Greater Des Moines

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

June 2019

511 E. 6th St., Suite B, DM 50309
www.namigdm.org
Mental Health Education, Support and Advocacy

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Serving Polk, Dallas, Warren, and Madison counties

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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*

NAMI Greater Des Moines Fundraisers – 2019

The Walk was one of two fundraisers NAMI GDM has had for several years - to support the costs of our mental health education, support, wellness and advocacy programs for residents of Polk, Dallas, Madison and Warren Counties

Due to circumstances beyond our control, NAMI Greater Des Moines cannot participate in the NAMI Walk in 2019.

With your support and commitment over the past year, **NAMI Greater Des Moines served 45,888 individuals** in our community. Your contribution made a significant improvement in the lives of these individuals, as well as their friends and family. People like you make our community a better place and we're so grateful for your contribution.

Our primary fundraiser in 2019 will be the celebration of the **4th Annual NAMI Greater Des Moines Benefit Golf Tournament on Friday, September 13, 2019.**

There are many opportunities to participate in and support the tournament. **100% of net proceeds from the Benefit Golf Tournament are used to support our friends and neighbors through NAMI Greater Des Moines' programs.**

Sponsorship levels for the Golf Tournament: $15,000, 10,000, $5,000, $3000, $2000, $1500, $1000, $500, $250 and $200.

More details will be forthcoming. There will be a maximum of 36 4-person golf teams. Per person cost is $85 and a 4-person golf team will be $340.

Social Security

Justice in Aging

Last month the Board of Trustees released its 2019 Social Security Trustees Report. The report provides an annual assessment of the health of the Social Security program's finances. Social Security has two trust funds — a trust for retirement and survivors' benefits, called the Old Age and Survivors (OASI) trust, and another trust for disability insurance (DI).

The report finds that the Social Security DI trust fund is now projected to be fully funded another 33 years, until the year 2052. This projection is 20 years longer than what was estimated just last year, and is a result of years of declining DI applications and disability beneficiaries.

The Trustees' Report also finds that the retirement and survivors trust fund will be fully funded until the year 2034, after which it will be able to pay individuals approximately 77 percent of the benefits they are owed over the next 75 years.

While it is comforting to know that Social Security is around for the long haul, any decrease in benefits will cause serious harm to the people who rely on Social Security for their income as they age. It is critical that Congress passes legislation to fully fund Social Security, as well as to increase benefits so that low and middle-income workers and their families are not left at or near poverty after decades of work. This means making decisions now about how to shore up the trust funds for the future.

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 Gov in 2015 Mt. Pleasant MHI closed by Gov 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
64 beds for youth, the rest 36 for adults, downtown beds switch to all for adults
Equals a proposed new total of 1053. (shortage of 497 remains)

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.

Some of the Services Built in the Regions as of 9-30-18	In operation	Planning stage
Jail Diversion (# of counties)	66	25
Crisis Services Being Built		
Mobile Crisis Response (# of counties)	41	32
23 hr Crisis Observation beds (# of Beds)	50	3
Residential Crisis Beds – 3 to 5 day stay - (# of beds)	85	19
24 hour crisis line	11	1
Adult Complex Needs Services		
ACT teams	11 teams 33 co's	11 co's
# of Subacute Beds	9	16
Intensive Residential 24/7 Service Homes (# of beds)		1
Access Centers (# of regions)		5
Tertiary Care beds (long term beds for highly complex individuals)		

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**

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

Substance Abuse and Co-Occurring Information

8% of our population has Substance Abuse Disorder or around 248,000 people

23 of 120 substance abuse providers programs in Iowa 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.

Find a complete list of substance abuse providers at:
https://idph.iowa.gov/substance-abuse/treatment

Iowa Crisis Chat
Chat: iowacrisischat.org
Call:1-855-325-4296
Text:1-855-325-4296

House of Mercy *(Co-occurring treatment, residential for women)* 1409 Clark Street, Des Moines (515) 643-6500
Mercy One House of Mercy provides mental health counseling and psychiatric services

In 1955 – we had 4 mental health institutes and 5300 beds
In 2019 – we have 2 mental health institutes and 96 beds
In 1955 – we had 3 prisons with around 2200 inmates
In 2019 – we have 9 prisons with around 8525 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 April 2019	In Process	# on waiting list
Aids/HIV	31	2	0
Brain Injury	1457	310	1245
Children's Mental Health	988	526	1062
Elderly	7806	2120	0
Intellectual Disability	12,242	1008	2552
Health and Disability	2318	600	3261
Physical Disability	1002	641	1033
Total	**25,844**	5207	**9153**

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 2019, 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.

