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.

January 2019

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

In this issue –

Help Our Membership Grow!!

You can join NAMI at the 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*

Treat Yourself to a Mental Health Boost that Lasts

Healthyplace.org

Do you want to know how to boost your mental health? One of the simplest ways to **improve your mental health** is to treat yourself to something you like. People living with mental illness tend to be **extremely hard on themselves**, blaming themselves for something that isn't their fault. Boost your mental health by treating yourself.

Do something nice for yourself. Treating yourself to something special, no matter how small, teaches you that you are worthy: of respect, of kindness, of happiness.

However, how do you treat yourself when you don't believe in yourself and it feels like nothing matters?

These are real concerns that mean your need to treat yourself is high. Here are a few tips for doing it:

- Do it anyway. The action of treating yourself comes before you feel like doing it. It's the act of giving yourself a treat that provides the energy—the burst of fun that can lift the heavy weight of mental illness—that leads to more.
- Make it personal. Your treat is for you. Maybe you like listening to music and moving to the beat. Perhaps plan a small garden. Get a chinchilla. Bake cookies. Journal. Draw. Color. Buy a pack of gum. Anything that gives you even a small amount of pleasure is a treat.
- Make it a habit for your mental health. It creates the lasting power of something to look forward to. That's a treat in and of itself.

So, there you go. Treating yourself to something nice will give you a mental health boost that lasts. You're showing yourself that you are indeed worthy.

HR 6964 The Juvenile Justice Reform Act of 2018

The House and Senate have passed H.R. 6964 which strengthens and updates the federal law that has been protecting justice-involved youth for nearly 45 years. The final bill passed by Congress strengthens national standards by reducing the placement of youth in adult jails pre-trial and providing more structure to the law's requirement to decrease racial and ethnic disparities, a critical provision ensuring that children, regardless of their race or ethnicity will be treated fairly and equitably by our legal system. The bill also promotes:

- the use of alternatives to incarceration;
- supports the implementation of trauma-informed, evidence-based practices;
- calls for the elimination of dangerous practices in confinement, including eliminating the use of restraints on pregnant girls;
- improves conditions and educational services for incarcerated youth;
- focuses on the particular needs of special youth populations, such as trafficked youth and Tribal youth;
- increases local control in delinquency prevention programming; and increases accountability.

The legislation also includes a two-year reauthorization of the Runaway and Homeless Youth Act (RHYA). Nearly 62 percent of youth experiencing homelessness have been arrested and 44 percent have been detained. For more information go to www.ACT4JJ.org

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

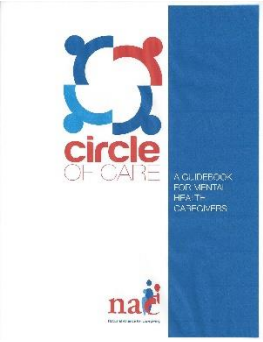
The entire Clarinda MHI campus is now controlled by Dept. of Corrections – they have a 795 bed prison and a 147 bed minimum security unit.

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 in Des Moines and 15 VA beds in Iowa City = 775 total acute care beds in Iowa
Add 85 crisis residential beds developed by the 14 regions
Add 9 subacute beds
Add 72 bed new psychiatric hospital approved in SE 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 1053.
Beds needed in Iowa 31 X 50 = 1550 minus 1053 = 497 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 9-30-18		In development	
Jail Diversion (# of counties)	66	25	
Mobile Crisis Response (# of counties)	41	32	
23 hr Crisis Observation (# of Beds)	50	3	
Residential Crisis Beds	85	19	
Crisis Stabilization – Community Based (# of co's)	2	2	
24 hour crisis line	11	1	
ACT teams	11 teams 33 counties	11 counties	
# of Subacute Beds	9	16	

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 which 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 Dec 2018	In Process	# on waiting list
Aids/HIV	32	11	0
Brain Injury	1412	256	1253
Children's Mental Health	1006	539	966
Elderly	7822	2303	0
Intellectual Disability	12,160	1292	2227
Health and Disability	2318	749	2802
Physical Disability	1044	624	999
Total	**25,794**	5774	**8247**

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

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

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

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

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

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-day/survivor-day-documentaries/

In addition to these groups, other help may be available depending on your community and may include: Compassionate Friends (13 groups in Iowa; Funeral Homes, Faith Organizations Employee Assistance Programs; Guidance Counselors; Hospice; and **Amanda the Panda.**

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.

