk County Community Resource Guide
go to Visiting Nurse Service of Iowa website
https://www.vnsia.org/resources/community-resource- directory/default.aspx
Dallas County Community Resource Guide
go to Generation Wellness Coalition – Dallas County website
http://media.wix.com/ugd/5080fb_21ca1d4434314d0fa5726e40ae45cde0.pdf

Clubhouse Passageway,6000 Grand Avenue, Suite G
Des Moines 515-243-6929 – *real work opportunities*

New Statewide Parent Referral Line

Parent educators will continue to offer the same friendly service - now available evening and weekend hours to help parents make informed choices about the care of their children.

855-CHILD-01

M/W - 7:00 a.m. to 7:00 p.m. T/Th/Fr - 8:00 a.m. to 4:30 p.m.
Sat - 8:00 a.m. to 12:00 p.m.

Community Resources

Polk County Mental Health Services
Polk County River Place – 2309 Euclid Avenue, DM – 243-4545
www.pchsia.org.
Central Iowa Community Services
1007 S. Jefferson, Indianola, IA 50125
515-961-1068 email: mentalhealth@warrencountyia.org
http://www.warrencountyia.org/mental_health.shtml
Dallas County Mental Health Services
25747 N Avenue, Suite D, Adel, IA 50003 *515-993-5869*
Toll free: 877-286-3227 E-mail: dccs@dallascountyiowa.gov
http://www.co.dallas.ia.us/department-services/community-services

Madison County Mental Health Services
209 East Madison, Winterset, IA 50273 515-462-2931
http://www.madisoncoia.us/OFFICES/comservices/index.htm

Polk County Community Mental Health Centers
Child Guidance Center – 808 5th Ave – 244-2267
Eyerly Ball Community MH Center 1301 Center St. – 243-5181
Broadlawns Medical Center- 1801 Hickman Road – 282-6770
New Connections Co-Occurring Outpatient Services – 282-6610
Eyerly Ball Golden Circle – 945 19th St – 241-0982

Dallas County Mental Health Services
Genesis Mental Health Services, 2111 Greene St., Adel
Main office is at 610 10th St. in Perry 50220. Ph 515-465-7541. Fax 515-465-7636. *Adel area patients should call the Perry number to be scheduled. We have an ARNP and therapists in Adel, and a psychiatrist--Dr. Fialkov--who comes to Perry.*

Madison County Mental Health Center
Crossroads Behavioral Health Services
102 West Summit Street – 515-462-3105

Primary Health Care & Behavioral Health
Engebretsen Clinic, 2353 SE 14th St. – 248-1400
The Outreach Project, 1200 University, Suite 105 – 248-1500
East Side Center, 3509 East 29th St. – 248-1600
Primary Health Care Pharmacy,1200 Univ.,Suite 103 262-0854

Iowa Lutheran Hospital – *psychiatric acute care units & outpatient services-700 E. University, Des Moines*
Emergency Services:: 515-263-5120
Adult services: 515-263-5249 Children's services: 515-263-5153
Adolescent services 515-263-2368
Powell Chemical Dependency Center 515-263-2424
https://www.unitypoint.org/desmoines/services.aspx
choose "behavioral and mental health"

Mercy Medical Center (Hospital) – *psychiatric acute care for children, adolescents and adults*
1111 6th Avenue, Des Moines
***Mercy Help Center** 515-271-6111 or toll free 800-595-4959*
***Mercy First Step** (co-occurring disorder treatment)*

Optimae Behavioral Health– and - Home Health Services
515-243-3525 – 600 E.Court Avenue 515-277-0134

Des Moines Pastoral Counseling Center
8553 Urbandale Avenue, Urbandale 515-274-4006
Accepts all insurances, sliding scale for fees
On-site psychiatrist, PA and counseling staff
Free Mental Health Counseling in Spanish and English
At the Library at Grace United Methodist Church
Wednesdays – 2 to 6 PM
For an Appointment: Por favor contacte a Alicia Krpan, at 515-274-4006 ext. 143 – or –
Contact Nathan Delange, LISW.,at 515-577-0190

Tell Me Where to Turn

SUPPORT GROUPS for Family Members

Eating Disorders – Coffee Connections for Parents
The Coffee Connection is open to parent(s) who have a child of any age struggling with an eating disorder and would like to connect in a supportive effort with other parents. We will meet the 2nd Sunday of the month from 4:00-5:30 pm at the Cafe Diem, 2005 S. Ankeny Blvd., Ankeny, IA. Check under Events Calendar for specific dates. Direct your questions to **edci@edciowa.org**

Mothers on the Front Line
https://mothersonthefrontline.com/ - a blog, advocacy tutorials and Children's Mental Health -information to help mothers navigate life with a special needs child.

NAMI Family Support Group
National Alliance on Mental Illness

Des Moines – 3rd Sunday of the month. 2:30-4 PM
If you are interested in attending, please contact Susie & Richard McCauley 274-5095 or mccauleyf@mchsi.com
Meetings are at Eyerly-Ball Community Mental Health Center-1301 Center, Des Moines

NAMI Family Support Group
National Alliance on Mental Illness

Ankeny – First Tuesday of the month. 7 to 8:30 PM
If you are interested in attending, please contact Nora Breniman at 964-1593 or Jeana King at 641-385-2379. Meetings are at Ankeny First United Methodist Church, 206 SW Walnut, Ankeny, Room 310/314. **Please note:** In January 2019, the meeting will be on Tuesday, Jan. 8.

NAMI Family Support Group
National Alliance on Mental Illness

West Des Moines – 2nd Thursday of the month – 6:30 to 8 PM
If you are interested in attending, please contact Grace & Russ Sivadge 205-9765. Meetings are at Lutheran Church of Hope, 925 Jordan Creek Parkway, in Room 102. The church offers supper (free will offering) at 5:30 prior to the support group.

NAMI Family Support Group
National Alliance on Mental Illness

The online support group for parents of minor children with mental health needs. It is a Closed FaceBook Group: "the Casserole Club" – In this group we offer each other kind words of encouragement and a listening ear. We also offer a forum to help you find others in your area if you are looking for a local support group. To join, send an email tammynyden@gmail.com with "*subscribe to NAMI IA support group*" in the subject line.

4th Monday of each month – 5:30 – 7 PM – a support group for Polk County **parents and caregivers** of minor children with severe emotional disturbance (SED) or mental illness – a sibling support group meets separately - at Capitol Hill Lutheran Church, 511 Des Moines St., in the basement – child care provided, can also provide free transportation and interpretation services – pre-register, if possible – call Angie at 558-9998.