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.

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.

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.

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

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.

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.

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.

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 reserve-tion, 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

Caremore Clinic – for Amerigroup clients

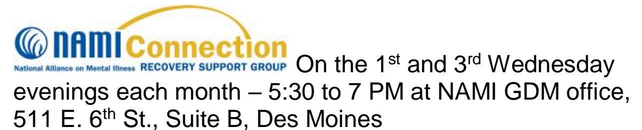
CareMore Clinic offers medical and behavioral health services for patients on Medicaid w/Amerigroup Insurance ages 14& up. CareMore cares about their patient’s body, mind and spirit. The Clinic is located at 1530 East Euclid Avenue, Des Moines, Iowa 50313 (515) 989-6001.

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

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



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

First Tuesday evening of the month, 7:00pm. 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

If you have an emergency, always
CALL
9-1-1

The Mental Health Mobile Crisis Team

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 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 Mobile Crisis 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.

Emergency Calls: 911
Non-Emergency Calls: 515-283-4811

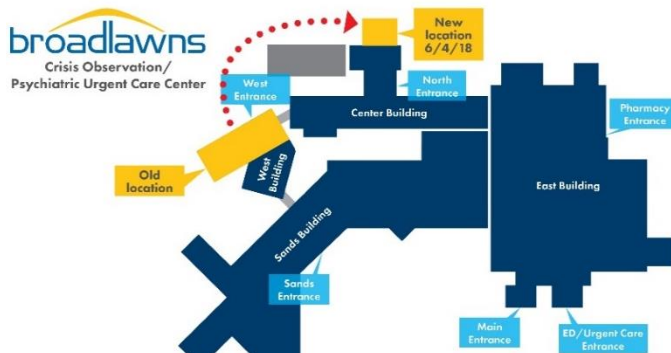
Be clear with the dispatcher what the situation is, that it is a mental health crisis, and request the Polk County Mobile Crisis Response Team to assist. In response to your phone call, the first people to arrive to the situation will be police officers. Officers will determine if it is a mental health 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 police liaison to the Mobile Crisis Team is Officer Lorna Garcia. Her hours are 8 to 4 Mon-Fri - phone is 205-3821.

Psychiatric Urgent Care Clinic for Adults: The Broadlawns Psychiatric Urgent Care will accept walk-in appointments for individuals 18 years of age or older who are experiencing an exacerbated mental health condition. Services at the clinic include mental health assessments, medication management, therapeutic counseling and coordination of services for healthcare and basic needs. Those individuals in urgent need will continue to be able to access services and stay in the Crisis Observation Center up to 23 hours.

Clinic hours are Monday through Friday from 9 am to 7 pm.
Located at Broadlawns Hospital (1801 Hickman Rd in DSM – West Entrance)
Phone: 515-282-5742

The Crisis Observation Center: 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. **Phone: 515-282-5742**
Crisis Observation Center is open 24/7.
Located at Broadlawns Hospital (1801 Hickman Rd in DSM – West Entrance) - See map for new location



Broadlawns Crisis Team: Provides comprehensive emergency mental health services including assessment, triage, crisis intervention, and discharge planning. Services are available by phone or in person through our Emergency Department. In addition to being the initial contact to the Inpatient Psychiatric Unit, the crisis team assists clients in finding the programs and services that are the most appropriate for their needs.
For assistance 24 hours a day, call 515.282.5752

The Pre-Petition Screener Service **The Pre-Petition Screener Service:** 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 prefer-able. 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 Monday-Friday 8:30am to 4:30pm.
Located at the Polk County Justice Center (222 5th Avenue in DSM)
Phone: 515-336-0599 (direct line) or 515-282-5742 (main office)

Broadlawns Community Access 515-282-6770

Mercy Medical Center: Mercy Behavioral Health provides hope and help for individuals struggling with mental health illness and substance abuse problems.