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

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

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 National Alliance on Mental Illness 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 National Alliance on Mental Illness 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

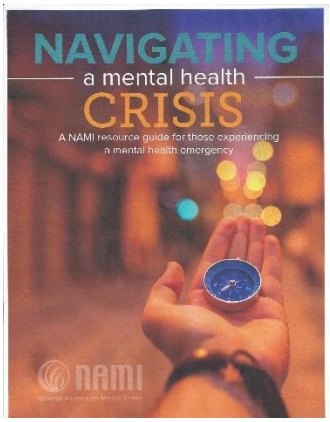
Krystina Engle, Director and the Eyerly Ball Staff, will provide the new **Mobile Crisis Response Service**. There is not an age limit nor income guidelines to this program. The service itself is free of charge and is available 24/7.

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/**



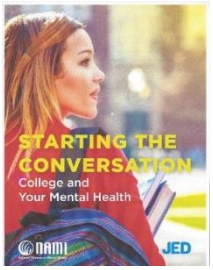
Navigating a Mental Health Crisis
To download a copy, go to www.namigdm.org, click on "Get Help" – the manual is the first item on the page

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.state.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.

What is the Alternative to Restraint?

Open Minds Daily Executive Briefing

This Photo by Unknown Author

I was surprised by a recent report on the use of restraints among organizations serving people with intellectual or developmental disabilities (I/DD). Approximately 78.4% of 2015 Medicaid waivers for home- and community-based services (HCBS) for people with I/DD allow the use of restraints; 75.7% allow the use of restrictive interventions; and 24.3% allow the use of seclusion for this population.

This is especially surprising considering the work done to show just how counter-productive this practice is. A 2015 research paper from the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that "restraint and seclusion are violent, expensive, largely preventable, adverse events" SAMHSA estimates that the use of restraints can claim as much as 23% of staff time and accounts for 50% of staff injuries. For consumers, the use of restraints can increase the risk of injury by 60%, and increases length-of-stay by six months.

So how can provider organizations build a strategy to reduce their use of seclusion and restraints for the complex consumer population? One organization, Grafton Integrated Health Network, a multi-state behavioral health care organization, has set out to solve this problem. They found that reducing the use of restraints and eliminating seclusion reduced staff injuries and lowered lost-time expenses, turnover cost, and workers compensation policy costs. The researchers reported that because the staff injury rate declined, Grafton saved more than $16M over 10 years due to cost reductions in lost-time expenses, workers compensation premiums, and staff turnover costs.

I asked V-P/COO Kimberly Sanders, why, in spite of the evidence showing the harm caused by these practices, they are still permitted by states. She explained:

I think the overarching answer is simple—they do not know that there is an alternative. To most leaders in organizations this issue is framed as "to restrain or not to restrain." Given their very real history and experience of staff and consumer injuries from aggressive acts, they just can't even imagine saying we are not going to use restraint. Once you can offer employees a physical alternative to keep everyone safe, it finally becomes a possibility worth considering. Grafton's approach is rooted in the belief that physical restraints are not only unnecessary, but also unproductive. We know that all intervention—educational and behavioral—should be built on an approach of comfort versus control.

Her advice on how to create a restraint-free system?

Utilize a trauma-informed approach to care—Trauma-informed care is focused on a delivery system that meets the needs of the consumer and their experience. Making this change in an organization's culture requires the executive team to examine every aspect of the organization. Ms. Sanders explained:

Our philosophy of comfort versus control required that everyone within the organization understand behavioral intent and client needs. We needed staff to reassure clients, to ask questions instead of making assumptions, to be flexible, to let go of the need to have the "upper hand," and to treat others with kindness and compassion. But first we needed to ensure that they knew they would also be taken care; that their safety was as important as that of our clients. And we needed to provide staff with meaningful alternatives to restraint and seclusion.

Get internal buy-in from staff—Becoming a trauma-informed organization is a cultural shift requiring buy-in from everyone to not only change current expectations, but to also teach staff to deliver effective, respectful, and person-centered services given the likelihood that most consumers in this space have a history of trauma. Ms. Sanders explained:

From the beginning, we worked hard to embed the philosophy of comfort versus control throughout our entire organizational culture. With collective buy-in and a universal willingness to adopt a new way of doing things, "comfort versus control" became far more than a mantra; it became our core operating principle. Meeting our objectives of minimizing or, where possible, eliminating restraint and seclusion required us shift our culture. And, though the CEO issued the initial call to action, real change can't happen as the result of one single person's vision, no matter his or her title. Making the vision a reality required the individuals working with our clients every day. Without active and consistent leadership, and the passionate support of people on the ground, we couldn't have achieved lasting change. But when a group of people is truly open and willing, real and lasting change is entirely possible.