1st and 3rd Tuesdays of each month –Voices to be Heard
Support group – Wesley United Methodist Church –800 E. 12th - Light meal at 5:30 P.M. Support group for adults and program for children from 6 PM to 7PM. –If you have a loved one in prison or parole system you are concerned about or if you are concerned about those in prison, please feel free to join us. If you have questions, please contact Melissa at melissag@chihousing.com

The Living Grace Group support group for people with any mental health difficulty or disorder meets on Tuesdays from 7 to 8:30PM in the Gathering Room at Capitol Hill Lutheran Church at 511 Des Moines St., Des Moines. For more information, please contact Brad Wilson at 515-441-4292 or by email at **Bradley.david.wilson@gmail.com**

TACA (*Talk About Curing Autism*) is a national non-profit organization whose mission is to educate, empower and support families affected by autism. Please contact Susan susan.straka@tacanow.org or visit http://www.tacanow.org

Support Groups for Families of Veterans
"Peaceful Homefront" @ Dallas County Hospital
in Perry, on 1st and 3rd Thursdays – 6:30 to 8 PM.
Groups available for adults and children ages 9 to 12.
For more information, call Genesis toll free 877-465-7541

Friends of Iowa Prisoners has a meeting at Noon on the 3rd Tuesday of the month at Wesley United Methodist Church, 800 12th St., Des Moines.

Coping After a Suicide Support Groups for Adults and Adolescents
https://afsp.org/chapter/afsp-iowa/
https://afsp.org/find-support/ive-lost-someone/
click on "find a support group"

http://www.suicide.org/support-groups/iowa-suicide-support-groups.html

documentary films on suicide loss can be found at:
https://afsp.org/find-support/ive-lost-someone/survivor-

Warning: Regular or heavy alcohol use can worsen most psychological states, such as anxiety, depression, bipolar, schizophrenia, or eating problems. Alcohol can change the way a person feels in the short run; however, the overall effect only worsens a disorder. Marijuana and other drugs can have similar or more serious effects on the brain.

Crisis Phone numbers and Text numbers

Text Crisis Line http://www.crisistextline.org/

Suicide Prevention Lifeline
1-800-273-8255
For every person that dies by suicide, more than 250 think seriously about it but do not die. It is possible to prevent suicide and save lives by connecting at-risk individuals to support in their area. If you are thinking of hurting yourself, tell someone who can help. If you cannot talk to your parents, your spouse, a sibling -find someone else: another relative, a friend, or someone at a health clinic. Or, call the National Suicide Prevention Lifeline at (800) 273-TALK (8255) - **http://ok2talk.org/**

Veteran Suicide Prevention Lifeline
1-800-273-8255 – press 1 Text to: 838255

Veteran Toolkit to Prevent Suicide can be downloaded from:https://www.va.gov/nace/docs/myVAoutreachToolkitPreventingVete ranSuicideIsEveryonesBusiness.pdf

Bullying, Suicide Hotline – Available 24/7. Your Life Iowa is a phone call or text away at **www.yourlifeiowa.org** or 855-581-8111. Trained counselors will provide guidance and support about bullying and critical help to youth.

http://iowahousingsearch.org/
A free resource to help you find a **rental home/apartment that fits your needs and budget**

Habitat for Humanity of Iowa has launched a new web site, houseiowa.org, intended as a one-stop shop for Iowans in search of affordable housing resources.

(MOMENTUM)
WORKS OF GROWTH AND RECOVERY

Community Support Advocates
6000 Aurora, DM 50322

We offer FREE art services for artists impacted by disability, brain injury, or living with a mental health issue. This includes free workshops, mentoring, and open studio hours where artists can come in and use our supplies. Contact Shannon @ 515-681-4099 or shannonk@teamcsa.org

Joy Ride Transport

Joy Ride is a transportation service available in the greater Des Moines area and surrounding communities To make a reservation, call **515-331-1100** or **855-225-7433** info@ridejoyride.com http://ridejoyride.com/ **Office Hours:** Monday – Friday 8:00 AM – 5:00 PM They try to accommodate same-day requests for transportation. Weekend and holiday transportation is also available with advance notice.

Excellent Magazines to Subscribe to:

Esperanza http://www.hopetocope.com/for articles on Anxiety and Depression
BP magazine http://www.bphope.com/ for articles on Bipolar
SZ magazine is not available in a hard copy magazine but can be found on their website http://mentalwellnesstoday.com/sz-magazine/ by subscription

Support Groups for Mothers Pre-Partum or Post-Partum

IOWA STATE COORDINATOR for Postpartum Support International - Karin Beschen, LMHC, Polk County Telephone: 515-222-1999 Email: kb@iowacounseling.com

Heartland Christian Counseling - Des Moines Clinic Postpartum Adjustment Group – 6-7 pm every Tuesday – DM Support group facilitator: Jill Thomas, licensed therapist and certified in treating perinatal mood disorders. Phone for registration or questions, call 515-331-0303 – Babies in arms are welcome to come!

Postpartum Support Group – Bellies, Babies and Beyond This group is held on the third Friday of the month 10 to 11:30 am at Balance Chiropractic & Wellness at 6611 University Ave., Suite 103, Windsor Heights, Iowa. Every month we invite you to come to this safe place with questions, concerns or just to meet other moms just like you.

For persons suffering from **postpartum depression** – a support group entitled "Amazing Girls Accepting Peace Everyday (AGAPE)". Information can be found at Meetup.com – enter AGAPE. You need to request to be a part of the group – contact Tricia at jrivas76@hotmail.com

Need Help or Training to Find a Job? Try these resources

Passageway-6000 Grand Avenue, Suite G, DM 243-6929
Goodwill of Central Iowa, Skills Training, Job experience, Job Coach, Work Experience - http://www.dmgoodwill.org/
Project Iowa - http://www.projectiowa.org/- 515-280-1274

Tell Me Where to Turn

Support Groups for Persons with Mental Illness

2nd & 4th Mondays of each month – 7 P.M. – depression, anxiety and bipolar support group., Heartland Presbyterian Church, 14300 HIckman, Clive. Julie 710-1487 candlesinthedarknesssg@gmail.com

NAMI Connection RECOVERY SUPPORT GROUP Every Tuesday afternoon 2-3:30 PM at the NAMI GDM office, 511 E. 6th, Suite B, DM For more information, contact Matthea Little Smith 515-783-2763 or Matthea.little.smith@gmail.com

NAMI Connection RECOVERY SUPPORT GROUP On the 1st and 3rd Wednesday evenings each month – 5:30 to 7 PM at NAMI GDM office, 511 E. 6th St., Suite B, Des Moines

Every Tuesday evening – 8-10 P.M. **-** Recovery Inc., a self-help group for people who have nervous and mental troubles at St. Mark's Episcopal Church, 3120 E. 24th St., Des Moines – Call 266- 2346 – Marty Hulsebus

Tuesday evenings 5:30-7:00 Dual Diagnosis support group at Eyerly Ball Mental Health Services – call 243-5181 for more info. Requires an assessment and has a cost.

Tuesday evenings 7:30 PM - 4211 Grand – Friends House – in the Meeting House – **Meditation and Mindfulness Group** – sponsored by Crossroads of Iowa

New! Tuesday evenings, 7:00pm. Weekly meetings will be held at the Gathering Room on the 2nd floor located at Capitol Hill Lutheran Church at 511 Des Moines St, Des Moines. For more info, please contact Brad Wilson at 515-441-4292.