The mental health and substance abuse programs are available to help people of all ages and include emergent/urgent assessments, crisis management support, professional consultations and referrals.

Access to treatment is available 24 hours a day, seven days a week by calling the Mercy Help Center at *515-271-6111 or toll free 800-595-4959*
Located at 1111 6th Ave in DSM
Phone: 515-271-6111

Unity Point: A continuum of mental health services and treatment to meet the needs of children and adults via psychiatric acute care units & outpatient services.
Located at 700 East University Ave in DSM
Emergency Services: 515-263-5120
Adult Services: 515-263-5249
Adolescent Services 515-263-2368
Children's Services: 515-263-5153
Powell Chemical Dependency Center: 515-263-2424

Crisis Services in Dallas County

24/7 Crisis Line – 1-844-428-3878

Mobile Crisis Response Team: Provides short term crisis assessment and intervention to individuals of all ages who are experiencing a mental health crisis. Individuals are assessed regardless of insurance status.

The Mobile Crisis team can be contacted though 911 or local law enforcement dispatch offices. 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.

For assistance 24 hours a day, call 911 or the local law enforcement dispatch office
Covers Dallas, Guthrie, Greene and Audubon Counties

Hope Wellness Center: A safe place where individuals who are experiencing a mental health crisis can voluntarily access crisis intervention services.
Hope Wellness Center is open 24/7
Located at 706 Cedar Avenue in Woodward
Phone: 515-438-2331

Hope Wellness Center Transitional Living Services: Provides short term (2-3 month) housing for individuals coming out of a placement or hospitalization who need to redevelop skills needed to be successful in the community. Individuals who are living with mental health conditions or disabilities will be paired with a variety of service providers to assist them to reach their highest levels of independence.

Phone: 515-438-2331

Crisis Services in Warren County

For emergency situations always call **911**
Website:
http://cicsmhds.org/services/crisis-services/

24/7 Crisis Line: **1-844-258-8858**
Provides support on the telephone, day or night, for people looking for immediate help with their emotions or mental health.

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.

Mobile Crisis Response: Teams of professionals 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.
To access mobile crisis response, call the Central Iowa Crisis line 24/7 at 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.

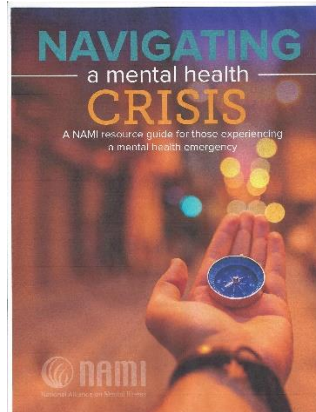
There is a booklet - "Mental Health Resources in Warren County".

Crisis Services in Madison County

For emergency situations always call 911.

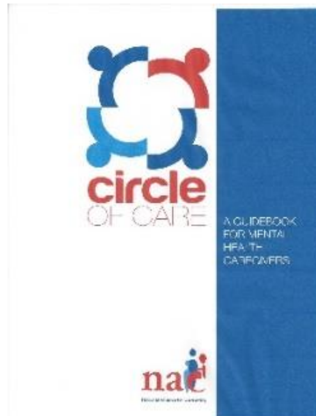
Website:
http://www.madisoncoia.us/offices/comservices/index.htm
For more information about the CICS Mental Health and Disability Services Region, go to: **http://cicsmhds.org/**

Mobile Crisis Response: Teams of professionals 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.
To access mobile crisis response, call the Central Iowa Crisis line 24/7 at 844-258-8858

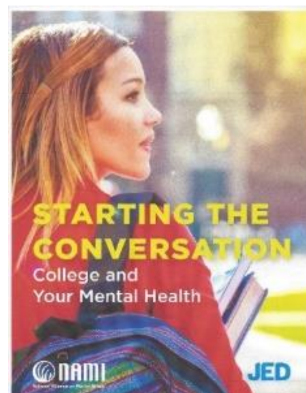


Navigating a Mental Health Crisis

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



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



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

Click on "Resources",
Click on "School Resources"
Download a copy

The Child Mental Health Gap—More Prevalence, Less Treatment, More Opportunity?