Provide meaningful alternatives to seclusion and restraints—Providing staff alternative tools to conflict resolution is just as important as providing trauma-informed care. This requires staff education of trauma-informed practices, conflict resolution, and the physical techniques and tools that help manage challenging behavior. Ms. Sanders explained that, for ex:

As Grafton implemented a restraint free approach, we quickly learned that traditional blocking materials were not effective—while some didn't offer adequate protection, others were physically or visually jarring to clients. So, we decided to build the materials we needed ourselves. We developed custom-made, soft, cushioned blocking tools that keep both our clients and our staff safe and comfortable. They are not hidden away only to be taken out in moments of crisis. You'll see them all throughout our facilities.

Create an infrastructure of support for staff—Internal buy-in isn't static and doesn't just mean convincing staff to adopt this approach. It means providing ongoing leadership, training, and support to encourage staff. Ms. Sanders explained:

Beyond training, the leadership team provided concrete support, changing their hours to have a presence during all shifts. Additionally, they often went to group homes in the evenings and classrooms during the day. Finally, they made it a point to simply ask employees what they think, how they felt about the transition and how they were handling it.

As long as the use of seclusion and restraints is permitted, it will continue to be a challenge for provider organizations. The path forward is to create a culture shift where restraint is not an acceptable option, and giving staff education, training, and tools they need to utilize more effective alternatives.

Did You Know?

A working group has met to revise the Iowa Dept. of Education Chapter 103 administrative rules for "Corporal Punishment, Physical Restraint, Seclusion and other Physical Contact with Students". There is a working draft dated 9-14-18 which has been shown to various advisory groups.

The purpose: In conjunction with Iowa Code section 280.21, the purpose of this chapter is to define and exemplify generally the limitations placed on employees of public schools, accredited nonpublic schools, and area education agencies in applying physical contact or force to enrolled students, and to require that

any such force or contact is reasonable and necessary under the circumstances. These rules also provide requirements for administrators and staff of public schools, accredited nonpublic schools, and area education agencies regarding the use of physical restraints and physical confinement and detention. The applicability of this chapter to physical restraint or physical confinement and detention does not depend on the terminology employed by the organization to describe physical restraint or physical confinement and detention.

How Many Shelter Beds are Enough?

Open Minds

In September, a federal appeals court panel ruled that arresting homeless people for sleeping in public when there are insufficient shelter beds violates the 8th Amendment against cruel and unusual punishment.

How many beds are available for the homeless population nationally? The U.S. Department of Housing and Urban Development (HUD) estimates that in 2017 there were 899,059 beds available on a year-round basis; this includes emergency shelters (ES), safe havens (SH), transitional housing (TH), rapid rehousing (RRH), permanent supportive housing (PSH), and other permanent housing (OPH). Are those beds sufficient? Answering that question is complicated.

According to HUD, on any given night in 2017, 553,742 people were experiencing homelessness in the United States—approximately two-thirds (65%) of that population were staying in emergency shelters or transitional housing programs, and about one-third (35%) were in unsheltered locations (see **The 2017 Annual Homeless Assessment Report (AHAR) To Congress**). Looking at those estimates, the numbers may make it appear that we "have enough" shelter beds nationally. But geographic variations mean that the beds don't always line up with the need. Many cities around the country report an inability to fill existing shelter beds while others report on a shortage of beds.

The homeless population comes frequently into contact with the criminal justice system. Formerly incarcerated people are 10 times more likely to be homeless than the general public, and in many cities around the country, homelessness is grounds for arrest (see **Homeless Rate Nearly 10 Times Higher For Former Prisoners**). While there isn't a clear national picture on how many homeless people face arrest, a quick look around the country finds some patterns. Last year most arrests in Portland, Oregon were for homelessness—a group that counts for 3% of the population, but 52% of arrests. And in Los Angeles earlier this year, the LAPD received criticisms for its 10% increase arrests of homeless people, which included 14,500 misdemeanor arrests and 6,400 felony arrests. And in Colorado, 30% of all citations that Grand Junction issued are related to an anti-homeless ordinance.

As Mr. Louis explained, there needs to be better coordination among law enforcement, mental health provider organizations, and social service agencies.

I don't see a decrease in legitimate misdemeanor or felony arrests anytime soon. As thousands of homeless people live in the streets of the Greater Los Angeles area, law enforcement officers have taken on a dual role as peace officer and social worker. As an active duty reserve police officer in East Los Angeles, I have seen law enforcement officers increasingly involved in finding assistance for the homeless. Surprisingly a very large number of homeless people refuse all services making it difficult for local municipalities to address the problem. Arrests for sleeping in public places seems to be deceasing as the right to be homeless is a more common theme with surrounding city government officials.