Every Thursday evening 6:30-7:30 PM – 4211 Grand – Friends House – in the Conference Room – H30 - a support group with a focus on opiate, heroin and prescription pill addiction for **Women** – sponsored by Crossroads of Iowa 633-7968 – please pre-register

Every Thursday evening – 7:45 – 9:45 P.M. – Recovery, Inc. - a self-help group for people who have nervous and mental troubles – at St. Timothy's Episcopal Church, 1020 24th St., in West Des Moines. Call – 277-6071-Deb Rogers.

Every Saturday afternoon –2–3:30 PM–the Depression and Bipolar Support Alliance meets at Iowa Lutheran Hospital – University at Penn Avenue – Level B – private dining room. Debbie Wallukait is the leader. Contact her at wally3610@yahoo.com

An **Epilepsy Support group**
The Epilepsy Empowerment Group held 4th Thursday of each month- 6 PM -Mercy Medical Center, East Tower, Room 3, 1111 6th Avenue, Des Moines. For more info, contact Roxanne Cogil 515-238-7660 or efiowa@efncil.org

Every Saturday evening-"The Road"-Christian Life Center, 710 NE 36th street in Ankeny (easy access from the new exit off I-35) – the schedule: 6 PM Pizza supper with free will offering, 7:15 PM Worship, 8 PM recovery groups. Child care available for infants and toddlers. For further questions, call 515-777-8333 to speak to a team member. Facebook page: TheRoad@AFUMC

Crisis Services in Polk County

The Mental Health Mobile Crisis Team provides community-based assessments of individuals in crisis. The team is staffed with behavioral health specialists including registered nurses, Master's level psychotherapists and social workers. The team is activated when a law enforcement officer responding to an emergency call requests the presence of the Crisis Mobile Team. An evaluation, including a determination about the appropriate level of care needed, is completed in the field by a member of the team. The team member completing the evaluation will then make recommendations for appropriate interventions based upon the current needs of the individual in crisis. They will also provide information, education, and potential linkage to community resources. The mobile crisis team is located at Police Headquarters, 25 E. 1st, lower level.

Mobile Crisis Response Team
Emergency Calls: 911
Non-Emergency Calls: **515-283-4811**

If you have a mental health crisis in your family and are in need of emergency assistance – call 911 Be clear with the dispatcher what the situation is, that it is a mental health crisis, and you need the Polk County Mobile Crisis Response Team to assist. The goal is to keep everyone safe and to seek the appropriate level of assistance for the ill family member or friend.

The Mobile Crisis Response Team provides short term on-site crisis assessment and intervention for children, youth and adults experiencing a mental health crisis

The non-emergency phone number for the mobile crisis team is **515-283-4811**. The police liaison to the Mobile Crisis Team is Officer Lorna Garcia. Her hours are 8 to 4 Mon-Fri phone is 205-3821.

If the crisis situation is in Polk County - in response to your phone call, the first people to arrive to the situation will be police officers. Officers will determine if it is a mental health related issue and maintain safety at the scene. Officers make a request through dispatch if the Mobile Crisis Team is needed. Mobile Crisis only takes referrals from law enforcement.

The Crisis Observation Center and Psychiatric Urgent Care is intended to meet the needs of individuals who are experiencing an acute behavioral health stressor that impairs the individual's capacity to cope with his/her normal activities of daily living. The goal of the Crisis Observation Center is to offer a place for individuals to seek crisis intervention services and stabilize them quickly so they can return to the community. The length of stay is up to 23 hours. Services offered include a nursing assessment, care/service coordination, crisis intervention therapy, and access to a psychiatric prescriber if needed. Staff include registered nurses, Master's level psychotherapists, psychiatric technicians, and care/service. These services are offered in a safe and supportive environment. **Crisis Observation Center – open 24/7.**
Broadlawns Hospital, West entrance, 1801 Hickman, DM
Phone: 515-282-5742 – See map for new location

The Pre-Petition Screener Service is a resource for Polk County residents who want to file a petition for involuntary behavioral health services through the Clerk of Court. The screener is a mental health professional who is available to assist applicants and respondents before, during, and after the petition process. The role of the Pre-Petition Screener is to gather back-ground information from both applicants and respondents, and help determine if another path toward treatment may be preferable. In the event that a judge denies a petition, the screener is available to discuss appropriate next steps and help make connections with available resources. The Pre-Petition Screener is available without an appointment M-W from 8:30am to 4:30pm. If you or someone you know is in need of a psychiatric and/or substance abuse evaluation, please contact Chelsea Sailsbury, LMSW by calling either 515-336-0599 (direct line) or **515-**282-5742 (main office) or via email at csailsbury@broadlawns.org. The County clerk of court and the pre-petition screener are located in the same building.

Broadlawns Crisis Team 515-282-5752 – mental health professionals on duty 24/7 for responding to mental health emergencies

Broadlawns Community Access 515-282-6770

Under consideration

1. Working with stakeholders to establish a sobering center/engagement center.
2. Working with Polk County Supervisors to identify uses for the three 9 bed transitional homes they own. In all likelihood, one facility will be for subacute, one will be for crisis residential, and the third will be a residential group home for persons with mental illness.

Crisis Services in Dallas County

24/7 Crisis Line – 1-844-428-3878

Mobile Crisis Team - For a mental health crisis in need of emergency assistance call 911. Tell the dispatcher that the situation is a mental health crisis and you need the Mobile Response Crisis Team to assist. In response to your phone call, the first people to arrive will be law enforcement officers. Officers will determine if it is a mental health related issue and maintain safety at the scene. Officers make a request through dispatch if it is determined the Mobile Crisis Unit is needed. *(Covers Dallas, Guthrie, Greene and Audubon)*

Hope Wellness Center, 706 Cedar Street, Woodward, IA 50276 Director – Karen Rosengreen 515-438-2331 – a safe place where individuals who may be experiencing a mental health crisis can voluntarily access crisis intervention services. Open 24 hours a day/7 days a week. Typical stay is less than a week.

Hope Wellness Center Transitional Living Services – provides short term (2-3 month) housing for an individual coming out of a placement or hospitalization who needs to redevelop skills needed to be successful in the community.

Crisis Services in Warren County

Website for more information:
http://cicsmhds.org/services/crisis-services/

24/7 Crisis Line – 1-844-258-8858

Monday through Friday – 9 AM to 3 PM you can also **chat one to one on-line** at www.Foundation2CrisisChat.org or by texting 800-332-4224, All contacts are confidential.

For emergency situations always call 911. Tell the dispatcher that the situation is a mental health crisis and you need the Mobile Response Crisis Team to assist.
Mobile Crisis Team – 1-844-258-8858

Warren County Community Services Director – Betsy Stursma - 515-961-1059 betsy.stursma@cicsmhds.org
The main phone number is 515-961-1068.

There is a "Mental Health Resources in Warren County" booklet you can ask for.