Open Minds

First, there is an increase in prevalence in mental and developmental issues among children and youth.

- The rate of adolescents who reported experiencing symptoms of major depressive disorder increased by 52% between 2005 and 2017.
- Among young adults ages 18 to 25, the rate of those reporting symptoms of major depression increased by 63% from 2009 to 2017.
- Between 1997 and 2016, the prevalence of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents increased from 6.1% to 10.2% in the U.S.

What has lead to this increase in prevalence? The studies cited offer different explanations:

- an increased use of technology;
- increases in sleep disruptions, which may play a role in mood disorders;
- an increase in awareness, which may lead to more screenings and diagnoses;
- and other environmental and other prenatal and perinatal risk factors.

At this point in time, most research cannot offer a definitive conclusion.

Then, there is the access issue. A recent analysis found:

- 16.5% (7.7 million) of the 46.6 million children in the United States, ranging from ages 6 to 17, have a mental health condition.
- Of these 7.7 million youth, about 3.81 million (**49.4%**) have not received treatment or counseling from a mental health professional.
- About 11.6% of school-aged children in the United States diagnosed with ADHD had unmet treatment need.
- Approximately 30.7% of students with ADHD receive no school-based intervention services.

The lack of community-based mental health care may be leading to over utilization of emergency resources.

Recent findings presented at the American Academy of Pediatrics National Conference & Exhibition also showed:

- Pediatric emergency department (PED) visits for mental health problems increased by **55.8%** between 2012 and 2016—from **50.4** PED visits per 100,000 children in 2012 to **78.5** PED per 100,000 in 2016.
- The rates of PED visits were significantly higher among black children than non-Hispanic white children.

There are some more tangible factors explaining the treatment gap:

- There is general lack of awareness and stigma about mental health issues.
- There are high rates of unaddressed trauma in the lives of children in the juvenile justice and foster care systems.
- Unaddressed mental health stigma, especially in culturally diverse neighborhoods, leads to parents, caregivers, and communities being less receptive the treatment.
- There is a shortage of sufficiently skilled mental health professionals to meet demand throughout the country—these shortages may result in regional disparities and reduced access treatment services, particularly in rural areas and in poorer communities. These shortages are fueled by the limited cultural expertise in culturally diverse neighborhoods among most provider organizations and clinical professionals.

Finally, there are systemic issues.

- A lack of care coordination throughout the systems of care—school, physical health services, mental health services, social support services—that serves children and their families makes it difficult to develop a treatment plan.
- There are significant costs associated with providing a full range of services, especially in-low density rural areas or high-risk neighborhoods.

The researchers came to a group of slightly different opportunities:

- including renewed state policy efforts that focus on reducing the treatment burden,
- with a focus on developing child mental health policies,
- implementing prevention and early intervention strategies for transition-age youth,
- and reducing disparities for mental health care use. Specifically, for children with ADHD, these consumers may benefit from initiatives that target each consumer's specific impairments with evidence-based intervention approaches.

What are the opportunities for provider organization's serving children? The first step in this process is to determine if there are opportunities in your market. While there may be nationwide gaps when it comes to mental health need vs. treatment for children, the picture in your market may be different. The provider executive team is to first understand the market need and market attractiveness (i.e., potential for growth, competitors, reimbursement and funding potential, etc.).

- Review state policies and financing: Are there programs targeted at early intervention? How are Medicaid services for children managed and financed? What community-based funding and state program grants are available? Who are the key payers for these services?
- Monitor and analyze the potential customer base: Who are the children in need of services and what are those services? How many children are in need of services in your area? Where are there gaps in care? What do families and caregivers in your community say that they need?
- Track current competitors: What organizations are currently delivering services to children in your area? Who are their primary payers? What are their current contracts and partnerships? Who are the biggest potential referral sources?
- Talk to payers and health plans: What are their specific needs in children's services? Where have they identified gaps in their network?