Executives in health care organizations may think this is a discussion without great relevance for them, but the data is clear that lack of stable housing drives up health care costs. Data show that mortality rates for the homeless are three time greater than the general population. And when a consumer who is high utilizer of health care services gains supportive housing, average hospital cost savings are $3,022 per person per month, or 86% of prior costs (see **Is Housing Health Care?**)

Hopefully with increased coordination between law enforcement, mental health, and social service agencies there will be increased access to stable living arrangements and access to other essential services that will result in less crime and fewer arrests.

What is a Strengths-Based Approach to Mental Health?

Healthy Place Newsletter

You are not your mental illness, nor does your illness define who you are and how you live your life. A strengths-based approach to mental health recognizes and embraces these facts.

"Strengths" is a concept that encompasses many aspects of who people are. Strengths include character traits, talents, and abilities. When you recognize, develop, and use them, you can take forward action and be who you are. You are empowered to **live well in spite of mental illness** and other challenges.

Therapists draw from a variety of theories and techniques to help people work past mental health challenges. Some are problem-oriented and seek to uncover what is wrong. Other mental health professionals, such as strengths-based counselors, aren't as concerned with the problem as they are with what is already working and what people have within them.

A strengths-based approach to mental health leans heavily toward exploring, developing, and using your traits and abilities to transcend problems; however, that doesn't mean that strengths-based therapy never explores problems. Therapy is rarely all-or-nothing but instead uses a wide range of approaches to help people heal. Strengths-based therapy just focuses more on things within you that already work.

America's Crime Problems Are Being Fed by a Broken Mental Health System

John Snook, Treatment Advocacy Center

Severe problems are a health crisis, but they are being treated as crimes. A homeless woman freezes to death on a city sidewalk. A man with delusions is shot dead by police. A teen in psychosis murders his grandmother. These are all preventable tragedies.

America's mental health treatment system is broken, leaving those most in need to fall through the cracks. An estimated 8.3 million adults in the United States have a severe mental illness. At any given time, 3.9 million go untreated.

With medication and other support services, those with severe mental illness are no more dangerous than anyone else, capable of leading happy, productive lives. Without treatment, their prospects worsen.

Yet the odds are stacked against these individuals. Our health care system actively denies them care, and we criminalize the

symptoms of their diseases.

When someone has a heart attack, an ambulance takes them to an emergency room. When someone is in the depths of psychosis, however, police are called and frequently cart that person off to jail.

My organization is dedicated to eliminating barriers to treatment for people with severe mental illnesses—to root out systemic impediments to psychiatric care. It is a daunting challenge.

Families call us every day with heartbreaking stories. Many follow a familiar pattern. A parent notices a young adult child acting differently, growing paranoid and withdrawn. As the illness progresses, the child may hallucinate and become agitated or aggressive.

Troubled by these symptoms, parents reach out to doctors or crisis services seeking help on behalf of their loved one. However, if their child is too ill to understand the need for treatment, they are rebuffed, told that unless that child himself or herself seeks care, treatment is only available once the child becomes dangerous.

And so begins a cataclysmic cycle.

Without treatment, those with severe mental illness experience a host of negative consequences. Many take their own lives. Others face a shortened life span due to a much-increased risk for other chronic health conditions. Ultimately, those with severe mental illness die, on average, 25 years earlier than their peers.

Others are lost to the streets. Conservative estimates suggest that one quarter of the homeless population suffers from a severe mental illness. In 2017, that amounted to 138,435 individuals on any single night. Also common are arrests for so-called “quality of life” crimes like loitering and public urination—behaviors that are triggered by illness, not criminal intent.

As a result, incarceration has become the norm for those with severe mental illness. Forty percent of them are incarcerated at some point in their lives. Two million are booked into jails each year. The Treatment Advocacy Center estimates that 383,000 individuals with severe mental illnesses were incarcerated in 2016, although many belonged in hospitals instead.

But jails are the worst place to provide mental health treatment. Would-be patients are isolated. They deteriorate, are victimized and receive inadequate care. Their symptoms result in additional offenses and time behind bars. A 2018 national investigation revealed that since 2010, more than four hundred people with mental illness have died in our nation’s jails.

Others die before ever reaching a cell. According to our report, “Overlooked in the Undercounted,” at least one in four fatal law enforcement encounters involve an individual with severe mental illness. They are 16 times more likely to be killed in such an encounter than other civilians.

Law enforcement is taking steps to train its officers to defuse such situations whenever possible. But those laudable efforts are responsive measures, not preventative ones. They do nothing to answer the broader question we ignore: Why do we make law enforcement responsible for a public health crisis?

No matter how one looks at the challenges posed by untreated severe mental illnesses — whether from the perspective of would-be patients, family members, first responders or the general public — the status quo is untenable.

Yet opportunities to improve the existing mental health system abound.

First, we can and should increase the availability of psychiatric beds, now at a historic low. Even a modest increase would alleviate inhumane bed waits for people in need of inpatient care.