Crisis Services in Madison County

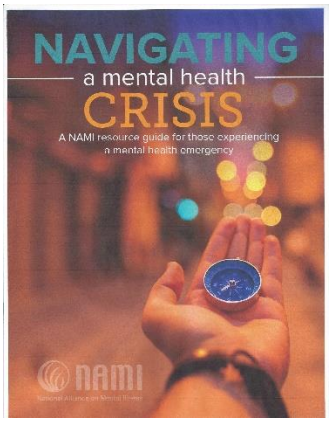
Krystina Engle, Director and the Eyerly Ball Staff, will provide the new **Mobile Crisis Response Service**. There is not an age limit nor income guidelines to this program. The service itself is free of charge and is available 24/7.

Mobile Crisis Response is a service that provides teams of professionals that can provide on-site, face-to-face mental health services for an individual or family experiencing a mental health crisis. They can respond wherever the crisis is occurring—in an individual's home, the community, or other locations where an individual lives, works, attends school, or socializes.

The team will be dispatched through the existing CICS Crisis Line (844-258-8858) available 24/7.

For emergency situations always call 911. Tell the dispatcher that the situation is a mental health crisis and you need the Mobile Response Crisis Team to assist.

For more information about services in Madison County, please see the website at:
http://www.madisoncoia.us/offices/comservices/index.htm
For more information about the CICS Mental Health and Disability Services Region, go to**:** **http://cicsmhds.org/**



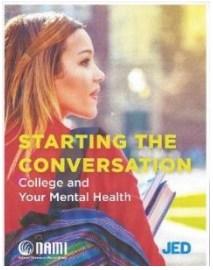
Navigating a Mental Health Crisis
To download a copy, go to www.namigdm.org, click on "Get Help" – the manual is the first item on the page

MCO's – Managed Care Organizations

If you have a question or a problem, call:	If problems remain unresolved, contact:
Amerigroup Iowa, Inc. 1-800-600-4441 www.myamerigroup.com/IA/	**Managed Care Ombudsman Program (866) 236-1430 or email ManagedCareOmbudsman@iowa.gov** Only for people on waivers – see the complaint form www.namigdm.org Click on "Get Help", click on "Health Insurance" scroll to bottom of page
United Healthcare Plan of the River Valley, Inc. 1-800- 464-9484 www.UHCCommunityPlan.com/ia/	**Office of Ombudsman** Toll-free 888-426-6283 http://www.legis.iowa.gov/Ombudsman/ For members who are not Long term Services and Supports (LTSS) or are non-Waiver cases – also take complaints from Medicaid providers
If there are unsuccessful repeated attempts to resolve, contact Tony Leys at tleys@dmreg.com or send a letter to 400 Locust St., Suite 500, Des Moines, Ia. 50309	
Emergency Medical Transportation (NEMT) Amerigroup Iowa Inc. Logisiticare 1-844-544-1389 United Healthcare Plan.- MTM 1-888-513-1613	
Iowa Medicaid Member Services 1-800-338-8366 (toll free) www.IAHealthLink.gov IMEMemberServices@dhs.sta te.ia.us	**For Iowa Medicaid Providers IME Provider Services** Phone: 1-800-338-7909 (toll free) IMEProviderServices@dhs.state.ia.us Provider Managed Care Organization Contacts: https://dhs.iowa.gov/ime/providers/MCO-contact-info

Caremore Clinic – for Amerigroup clients

CareMore Clinic offers medical and behavioral health services for patients on Medicaid w/Amerigroup Insurance ages 14& up. CareMore cares about their patient's body, mind and spirit. The Clinic is located at 1530 East Euclid Avenue, Des Moines, Iowa 50313 (515) 989-6001.



Starting the Conversation: College and Your Mental Health - go to www.namigdm.org

Click on "Resources", Click on "School Resources"

*Suicide is the 10th leading cause of death across all age-groups, with suicide rates increasing **30%** since 1999 and half of states experiencing an increase in suicide of more than 30% during that time period. (Iowa 36%) There were **44,965** deaths by suicide in the United States in 2016, almost 20% of all injury-related deaths, according to new data released from the Centers for Disease Control and Prevention (CDC).*

Factors contributing to suicide risk are extremely complex and can include mental illness as well as a host of other factors including substance misuse or financial instability.

Individuals with serious mental illness have more than a 20-times higher risk of suicide compared to the general population.

Approximately 50% of all suicides occur by firearms and 63% of all firearm injuries in the United States are self-inflicted.

Mental Health Stigma Dissipates, but Cost and Coverage Barriers Remain

Modern Healthcare

Although demand for mental health services is stronger than ever, treatment is often inaccessible, according to a new survey.

More than half (56%) of 5,024 Americans surveyed want mental health services either for themselves or for a loved one, but about three-quarters said there are access issues, with 34% pointing to cost or poor insurance coverage, according to a survey commissioned by Cohen Veterans Network and National Council for Behavioral Health. Others pointed to social stigma, lack of direction and poor quality of care as barriers to mental healthcare.

"Access has been a major problem. It is a crisis in America," said Anthony Hassan, president and CEO of Cohen Veterans Network. "When you wonder why there are such high suicide rates among children, it's because they are not getting the care when they need it.

Sometimes cost is prohibitive and providers are overworked. Some CEOs of community health centers are operating on shoestring budgets that make it hard to hire skilled staff, employ evidence-based practices and adopt new technologies, he added.

Top barriers to accessing mental health services

Cost and lack of information are the biggest hurdles to being seen.

	For Themselves	For Americans in General
Cost/Poor Insurance coverage	**34%**	**42%**
Not Knowing Where to Start	**18%**	**15%**
Social Stigma Around Receiving Treatment	**12%**	**17%**
Quality of Care	**9%**	**7%**

One in four reported having to choose between getting mental health treatment and paying for daily necessities. Nearly one in five of Americans, or 17%, noted they have had to choose between getting treatment for a physical condition and a mental health condition due to their insurance coverage, or lack thereof.

If they can afford it, 38% have had to wait longer than one week for mental health treatments and nearly half (46%) had to, or know someone who had to drive more than an hour round-trip to their appointment.

Part of it is that there isn't uniform standards of care throughout the country, said Linda Rosenberg, president and CEO of National Council for Behavioral Health, citing variations in Medicaid coverage, demographics and policy.
Minimal reimbursement also limits telehealth options to treat behavioral health, Rosenberg said.

While most have heard that telehealth is an option for treating mental health issues, only 7% have reported using it. When asked if they would be open to using it, 45% of those who have not already tried telehealth services for mental health said they would be open to it.

While there has been progress, "we still have a long way to go until telemedicine is fully reimbursed by Medicaid, Medicare and commercial insurance in all instances," Rosenberg said.

More than three-quarters surveyed believe mental health is just as important as physical health. But as the stigma of dealing with mental health has diminished, it's still a hurdle.

Thirty-one percent of those surveyed said they have worried about others judging them and 21% have even lied to avoid telling people they were seeking mental health services. This stigma is particularly true for younger people, who are more likely to worry about being judged, according to the survey.