Once your team understands your local market, then you can explore how your organization can fulfill that need in your community. The answers to these questions will help to point your organization in the right direction when it comes to the new service line development process. Whether its delivering more school-based services, offering telepsychiatry to reach rural and high-risk communities, enhancing cultural competency training in your current service lines to reach new communities in need, or collaborating with social service agencies to better coordinate care for children in need—the right opportunity will depend on the specific needs of your community.

Postpartum Depression
COMMON SYMPTOMS

Changes in sleep patterns

Anger/Rage

Weepiness or sadness

Difficulty concentrating

Change in appetite

Anxiety

For more information on postpartum depression, visit www.babycenter.com.

Study finds four factors that may help identify risk of postpartum depression

The Washington Post

Postpartum depression affects 1 in 7 women, according to the American Psychological Association. New research is homing in on risk factors for the severity of the condition, whose symptoms can include feelings of hopelessness, fatigue and, in rare cases, thoughts of self-harm. After surveying 507 women diagnosed with postpartum depression, researchers from Northwestern University identified four risk factors that may help doctors predict the seriousness of postpartum depression in mothers:

- education,
- the number of children a woman has,
- ability to function at work and at home, and
- depression severity at four to eight weeks postpartum.

Taking these factors into account can guide medical professionals in mental-health screenings for mothers and can inform potential treatment plans, researchers said. “This information can help us predict the severity of maternal depression, which can benefit the well-being of a mother early on,” Sheenhan Fisher, lead author of the study, told The Washington Post.

The Pay-Off of Finding and Using Insight

Gaining insight into your triggers and treatment strategies to manage mood swings takes patience and dedication, but it can payoff by helping you achieve stability.

By Karl Shallowhorn

There is a term that is used in the mental health world called “insight.” In the dictionary, insight is defined as, “the act or result of apprehending the inner nature of things or of seeing intuitively.”

For those of us living with mental illness, insight is usually something that is discovered over a period of time. For me, it took several years to get a handle on my illness; how it affected my life and what I needed to do to treat it.

Sticking with a Difficult Process - At first, this can be a really frustrating experience. The ability to know one’s triggers and symptoms can be both overwhelming and confusing at the same time. Often, we have to go through many painful situations before we learn how to act or respond to the issue at hand.

For instance, I had to learn the hard way, after a number of years, the importance of maintaining my medication regimen. I also had to learn that it wasn’t just the meds that would help me remain stable. I found that exercise greatly helped me to sleep better and that caffeine later in the day was a “no, no.” And then there were illicit drugs and alcohol, which were one of the primary things that kept me in the revolving door cycle of hospitalizations.

Truly Getting to Know Yourself - If you’ve read any of my posts before, you’ll know that I’ve been living with mental illness for a long time. A real long time. But with this time comes the knowledge of knowing “what makes me tick.” Sometimes it’s a blessing and sometimes it’s a curse. Despite this self-knowledge, I can still fall prey to behaviors that test my recovery. When I choose to shut myself off from others, my mood inevitably suffers. It’s kind of funny.

For a period of time, Sunday afternoons were tough for me. I don’t really know why. My wife, Suzy, used to call it “Sundayitis.” It sounds strange, I know, but on those days all I wanted to do was to crawl into bed and take a nap. Fortunately, I don’t deal with Sundayitis much anymore, but that doesn’t mean that I will never experience it again. I just need to be aware of how I’m feeling and take the appropriate steps to not fall into that state of inertia.

Putting Your Insight to Use - So, how can you gain insight into your condition? Well, therapy can certainly help with this. I’ve spent countless hours over the course of my years living with mental illness speaking with therapists and psychiatrists. Believe it or not, I’ve had a relationship with my current therapist for almost 25 years. I guess you could say she knows me pretty well (haha).

That said, having such a deep connection with someone on a therapeutic level can be incredibly beneficial when it comes to learning about oneself. One of the concepts behind therapy is to “hold a mirror up to oneself.” By doing so, we can see ourselves as we truly are, “warts and all”.