We must also fund a robust continuum of community support services that prevent the severely ill from reaching a crisis state, and reduce the need for a law enforcement response.

And we must make it easier to intervene on behalf of those in need. Family members and other caregivers are also victimized by the destructive symptoms of these chronic illnesses, and should have a right to seek treatment for their afflicted loved ones.

Untreated mental illness need not be an intractable problem. We can either continue to condemn families to predictable, preventable tragedies or we can provide necessary treatment to those who desperately need it. But first we must finally agree as a nation to take the treatment of severe mental illness seriously.

Veterans and Mental Health Issues

Mental Health First Aid Newsletter

It is estimated there are 19.6 million veterans living in the U. S. While military service can increase resilience in those who serve and build strength in their families, **some experience mental health issues that require support and treatment.**

The statistics surrounding veteran mental health and substance-use are troubling:

- Veteran suicide rates remain steady, despite the decreasing size of the veteran community.
- Veterans have a 41-61 percent higher risk of suicide than nonveterans.
- Veterans with a diagnosis of PTSD or another mental health disorder were more likely to receive an opioid prescription.
- The rate of post-traumatic stress disorder (PTSD) in veterans is nearly 15 times higher than civilians due to exposure to events like military combat, assault and disasters.
- The rate of depression is five times higher than among civilians.
- Almost a quarter of all women veterans experienced military sexual trauma, compared to 4% of male veterans. More than half of all women and more than a third of all men experienced sexual harassment in the service.
- Only 50 percent of returning veterans receive mental health treatment.

Stepping back from the brink of burnout: How I'm tackling the epidemic of physician suicides

USA Today

Night after night, after just a few hours’ sleep, I woke with a pounding heart and profound exhaustion. As a physician, I recognized the signs of extreme stress and realized that I was pushing myself dangerously close to the edge, putting myself at risk for a heart attack, stroke or worse.

The escalating stress set in months after I threw myself into a demanding new role — one that inspired me but that also

heightened my workaholism that, unchecked, took over my life. Consumed by the responsibilities of my new role and dealing with the grief of losing my mother after a prolonged battle with dementia, I disengaged from friends and loved ones, stopped exercising, and couldn't escape the constant pressure I felt. Yet I kept pushing to honor my commitments.

As the physical manifestations of stress intensified, I realized that if I didn't change, I would lose those things most dear to me — including, possibly, my life.

Fortunately, I was among the lucky ones who recognized the need to pull back from the brink of burnout. My personal experience heightened my awareness of the need to embrace and advocate for physician wellness.

Increased stress, decreased support

Many colleagues in health care drive themselves beyond exhaustion and into depression, putting them at increased risk of suicide. Celebrity suicides sparked a national conversation about the complex causes that put people at risk. Meanwhile, health care is undergoing an all-but-silent epidemic: physician suicides.

An estimated 300-400 physicians in the United States take their own lives each year. Suicides among male physicians are 40 percent higher than the general population, and among female physicians a staggering 130 percent higher.

Physicians today experience far greater stress than when I began my practice in 1984 as a family medicine physician. Very long hours, complex and oftentimes inefficient systems and time-intensive responsibilities including maintaining electronic health records, diagnostic coding and regulatory compliance all take their toll.

Compounding these stressors are attributes shared by many physicians: self-sacrifice, hyper-accountability, perfectionism, challenges with setting boundaries and the perception that asking for help is a sign of weakness. Taken together, these stresses too often lead to burnout.

I have attended funerals of colleagues lost to suicide and looked into the heartbroken eyes of loved ones dealing with indescribable loss. At least two of my medical school classmates succumbed to suicide before we finished our residencies. I say "at least" two because the nature of such losses is not always clear. Such is the stigma associated with suicide. Acknowledging suicide and its causes is essential if we are to save the lives of those who save lives.

Lightening the load of doctors

Personally, acknowledging my health was at risk was the first step to combating burnout. The second step was to prioritize measures that would lead me to wellness. I started with sleep. With more rest, I felt better, could think more clearly, had renewed optimism, greater resilience and more energy. Recognizing the importance of exercise, I doubled down on adding steps to my day. I incorporated more plants into my diet. I downloaded an app and began practicing gratitude. I sat down with my family and told them that I was sorry for not having been there for them in the ways they needed me.

They have been terrifically supportive. Each day when I got home, I turned off all devices for at least two hours to be truly present with my loved ones. Over time, these changes led me to a much better place.

Professionally, I advocated for physician wellness. In 2013, I appointed a physician chief wellness officer to the Southern California Permanente Medical Group, the physician-led medical group that provides care for 4.5 million Kaiser Permanente members in Southern California.