“Stigma is no longer the No. 1 barrier," Rosenberg said. "Where we get care and how do we pay for it is the big problem."

The survey also included a state-by-state breakdown that indicated states are struggling to keep up with demand due to lack of funding and facilities.

Texas, Wisconsin and Georgia ranked among the lowest because they don't have enough providers, facilities and funding to support their needs. Pennsylvania, New York and Minnesota were some of the best in meeting demand.

There is also a large disparity in access to mental healthcare based on income and location. Coverage gaps are felt acutely in rural areas and by lower-income individuals.

Philanthropy can help fill those gaps, Hassan said. Billionaire hedge fund investor Steven Cohen pledged $275 million to create a national network of free mental health clinics for military veterans and their families. The Cohen Veterans Network will use that donation to open 25 clinics by 2020.

As for a more permanent solution, Medicare has started to pay for collaborative care, where a mental health counselor or case manager can get paid to join a primary-care physician during a visit, or a psychiatrist can remotely sit in, Rosenberg said. It's also important that the Mental Health Parity and Addiction Equity Act is enforced in each state, she said.

The act requires health insurers that cover mental health or substance abuse treatment to offer coverage commensurate for medical and surgical care. But ParityTrack found that the proportion of inpatient care that was provided out-of-network was more than four times higher for behavioral care than medical/surgical. Also, medical/surgical providers received higher reimbursement rates than behavioral providers for comparable services.

While the recently passed federal opioid bill was a step in the right direction, it did not require long-term funding for mental health and substance abuse treatment, only temporary pilot programs, Rosenberg said.

"Providers need to be reimbursed based on cost, not rely on a seed grant from the state government," she said.

Certified community behavioral health clinics, which are similar to federally qualified health centers but specialize in mental health and addiction, receive cost-based reimbursement and provide evidence-based treatment, are valuable resources, Rosenberg said.

"We are seeing the beginning of solutions to meet the growing demand," she said.

The growth of peer-to-peer counseling efforts aided by technology is also promising, Hassan said. "That could be an important part of continued care before and after treatment," he said.

In September 2016, the journal Neurology *published an article titled "The Terrorist Inside My Husband's Brain," written by Susan Schneider Williams, the widow of Robin Williams.*

It is a personal and heartbreaking account of the journey, experienced by two loving people as they navigated through the uncertainty and misdiagnosis associated with Lewy body disease.

There is no finger-pointing; it was written for neurologists, "for you," as Ms. Williams states at the beginning. Its purpose was "to help you understand your patients along with their spouses and caregivers a little more," to share a personal and tragic story with you . . . that may help to "make a difference in the lives of others," she states.

The Terrorist inside my Husband's Brain

By Susan Schneider Williams, the widow of Robin Williams

I am writing to share a story with you, specifically for you. My hope is that it will help you understand your patients along with their spouses and care-givers a little more. And as for the research you do, perhaps this will add a few more faces behind the why you do what you do. I am sure there are already so many.

This is a personal story, sadly tragic and heartbreaking, but by sharing this information with you I know that you can help make a difference in the lives of others.

As you may know, my husband Robin Williams had the little-known but deadly Lewy body disease (LBD). He died from suicide in 2014 at the end of an intense, confusing, and relatively swift persecution at the hand of this disease's symptoms and pathology. He was not alone in his traumatic experience with this neurologic disease. As you may know, almost 1.5 million nationwide are suffering similarly right now.

Although not alone, his case was extreme. Not until the coroner's report, 3 months after his death, would I learn that it was diffuse LBD that took him. All 4 of the doctors I met with afterwards and who had reviewed his records indicated his was one of the worst pathologies they had seen. He had about 40% loss of dopamine neurons and almost no neurons were free of Lewy bodies throughout the entire brain and brainstem.

Robin is and will always be a larger-than-life spirit who was inside the body of a normal man with a human brain. He just happened to be that 1 in 6 who is affected by brain disease.

Not only did I lose my husband to LBD, I lost my best friend. Robin and I had in each other a safe harbor of unconditional love that we had both always longed for. For 7 years together, we got to tell each other our greatest hopes and fears without any judgment, just safety. As we said often to one another, we were each other's anchor and mojo: that magical elixir of feeling grounded and inspired at the same time by each other's presence.

One of my favorite bedrock things we would do together was review how our days went. Often, this was more than just at the end of the day. It did not matter if we were both working at home, traveling together, or if he was on the road. We would discuss our joys and triumphs, our fears and insecurities, and our concerns. Any obstacles life threw at us individually or as a couple were somehow surmountable because we had each other.

When LBD began sending a firestorm of symptoms our way, this foundation of friendship and love was our armor.
The colors were changing and the air was crisp; it was already late October of 2013 and our second wedding anniversary. Robin had been under his doctors' care. He had been struggling with symptoms that seemed unrelated: constipation, urinary difficulty, heartburn, sleeplessness and insomnia, and a poor sense of smell—and lots of stress. He also had a slight tremor in his left hand that would come and go. For the time being, that was attributed to a previous shoulder injury.

On this particular weekend, he started having gut discomfort. Having been by my husband's side for many years already, I knew his normal reactions when it came to fear and anxiety. What would follow was markedly out of character for him. His fear and anxiety skyrocketed to a point that was alarming. I wondered privately, Is my husband a hypochondriac? Not until after Robin left us would I discover that a sudden and prolonged spike in fear and anxiety can be an early indication of LBD.

He was tested for diverticulitis and the results were negative. Like the rest of the symptoms that followed, they seemed to come and go at random times. Some symptoms were more prevalent than others, but these increased in frequency and severity over the next 10 months.

By wintertime, problems with paranoia, delusions and looping, insomnia, memory, and high cortisol levels—just to name a few—were settling in hard. Psychotherapy and other medical help was becoming a constant in trying to manage and solve these seemingly disparate conditions.

I was getting accustomed to the two of us spending more time in reviewing our days. The subjects though were starting to fall predominantly in the category of fear and anxiety. These concerns that used to have a normal range of tenor were beginning to lodge at a high frequency for him. Once the coroner's report was reviewed, a doctor was able to point out to me that there was a high concentration of Lewy bodies within the amygdala. This likely caused the acute paranoia and out-of-character emotional responses he was having. How I wish he could have known why he was struggling, that it was not a weakness in his heart, spirit, or character.

In early April, Robin had a panic attack. He was in Vancouver, filming *Night at the Museum 3*. His doctor recommended an antipsychotic medication to help with the anxiety. It seemed to make things better in some ways, but far worse in others. Quickly we searched for something else. Not until after he left us would I discover that antipsychotic medications often make things worse for people with LBD. Also, Robin had a high sensitivity to medications and sometimes his reactions were unpredictable. This is apparently a common theme in people with LBD.

During the filming of the movie, Robin was having trouble remembering even one line for his scenes, while just 3 years prior he had played in a full 5-month season of the Broadway production *Bengal Tiger at the Baghdad Zoo*, often doing two shows a day with hundreds of lines—and not one mistake. This loss of memory and inability to control his anxiety was devastating to him.