I actually believe everyone, whether they have a diagnosable condition or not, should have therapy at least once in their life. The value of having someone who is objective and non-judgmental and who is willing to listen can be liberating. Mind you, not everyone has such a fulfilling experience when they enter therapy. And some therapists are better than others. But it is also important to recognize that you are the one in charge. It is your recovery, after all. And if you are not getting what you need from your counselor, then it is certainly your prerogative to seek out someone else.

As I stated previously, it can take time to develop the insight necessary to get to the place you feel you need to be, but it is important to practice patience. Gaining insight is a process and it doesn’t happen overnight (but it is possible to have an “aha” moment). Once you can figure out what works in your recovery or what your triggers may be, then you’re on your way!

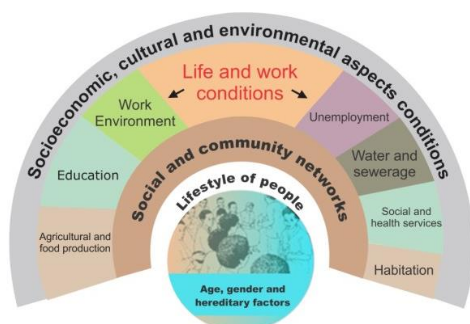
UnitedHealthcare, AMA unveil more medical codes for social determinants

Modern Healthcare

UnitedHealthcare and the American Medical Association said they want to expand the set of ICD-10 diagnostic codes to include more specific diagnoses related to a person's social determinants of health.

The hope is that these codes would allow clinicians to document patients' social determinants in a standardized way, which

would allow them to better tailor care plans or refer patients to community organizations that could meet those social needs.



"If someone has a transportation barrier and they are unable to get to their doctor's appointment or to pick up their prescription, today in the ICD-10 codes, there isn't a way to diagnose that," said Sheila Shapiro, senior vice president for national strategic partnerships in UnitedHealthcare's clinical services team. "There is no common way for the system to communicate around not only that barrier, but the solutions that can be brought to assist that individual."Today, a clinician may use medical code that identifies a patient as low-income, but that's as granular as it gets. United Health care's proposed set of codes would more specifically identify the per-son as unable to pay for transportation for medical appointments of prescriptions, for instance.

That would then tell the healthcare provider they should order prescriptions mailed to the home or possibly provide some form of transportation, explained Dr. Tom Giannulli, chief medical officer at the AMA's Integrated Health Model Initiative, which is supporting UnitedHealthcare's proposal.

Expanding diagnostic codes related to social determinants of health is another step in the healthcare industry's journey to address those factors outside of the doctor's office that often have a greater impact on outcomes than clinical care. In recent years, social determinants have become a buzzword in the healthcare industry as insurers and providers have looked for new ways to control health spending. Now insurers and health systems are moving beyond initial pilot projects to address those factors in a sustainable, scalable way.

The existing ICD-10 family of diagnostic and procedural codes includes 11 codes that identify social and environmental barriers to a patient's care, but they are broad categories. United Health Care's proposal would add 23 more codes to that list. Some of those codes would indicate a patient's inability to pay for prescriptions, inadequate social interaction, or fears about losing housing.

The founder of Socially Determined, a company that uses data to help organizations build programs to address their patients' social needs, said expanding the codes to include more specific diagnoses is a good start and an opportunity to better document social risk factors among a population.

It also could prompt more discussion among stakeholders about providing reimbursement that is risk-adjusted based on a patient's social determinants, Williams said. Some groups, including the National Academy of Medicine and the Medicare Payment Advisory Commission, have explored the feasibility of adjusting Medicare payments for socioeconomic status. Congress has also commissioned reports on the subject. But so far Medicare payments remain unadjusted for social factors.

UnitedHealthcare presented its recommendation to expand the codes at the ICD-10 Coordination and Maintenance Committee meeting in March. Following a 60-day comment period, the committee will determine whether to act on UnitedHealthcare's recommendation in the early summer. The new codes would be available to use as early as 2020, if the committee approves.

Why Home-Delivered Meals Benefit Those Struggling With Behavioral and Mental Health Issues

Mom's Meals – Nourish Care - March 5, 2019

The concept of delivering nutrient-rich meals directly to people who most need them, in an effort to decrease overall healthcare spending, has gained considerable momentum over the past several years.