To minimize daily burden for physicians, we launched a voluntary training program on how to optimize use of electronic systems. Colleagues say this saves them up to an hour a day. To provide better work-life integration, we offer physicians greater options for flexibility, including potentially reducing their hours by up to 50 percent.

Removing the stigma associated with mental health challenges — especially in the medical community — is critical. If we see a physician struggling, we provide resources to help them, including peer-to-peer support groups and education about mindfulness, meditation, the importance of sleep, exercise, stress management and nutrition. Because of these efforts, physician ratings of key workplace "culture of health" measures in our medical group improved by a range of 11 percent to 23 percent, compared with ratings three years earlier.

Through the planned Kaiser Permanente School of Medicine in Pasadena, we plan to establish a learning environment and curriculum that supports, teaches, and models well-being and resilience — skills and techniques that students can employ throughout their lives.

Colleagues say that sharing my own story, bringing burnout into the open, and making physician wellness a priority have inspired them to improve their own well-being. More than one physician has said that because of our efforts, they sought help. This is progress, but we have more work to do.

By transforming inefficient systems, building supportive communities, and offering wellness solutions we can help to reconnect physicians to the meaning, purpose and joy of medicine.

Edward M. Ellison is executive medical director and chairman of the board of the Southern California Permanente Medical Group. He is the co-CEO of The Permanente Federation, LLC.

Psychiatry's Ancient Origins

Psychiatric Times

When did psychiatry begin? Was it with the discovery of the unconscious? Or was it the discovery of neurotransmitters? As it turns out, healers have been treating mental disorders for thousands of years. Modern psychiatry reflects some, but not all, the values and concepts held by early civilizations. Ancient Greek, Indian, Chinese, Egyptian, Hebrew, European, Arabic, and other cultures explored dimensions of mental and physical health and disease. In the Group for the Advancement of Psychiatry's (GAP) 2018 most recent installment in our series of videos on the history of psychiatry, the Committee on Arts & Humanities explores how mental illness was understood from post-stone-age cultures through the Middle Ages.

Early civilizations relied on shamans, sorcerers, magicians, mystics, priests, and other approved healers to treat illnesses. Using rituals, incantations, and offerings, sickness could be prevented or healed. Somatic therapies, not unlike neurosurgery, can be inferred from archeological findings from France (6500 BCE) and China (5000 BCE). For example, skeletal remains of children with marked skull abnormalities and traumas suggest the ways in which humans cared for mentally impaired children 77,000 years ago.[1]

Some ancient peoples believed diseases occurred due to loss of the soul. Shamans entered into trances or altered states of consciousness, enabling their souls to journey into spirit worlds, sometimes into the underworld.[2] During the journey, shamans connected to souls of the dead and to living souls that had strayed or been stolen. Interacting with demons and lost souls without losing their own souls, they brought about cures. The shaman acted as both priest and healer.

In Classical Greece (fifth century BCE), philosophers taught "naturalism," the belief that laws of nature shape our world, as opposed to gods and demons determining human fate. Alcmaeon, for example, believed the brain, not the heart, was the "organ of thought."[3] He tracked the ascending sensory nerves from the body to the brain, theorizing that mental activity originated in the CNS and that the cause of mental illness resided within the brain. He applied this understanding to classify mental diseases and treatments.

Hippocrates developed a theory of chemical imbalance based on four humors: black bile, yellow bile, phlegm, and blood. Disease resulted from disproportions among the humors. His thinking influenced the practice of medicine for 2000 years.[4] Today the term melancholia (too much black bile) is still in use. Hippocrates may have been "wrong" by current scientific thought, but theories of "chemical imbalance" remain.

In India, the ancient textbook on Yoga Sutra describes dynamics leading to health and illness.[5] In later centuries, the external causes of mental illness were attributed to patients' sins committed during current or previous lives. For example, disregarding important deceased persons, superhuman agents, ghosts, deities, and celestial beings could bring about various symptoms, depending on which spirits were offended.

Chinese texts from 3000 years ago mention neuropsychiatric illness, including descriptions of mania and psychosis with or without epilepsy. "Imbalance" was the mechanism of psychosis. Other conditions described include confusion, visual illusions, intoxication, stress, and even malingering. Psychological theories about stages of human development can be traced to the time of Confucius, about 2500 years ago.[6]

During Europe's Middle Ages, the focus of theories about mental illness shifted back from physiology to spirituality. As Christianity spread, ideas about sin dominated, and the "psychotherapists" of the era were priests rather than physicians. The notion of demons in the Old Testament continued into the writings of the New Testament. Demonic possession remained a basic assumption. Christian physicians embraced some of the old beliefs of the Greeks and Romans, however, the natural therapy of the Greeks was lost as treatment turned to astrology, alchemy, theology, magic rites, and exorcism.