While I was on a photo shoot at Phoenix Lake, capturing scenes to paint, he called several times. He was very concerned with insecurities he was having about himself and interactions with others. We went over every detail. The fears were unfounded

and I could not convince him otherwise. I was powerless in helping him see his own brilliance.

For the first time, my own reasoning had no effect in helping my husband find the light through the tunnels of his fear. I felt his disbelief in the truths I was saying. My heart and my hope were shattered temporarily. We had reached a place we had never been before. My husband was trapped in the twisted architecture of his neurons and no matter what I did I could not pull him out.

In early May, the movie wrapped and he came home from Vancouver—like a 747 airplane coming in with no landing gear. I have since learned that people with LBD who are highly intelligent may appear to be okay for longer initially, but then, it is as though the dam suddenly breaks and they cannot hold it back anymore. In Robin's case, on top of being a genius, he was a Julliard-trained actor. I will never know the true depth of his suffering, nor just how hard he was fighting. But from where I stood, I saw the bravest man in the world playing the hardest role of his life.

Robin was losing his mind and he was aware of it. Can you imagine the pain he felt as he experienced himself disintegrating? And not from something he would ever know the name of, or understand? Neither he, nor anyone could stop it—no amount of intelligence or love could hold it back.

Powerless and frozen, I stood in the darkness of not knowing what was happening to my husband. Was it a single source, a single terrorist, or was this a combo pack of disease raining down on him?

He kept saying, “I just want to reboot my brain.” Doctor appointments, testing, and psychiatry kept us in perpetual motion. Countless blood tests, urine tests, plus rechecks of cortisol levels and lymph nodes. A brain scan was done, looking for a possible tumor on his pituitary gland, and his cardiologist rechecked his heart. Everything came back negative, except for high cortisol levels. We wanted to be happy about all the negative test results, but Robin and I both had a deep sense that something was terribly wrong.

On May 28th, he was diagnosed with Parkinson disease (PD).

We had an answer. My heart swelled with hope. But somehow I knew Robin was not buying it.

When we were in the neurologist's office learning exactly what this meant, Robin had a chance to ask some burning questions. He asked, “Do I have Alzheimer's? Dementia? Am I schizophrenic?” The answers were the best we could have gotten: No, no, and no. There were no indications of these other diseases. It is apparent to me now that he was most likely keeping the depth of his symptoms to himself.

Robin continued doing all the right things—therapy, physical therapy, bike riding, and working out with his trainer. He used all the skills he picked up and had fine-tuned from the Dan Anderson retreat in Minnesota, like deeper 12-step work, meditation, and yoga. We went to see a specialist at Stanford University who taught him self-hypnosis techniques to quell the irrational fears and anxiety. Nothing seemed to alleviate his symptoms for long.

Throughout all of this, Robin was clean and sober, and somehow, we sprinkled those summer months with happiness, joy, and the simple things we loved: meals and birthday celebrations with family and friends, meditating together, massages, and movies, but mostly just holding each other's hand.

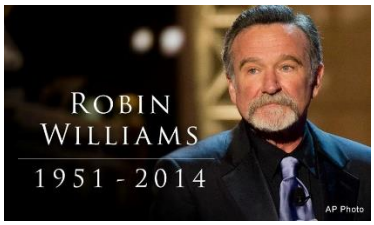
Robin was growing weary. The parkinsonian mask was ever present and his voice was weakened. His left hand tremor was continuous now and he had a slow, shuffling gait. He hated that he could not find the words he wanted in conversations. He would thrash at night and still had terrible insomnia. At times, he would find himself stuck in a frozen stance, unable to move, and frustrated when he came out of it. He was beginning to have trouble with visual and spatial abilities in the way of judging distance and depth. His loss of basic reasoning just added to his growing confusion.
It felt like he was drowning in his symptoms, and I was drowning along with him. Typically the plethora of LBD symptoms appear and disappear at random times—even throughout the course of a day. I experienced my brilliant husband being lucid with clear reasoning 1 minute and then, 5 minutes later, blank, lost in confusion.

Prior history can also complicate a diagnosis. In Robin's case, he had a history of depression that had not been active for 6 years. So when he showed signs of depression just months before he left, it was interpreted as a satellite issue, maybe connected to PD.

Throughout the course of Robin's battle, he had experienced nearly all of the 40-plus symptoms of LBD, except for one. He never said he had hallucinations.

A year after he left, in speaking with one of the doctors who reviewed his records, it became evident that most likely he did have hallucinations, but was keeping that to himself.

It was nearing the end of July and we were told Robin would need to have inpatient neurocognitive testing done in order to evaluate the mood disorder aspect of his condition. In the meantime, his medication was switched from Mirapex to Sinemet in an effort to reduce symptoms. We were assured Robin would be feeling better soon, and that his PD was early and mild. We felt hopeful again. What we did not know was that when these diseases “start” (are diagnosed) they have actually been going on for a long time.



By now, our combined sleep deficit was becoming a danger to both of us. We were instructed to sleep apart until we could catch up on our sleep. The goal was to have him begin inpatient testing free of the sleep-deprived state he was in.

As the second weekend in August approached, it seemed his delusional looping was calming down. Maybe the switch in medications was working. We did all the things we love on Saturday day and into the evening, it was perfect—like one long date. By the end of Sunday, I was feeling that he was getting better.

When we retired for sleep, in our customary way, my husband said to me, “Goodnight, my love,” and waited for my familiar reply: “Goodnight, my love.”

His words still echo through my heart today.

Monday, August 11, Robin was gone.

After Robin left, time has never functioned the same for me. My search for meaning has replicated like an inescapable spring

throughout nearly every aspect of my world, including the most mundane.

Robin and I had begun our unplanned research on the brain through the door of blind experience. During the final months we shared together, our sights were locked fast on identifying and vanquishing the terrorist within his brain. Since then, I have continued our research but on the other side of that experience, in the realm of the science behind it.

Three months after Robin's death, the autopsy report was finally ready for review. When the forensic pathologist and coroner's deputy asked if I was surprised by the diffuse LBD pathology, I said, “Absolutely not,” even though I had no idea what it meant at the time. The mere fact that something had invaded nearly every region of my husband's brain made perfect sense to me.

In the year that followed, I set out to expand my view and understanding of LBD. I met with medical professionals who had reviewed Robin's last 2 years of medical records, the coroner's report, and brain scans. Their reactions were all the same: that Robin's was one of the worst LBD pathologies they had seen and that there was nothing else anyone could have done. Our entire medical team was on the right track and we would have gotten there eventually. In fact, we were probably close.

But would having a diagnosis while he was alive really have made a difference when there is no cure? We will never know the answer to this. I am not convinced that the knowledge would have done much more than prolong Robin's agony while he would surely become one of the most famous test subjects of new medicines and ongoing medical trials. Even if we experienced some level of comfort in knowing the name, and fleeting hope from temporary comfort with medications, the terrorist was still going to kill him. There is no cure and Robin's steep and rapid decline was assured.