Those who have benefited the most include:

- adults aging at home,
- people with disabilities remaining independent at home,
- people recovering after discharge from the hospital, and
- people struggling to manage one or more chronic conditions—like diabetes, heart disease, cancer and obesity.

However, there is another group who may benefit greatly from programs like these: individuals with behavioral or mental health issues.

Behavioral health issues (including substance abuse and addictions) and mental health issues (such as depression, bipolar disorder and schizophrenia) are among the costliest conditions to manage.

The Agency for Healthcare Research and Quality reported that mental health and substance abuse cases accounted for **1 in 8** emergency room (**ER**) **visits** in the U.S. in 2010.

According to the Centers for Disease Control and Prevention (CDC) **one in five** American adults will experience a mental illness in a given year, and **one in 25** American adults currently lives with a serious mental illness.

The Substance Abuse and Mental Health Services Administration (SAMHSA) published that in 2014, nearly **eight million** American adults battled both a mental health disorder and a substance use disorder, or **co-occurring disorders**.

Here's where nutrition comes in. A common symptom characterized by behavioral and mental illnesses is a major change in eating habits.

Someone with depression or anxiety may experience a decrease or an increase in appetite and may skip meals or overeat for emotional comfort. Alternately, people suffering from these and other conditions may feel too distracted or fatigued to prepare and consume healthy meals and snacks. Whether under- or over-eating, both scenarios can lead to poor nutritional status—which, in turn, can affect one's mental health.

In addition, when someone has not eaten or is malnourished, his or her medications may not be optimally absorbed or may cause controllable side-effects—such as stomach upset, which can impact medication efficacy and adherence.

Further, nutritional imbalances have been linked to depression. For example, vitamin B-12 and other B vitamins play a role in producing brain chemicals that affect mood and other brain functions. **Low levels of B-12 and other B vitamins, such as vitamin B-6 and folate, may be linked to depression**." As another example, **persons with bipolar disorder are believed to have lower levels of the chemical messenger serotonin, which can spark a craving for carbs and sweets.**

Research studies have provided evidence of a strong link between mental illness, mental health and physical health—especially as it relates to chronic disease occurrence, course and treatment. For example, depression has been shown to affect the occurrence, treatment and outcome of several chronic

diseases and conditions, including heart disease, diabetes, hypertension, cancer and obesity. (Chapman DP, Perry GS, Strine TW. **The vital link between chronic disease and depressive disorders. Prev Chronic Dis. 2005;2(1):A14**

The likelihood of depression increases with an increasing number of chronic conditions. Emerging evidence shows that positive mental health is associated with improved health outcomes. Researchers found a link between an upbeat mental state and improved health—including lower blood pressure, reduced risk for heart disease, healthier weight, better blood sugar levels and longer life.

A critical factor associated with both mental health and diet is **poverty**. A person's mental health, and many common mental disorders, are shaped by various social, economic and physical environments throughout different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality, the higher the inequality in risk (Jessica Allen, Reuben Balfour, Ruth Bell & Michael Marmot (2014) Social determinants of mental health, International Review of Psychiatry, 26:4, 392-407, DOI: 10.3109/09540261.2014.928270)

Medicaid plays a key role in covering and financing behavioral health care. In 2015, Medicaid covered:

- 21% of adults with mental illness,
- 26% of adults with serious mental illness (SMI), and
- 17% of adults with a substance abuse disorder (SUD).
- In comparison, Medicaid covered 14% of the general adult population.
- On a per-enrollee basis, average Medicaid spending for people with behavioral health diagnoses was nearly four times what it was for enrollees without these diagnoses ($13,303 versus $3,564).
- Medicare Advantage plans are also strongly impacted. Medicare plans pay for approximately 14% of mental health costs.

It's clear that individuals struggling with behavioral and mental health issues require **holistic programs of care**. Addressing nutrition, along with food access through a fully prepared meal-delivery program, can help optimize member engagement, clinical outcomes and overall cost of care.