Preoccupation with witches raged throughout the seventeenth century. Tens of thousands of suspected witches, mostly women, were killed. Those accused of witchcraft included individuals who exhibited aberrant behaviors that today would be considered examples of mental illness, while some had no symptoms.[7]

The interplay between supernatural and natural thinking can be seen across ancient cultures. Mental health practices continued to progress and regress throughout the centuries, eventually including the idea of dedicated institutions for the care of the mentally ill. Tensions among culture, religion, and science will continue to shape concepts about the treatment of individuals with mental illnesses. Studying psychiatry's origins and evolution gives us perspective on our own beliefs and practices.

BENEATH THE SURFACE OF BRUCE SPRINGSTEEN

For more than fifty years, he's traveled deep into the heart of America. But with his new Netflix special—a film of his intense, powerful one-man show on Broadway—Bruce Springsteen reveals that his bravest journey has been wrestling with his own mental health.

Excerpts from Esquire magazine

That evening, Springsteen is weeks from notching his sixty-ninth birthday. And as we stand there, I find it impossible not to think that the journey he has undertaken in this decade of his life has been nothing short of miraculous. He entered his sixties struggling to survive a crippling depression, and now here he is approaching his seventies in triumph—mostly thanks to the success of this powerful, intimate show, which is not a concert but an epic dramatic monologue, punctuated with his songs. After a year of sold-out shows, he will close it out on December 15, the same night it will debut on Netflix as a film.

He's a deep listener and acts with intent. He has a calm nature and possesses a low, soft voice. He has a tendency to be self-deprecating, preemptively labeling certain thoughts "corny." He smiles easily and likes to sip ginger ale. Sometimes before telling you something personal, he lets out a short, nervous laugh. Above all, he speaks with the unveiledness of a man who has spent more than three decades undergoing analysis—and credits it with saving his life.

Springsteen's first breakdown came upon him at age thirty- two, around the time he released *Nebraska.* It is 1982, and he and his buddy Matt Delia are driving from New Jersey to Los Angeles in a 1969 Ford XL. On a late- summer night, in remote Texas, they come across a small town where a fair is happening. A band plays. Men and women hold each other and dance lazily, happily, beneath the stars. Children run and laugh. From the distance of the car, Springsteen gazes at all the living and happiness. And then: Something in him cracks open.

As he writes, in this moment his lifetime as "an observer . . . away from the normal messiness of living and loving, reveals its cost to me." All these years later, he still doesn't exactly know why he fell into an abyss that night. "All I *do* know is as we age, the weight of our unsorted baggage becomes heavier . . . much heavier. With each passing year, the price of our refusal to do that sorting rises higher and higher….

Long ago, the defenses I built to withstand the stress of my childhood, to save what I had of myself, outlived their usefulness, and I've become an abuser of their once lifesaving powers. I relied on them wrongly to isolate myself, seal my alienation, cut me off from life, control others, and contain my emotions to a damaging degree. Now the bill collector is knocking, and his payment'll be in tears."

That breakdown sent him into analysis. It—and the work he did on himself—transformed his life. He became the man he yearned to be but hadn't known how to become. Springsteen's desire to share his demons, and to argue for the need he believes all of us have to confront our own—this is one of the show's great powers.

Nearly a decade after that night in Texas, Springsteen is at his home in Los Angeles. He's living with Patti Scialfa, and they are days away from welcoming their first child, Evan. It is early morning, and there is a knock on the door: his father.

Springsteen invites him in, and he and his father sit at the table. It is here, in his home, that his father tells him, "You've been very good to us." Springsteen has no words. He can only nod. Then his father says, "And I wasn't very good to you."

"It was, the greatest moment in my life, with my dad. And it was all that I needed…. Here in the last days before I was to become a father, my own father was visiting me, to warn me of the mistakes that he had made, and to warn me not to make them with my own children. To release them from the chain of our sins, my father's and mine, that they may be free to make their own choices and to live their own lives."

Late in his father's life, Springsteen received an answer that gave him even deeper insight. He learned that all those nights Doug Springsteen sat alone, brooding, silent, in the dark of that kitchen, he was a man lost. A man who would be diagnosed as a paranoid schizophrenic. The diagnosis gave Springsteen context to his boyhood. But it also gave him a new fear.

As Springsteen confesses to me, "I have come close enough to [mental illness] where I know I am not completely well myself. I've had to deal with a lot of it over the years, and I'm on a variety of medications that keep me on an even keel; otherwise I can swing rather dramatically and . . . just . . . the wheels can come off a little bit. So we have to watch, in our family. I have to watch my kids, and I've been lucky there. It ran in my family going way before my dad."