The massive proliferation of Lewy bodies throughout his brain had done so much damage to neurons and neurotransmitters that in effect, you could say he had chemical warfare in his brain.

One professional stated, “It was as if he had cancer throughout every organ of his body.” The key problem seemed to be that no one could correctly interpret Robin's symptoms in time.

I was driven to learn everything I could about this disease that I finally had the name of. Some of what I learned surprised me. One neuropathologist described LBD and PD as being at opposite ends of a disease spectrum. That spectrum is based on something they share in common: the presence of Lewy bodies—the unnatural clumping of the normal protein, α-synuclein, within brain neurons. I was also surprised to learn that a person is diagnosed with LBD vs PD depending on which symptoms present first.

After months and months, I was finally able to be specific about Robin's disease. Clinically he had PD, but pathologically he had diffuse LBD. The predominant symptoms Robin had were not physical—the pathology more than backed that up. However you look at it—the presence of Lewy bodies took his life.

The journey Robin and I were on together has led me to knowing the American Academy of Neurology and other groups and doctors. It has led me to discover the American Brain Foundation, where I now serve on the Board of Directors.

This is where you come into the story.

Hopefully from this sharing of our experience you will be inspired to turn Robin's suffering into something meaningful through your work and wisdom. It is my belief that when healing comes out of Robin's experience, he will not have battled and died in vain. You are uniquely positioned to help with this.

I know you have accomplished much already in the areas of research and discovery toward cures in brain disease. And I am sure at times the progress has felt painfully slow. Do not give up. Trust that a cascade of cures and discovery is imminent in all areas of brain disease and you will be a part of making that happen.

If only Robin could have met you. He would have loved you—not just because he was a genius and enjoyed science and discovery, but because he would have found a lot of material within your work to use in entertaining his audiences, including the troops. In fact, the most repeat character role he played throughout his career was a doctor, albeit different forms of practice.

You and your work have ignited a spark within the region of my brain where curiosity and interest lie and within my heart where hope lives. I want to follow you. Not like a crazed fan, but like someone who knows you just might be the one who discovers the cure for LBD and other brain diseases.

Thank you for what you have done, and for what you are about to do.

Fast Facts

Mental Health First Aid

In 2017, **103 firefighters** died by suicide – more than 93 firefighters who died in the line of duty.

Statistical evidence shows **37 percent** of fire and EMS professionals have considered suicide; nearly 10 times greater than the general population.

Marijuana Use and Schizophrenia

Treatment Advocacy Center

Given the degree to which marijuana use has become more accepted, if not ubiquitous, in recent years, the implications of inconclusive research connecting cannabis use to developing schizophrenia are becoming increasingly more troublesome. According to the Substance Abuse and Mental Health Services Association, 26 million individuals used marijuana in the past month in 2017. In addition, 6.5% of individuals 12-17 years of age and 22.1% of individuals 18-25 years old used marijuana in the past month, according to the survey. More than 2.5 million individuals between the ages of 12 and 25 who hadn't used marijuana previously started using marijuana last year.

Establishing causal links

Utilizing a more rigorous methodology and genetic approach, new research published in *Molecular Psychiatry* last month suggests that there is, in fact, a direct, causal relationship between cannabis use and the likelihood than an individual will develop schizophrenia.

Researchers from University of Lausanne in Switzerland, University of Pennsylvania in the United States Oxford University in the United Kingdom and other academic institutions around the world conducted an analysis of already

published, observational studies on cannabis use and schizophrenia. The results were then combined with a genetic analysis through complex statistical methods that allowed them to test the link between cannabis use and the development of schizophrenia. This complex study thus mimics a randomized control trial.

From both methods, the researchers found that any cannabis use increases the risk for developing schizophrenia. The genetic approach yielded a 1.37 times increased risk for developing schizophrenia among cannabis users compared to non-users, whereas the meta-analysis found a 1.43 times increased risk.

The findings of this study appear to validate the original hypothesis that use of cannabis increases the risk for developing schizophrenia. Moreover, their complex methodology and genetic test avoids ethical concerns raised by conducting experimental trials on individuals.

The authors are hopeful that their research will "help inform public health debate on cannabis use and preventive strategies to alleviate the burden of disease from schizophrenia." We feel the same.

Computer-Delivered Cognitive Training Significantly Helped Schizophrenia Patients in Rehab Setting

Brain and Behavior Research Foundation

Cognitive difficulties experienced by people with schizophrenia are the symptoms of the illness that tend to have the greatest impact on daily functioning and overall quality of life. Individuals who have reduced interest in activities, problems remembering and learning, or interpreting verbal cues, find it very difficult to hold jobs or cultivate social relationships that are central in normal functioning.

Knowing that the medicines commonly used to treat psychotic symptoms have no meaningful impact on the cognitive symptoms of schizophrenia, researchers have been trying for years to find therapies that will specifically improve cognitive functioning. Targeted cognitive training (TCT) has recently been shown to have moderate to high effectiveness when administered in carefully controlled academic settings. The training method targets the brain's auditory processing system, in which deficits have been shown to correlate with patients' deficits in auditory perception and verbal learning.

Now, a team led by Gregory A. Light, Ph.D., of the University of California, San Diego, has put TCT to a difficult real-world test. Dr. Light, recipient of the Foundation's Baer Prize in 2014 and a 2013 BBRF Independent Investigator and 2006 and 2003 Young Investigator, and team members, provided TCT to schizophrenia patients receiving court-mandated care in a locked residential rehabilitation center.

In this setting, the researchers set out to discover whether some of the most seriously afflicted patients could be helped. These patients suffered from severe symptoms and required stabilization on high dosages of antipsychotic medications, and, on average, had been sick for over 15 years. A commonly held assumption of the field was that cognitive remediation would work less well or not at all in these patients.

To the team's delight, this was not the case. The researchers followed 46 patients in this trial, all of whom received ongoing medication management, individual and group therapy, and structured social activities. Half of the patients also received 3-5 hours of TCT training per week. This training consisted of various training tasks delivered via laptop computers, focusing on a variety of auditory processes.

"TCT produced significant improvements in auditory perception and verbal learning," the team reported July 25, 2018 in *Schizophrenia Research*. They also experienced a "significant reduction in auditory hallucinations." Age, symptom severity, medication dosage and illness duration did not reduce TCT's effectiveness.

"The findings indicate that even highly symptomatic, functionally disabled patients with chronic illness benefit from this emerging treatment," the team said. Unfortunately, nearly one-third of the patients receiving TCT did not show a significant benefit, they noted, and continuing research will address how to boost the response rate. They also called for more careful study of how improved cognitive performance on computer-administered tests translates into patients' ability to perform in jobs and social situations.

One-Third of People with Heart Failure Have Symptoms of Depression & Anxiety

Psych U

Symptoms of depression and anxiety are present in about one-third of consumers with heart failure, and these consumers are at higher risk of progressive heart disease and other adverse outcomes. Depression and anxiety disorders in heart failure patients are common, under recognized, and linked to adverse outcomes.

These findings were reported in "Depression and Anxiety in Heart Failure: A Review".

Additional findings include:

- About 19% of those with heart failure met the criteria for depressive disorder.
- About 13% of those with heart failure met the criteria for a formal anxiety disorder. Of these, almost 30% showed significant levels of anxiety.
- Those with depression were associated with an 18% increased risk of heart failure. It is unclear whether those with anxiety have an increased risk of heart failure.

The researchers concluded that one reason for any increased risk of heart failure for these populations, is that those with those with depression and anxiety often find it difficult to follow a healthy lifestyle. Exercise, eating habits, smoking and drinking cessation, adherence to medications, and cardiac rehabilitation are all needed to decrease risk of heart failure. However those with depression and anxiety often find it difficult to implement these lifestyle changes. Because cognitive- behavioral therapy has been shown to improve mental health outcomes, it may also decrease the risk of heart failure in these populations. They recommend additional research into effective treatments for these disorders in those with heart failure.

The full text of "Depression and Anxiety in Heart Failure: A Review" was published in the July/August 2018 issue of Harvard Review of Psychiatry and is available online at Journals.LWW.com.

Suicide in Iowa: 433 deaths in 2017
Men kill themselves at 4X the rate of women.
Suicide is the 9th leading cause of death overall in Iowa.
On average, one person dies by suicide every 20 hours in the state.
Six times as many people die by suicide annually than by homicide.
---- *American Foundation for Suicide Prevention*

Understanding Anxiety in Children and Teens

Child Mind Institute

Anxiety is a normal and healthy physiological response to a threat in the environment. Anxiety disorders arise when we develop out-of-proportion anxiety responses to things most of us cope with easily.

- In the past 10 years, there has been increasing recognition of anxiety in young people by health care providers, including a 17% increase in anxiety disorder diagnosis.
- Yet anxiety disorders are described as the "invisible condition" – with symptoms minimized or ignored – or as the "great masquerader," mistaken for other conditions.
- Untreated anxiety disorders increase the risk for depression, school failure, substance abuse and difficulty transitioning to adulthood.

Prevalence

- At some point, anxiety affects 30% of children and adolescents, yet 80% never get help.
- Anxiety disorders are mild for 48%, moderate for 37% and severe for 15%
- In college students seeking mental health services, anxiety Is the most frequent concern (48%), followed by stress (39%).

Lack of recognition

- As little as 1% of youth with anxiety seek treatment in the year their symptoms begin, and most anxiety symptoms go untreated for years.
- Anxiety is often mistaken for another disorder, resulting in ineffective treatment.

Development

Average age of onset is **Age 11** for separation anxiety disorder and specific phobias and
Age 14 for social anxiety disorder.

Risks

- 50% of teens either consider themselves "shy" or are described as shy by their parents, but only 12% of those shy adolescents meet criteria for social anxiety disorder.
- Anxiety disorders are linked to a two fold increase in risk for substance use disorder
- When adolescents have depression alongside social anxiety, it is strongly associated with more suicidal ideation, suicide attempts and more depressive symptoms.

Social Media

Higher emotional investment in social media was strongly correlated with higher levels of anxiety.

Treatment Innovations

Combined behavioral therapy and medication treatment is effective in more than 80% of youth struggling with social anxiety, generalized anxiety or panic disorder.

Successful cognition behavioral therapy (CBT) treatment for anxiety disorders in youth results in long term recovery for 93% of participants.

Anxiety is a gateway disorder that leads to increased risk of depression, school failure, substance abuse and suicide. We need to get better at identifying the vast majority that never get help, or even know how and who to ask for it.

The Essential Guide to Help Men Recognize Depression

Bp Magazine

Not all men are tuned into their emotions or even physical changes and may miss some signs of depression; here's five signals to pay attention to:

#1 Exhaustion

Finding yourself more tired without a good reason like staying up late. If you believe you're getting enough sleep and you can't explain why you're so exhausted, it could very well be a sign of depression.

#2 Irritability

If you've always been an optimist or at least someone who's normally easy going and now find yourself on edge, more irritable and even exhibiting angry outbursts for seemingly no good reason, there may actually be a reason. This irritability could be a sign of depression.

#3 Change in diet and sleep

Changes in diet and sleep may seem like common symptoms of depression, but sometimes recognizing them in yourself isn't always so easy. You may be mindlessly eating more than usual or skipping meals and blaming it on being busy. Sleeping more than usual? Maybe you're used to getting up early on the week-ends but now you just want to sleep in late, or perhaps you're finding it more difficult to get to sleep.

#4 Physical symptoms

This can include everything from headaches, back pain, gut problems or other aches and pains that can't be easily explained.

#5 Cognitive difficulties

Something like brain fog may come on gradually, but if you find yourself having difficulty concentrating or focusing on writing that presentation at work, this could be a signal. You may just find yourself always searching for the right words when talking or telling a story, something that always came easy for you before.

Legislative Workgroup Results

To see legislative workgroup reports and progress on the **Children's State Mental Health Board strategic plan**, go to: **https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board**
Final report and recommendations due 11-15-18.

Involuntary Commitment Process Review Workgroup (Iowa codes 229 and 125) –**https://dhs.iowa.gov/mhds/community-integration/commitment-process-review-workgroup-meetings -** Final report and recommendations due 12-30-18.

Tertiary Care Workgroup – a level of care to treat persons with complex needs. **https://dhs.iowa.gov/mhds/community-integration/tertiary-care-psychiatric-hospitals-workgroup-meetings -** Final report and recommendations due 11-30-18

Mental Health and Disability Services Funding Study Committee –click on Committee information documents – **https://www.legis.iowa.gov/committees/committee?ga=87&session=2&groupID=31963**

A report on ACT (Assertive Community Treatment) reimbursement rates is due by 11-15-18.

National Alliance on Mental Illness of Greater Des Moines
511 E. 6th St., Suite B
Des Moines, Iowa 50309

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We like to call it the NAMI effect.

Every time you offer your hand to pick someone up, every time you share your strength and ability to persevere,
Every time you offer support and understanding to a family who is caring for a loved one, Your help changes lives.

CALENDAR OF EVENTS

Wed., Jan. 9 - NAMI GDM Board Meeting
You are welcome to attend. Board meetings will be held the second Wednesday every other month in 2019 –
Jan, Mar, May, July, Sept., Nov
Location: 511 E. 6th St., Suite B, DM
4:30 to 6 PM

Executive Director- Michele Keenan
515-850-1467 – **director@namigdm.org**
Associate Executive Director – Gary Rasmussen 515-277-0672
rasmussen@namigdm.org
Event Coordinator – Ashley Adams
events@namigdm.org

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How can you help individuals with mental illness and their families?

Volunteer – Join a committee!!
Advocacy and Outreach, Governance, Membership, Education & Support, Fundraising and Finance

Become a member
See Page1 for membership info

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Your donations to GDM make it possible to have **local** education programs, support groups and advocacy for Polk. Dallas, Warren and Madison counties.

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