Twenty years ago this past spring, his father died at age seventy-three in hospice.

Is there anything your father never said to you that you wish he had said? Were there any words unspoken?

"Well," Springsteen says, "he never said, 'I love you."
Never?
"Nope. He never got around to it."
Not even when he lay dying?
"Nope."
Does that hurt you?
Springsteen pauses again and looks back toward his mirror. Then: "No. Because (a) I know he did. And (b) it just wasn't in his repertoire. So he showed me he did, on many occasions. And so that was fine. My father was so nonverbal that . . . he cried whenever he left. When you'd say, 'I gotta go now, Dad'—*boom!*—tears. Later in his life, the last ten years, he was very visibly emotional."

In the show, Springsteen plays many moments for laughs. He's a natural actor, with a gift for landing a line or milking a moment. He's also good at building the intensity of a story—or, if he has to, deflating it, as he does at one point when he shifts gears for an intense stretch and jokes, "I'm going to release you from suicide watch right now."

But as I prepare for our final meeting, I find myself thinking he may be hiding in plain sight. I think about his description of his second breakdown, which descended upon him a few years after he turned sixty. It was a darkness that lasted on and off for three years; it was, he writes, "an attack of what was called an 'agitated depression.' During this period, I was so profoundly uncomfortable in my own skin that I just wanted OUT. It feels dangerous and brings plenty of unwanted thoughts. . . . Demise and foreboding were all that awaited."

It is the writing of a man desperate to escape profound pain. So when I see him, I ask: Have you ever attempted to take your life? "No, no, no."
But have you ever contemplated suicide?

"I once felt bad enough to say, 'I don't know if I can live like this.' Feelings became so overwhelmingly uncomfortable that I simply couldn't find a twelve-by-twelve piece of the floor to stand on, where I could feel a sense of peace on." As he tells me this, he brings his hands up to either side of his face, framing it like blinders on a horse, as though trying to conjure that small square of safe space.

"I had no inner peace whatsoever. And I said, 'Gee, I really don't know. I don't know how long I could . . .' It was a manic state, and it was just so profoundly emotionally and spiritually and physically uncomfortable that the only thing I've ever said was 'Gee, I don't know, man . . .' It gave me a little insight into . . ."

Springsteen's voice trails off and he slowly lets his hands fall into his lap. For a moment, neither one of us says anything. Then I break the silence and ask: Did you think you should be hospitalized?

"No one was *saying* that I should be . . ." Springsteen gives me a wry smile. "I had a couple very good doctors. But, unfortunately, it was August. That's when they all take off." Springsteen lets out one of his short, raspy laughs. "All I remember was feeling really badly and calling for help. I might have gotten close to that and for brief, brief periods of time. It lasted for—I don't know. Looking back on it now, I can't say. Was it a couple weeks? Was it a month? Was it longer? But it was a very bad spell, and it just came…."

And when you see someone like Anthony Bourdain, can you understand how that happens?

"Well, I had a very, very close friend who committed suicide. He was like an older son to me. I mentored him. And he got very, very ill. So, ultimately, it always remains a mystery—those last moments. I always say, Well, somebody was in a bad place, and they just got caught out in the rain. Another night, another way, someone else there . . . it might not have happened." He pauses. "They were ill, and they got caught out in the rain…. I don't know anyone who's ever explained satisfactorily the moments that lead up to someone taking that action. So can I understand how that happens? Yes. I think I felt just enough despair myself to—pain gets too great, confusion gets too great, and that's your out. But I don't have any great insight into it, and in truth, I've never met someone who has."

I ask if he has spent his life trying to love that boy his father denied.

"Those were big moments that I had through my analysis. I saw myself as a child and experienced my own innocence and realized, Oh my God, I was so fragile. I was so easily broken and dismissed. My father taught me to hate that person. So it took me quite a while to come back around and make my peace with who I was. That was a lot of what I was doing through my playing—trying to come to a place where I could just stand myself. [*Laughs*] It was just developing a self that allowed me to live with myself in a way that a lot of the self-loathing didn't allow. That's just a part of my DNA. I do a lot better with it now, but it's an ongoing struggle.

ProPublica/Frontline/The New York Times: Living Apart, Coming Undone - Adult home residents are given a subsidized apartment, called scattered site supported housing, and assigned a team of social workers and others to help navigate bureaucracies, housing problems and everyday tasks. But more than 200 interviews and thousands of pages of medical, social work and housing records reviewed by ProPublica and the PBS series Frontline, in collaboration with The New York Times, show that for some residents, the sudden shift from an institution to independence has proved perilous, and even deadly. (Sapien and Jennings, 12/6)
https://features.propublica.org/supported-housing/new-york-mentally-ill-housing-group-homes/

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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

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