Excellent SAMHSA publications focused on Adolescents as the Target Audience (good for parents, too)

Tips for Teens: **Meth**amphetamine
https://store.samhsa.gov/system/files/pep18-03.pdf

Tips for Teens: **Inhalants**
https://store.samhsa.gov/system/files/pep18-04.pdf

Tips for Teens: **Cocaine**
https://store.samhsa.gov/system/files/pep18-01.pdf

Tips for Teens: **Heroin**
https://store.samhsa.gov/system/files/pep18-02.pdf

Underage Drinking: Myths vs. Facts
https://store.samhsa.gov/system/files/sma18-4299.pdf

Medical School – Medical Residencies – Physician Workforce

Modern Healthcare Excerpts 5-6-19

With limits on how many GME slots in physician residencies Medicare will cover, hospitals find themselves taking on a growing percentage of the burden to fund their GME programs. That has forced those providers to make some difficult business decisions.

Most costs that hospitals incur for training physicians are reimbursed by the federal government through Medicare, which made up 71% of GME government funding in 2015 at $10.3 billion.

Other sources include Medicaid, which paid approximately $2.4 billion, followed by $1.5 billion through the Veterans Affairs Department. HHS earmarked another $248 million for GME training in children's hospitals and $76 million for community-based primary-care settings.

Medicare spending overall and spending on graduate medical education have risen dramatically since 2001; the cap on GME residents has not.

To curtail Medicare spending, the Balanced Budget Act of 1997 kept the number of medical residents for existing teaching hospitals at 1996 levels. An exception was made in 1999 to fund more slots at rural teaching hospitals. But for the majority of the more than 1,100 teaching hospitals in the U.S., residency positions have been relatively unchanged for more than two decades.

Last year saw a record 19,553 students graduate from medical school, an 18% increase from 2009. Subsequently, there was a rise in graduates applying for residency positions in 2019—38,300 compared with 33,167 in 2018. But due to limitations in the number of available posts, more than 3,100 applicants were left without a residency slot in 2019.

Still, 95% of residency positions were filled in 2019, about a 1.2% decline from the previous year. Various reasons explain why residency positions are left unfilled even with a rise in the number of applicants, ranging from graduates failing to gain high enough test scores to too much competition in a specialized field or training location.

"We have medical students graduating who aren't able to get post-graduate training spots," said Dr. Ana Maria Lopez, president of the American College of Physicians. "By limiting GME funds, that limits GME slots, which limits care for people."

Teaching hospitals have in recent years taken it upon themselves to create more residency positions at their own expense. The number of available first-year residency positions increased by 1,962 to 32,194 in 2019, a 6.5% rise over 2018, according to figures from the National Resident Matching Program.

Between 15,000 and 21,000 of the nation's 140,000 physician residents are training in teaching hospitals without Medicare support. Johnson estimated the decision to go over the cap costs each hospital $150,000 to $200,000 annually per resident, typically for salaries and other overhead costs related to training residents.

Hospitals have been calling for increasing the Medicare GME cap for years without much success, but recent signs indicate lawmakers in Washington are beginning to listen with greater interest.

Reports of the pending physician shortage—potentially reaching 122,000 by 2032, according to the Association of American Medical Colleges—has spurred congressional interest. An estimated 44% of the more than 890,000 active doctors in 2017 were 55 and older, which means there will be an exodus of professionals as they reach retirement age.

VOICES
The Multiple Worlds of Mental Illness and Stigma: Is it us? Is it them? Or is it both?
By Carl R. Smith

In 1972, I began my Ph.D. program at the University of Iowa. I was a *newbie* to Iowa and intended to complete my program in 3 to 4 years and then start my career in behavioral disorders in a somewhat warmer climate. I soon encountered these perspectives.

- Thomas Szasz argued that mental illness is a myth and criticized the moral and scientific foundations of psychiatry. He argued that mental illness was just normal problems in living, not "illness" and that "madness" was manufactured (Szasz, 1961).
- Erving Goffman, a sociologist, documented the regimented and carefully controlled existence of those who were unfortunate enough to be identified as a person with mental illness in psychiatric institutions in his book *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961).
- D.L. Rosennhan questioned whether experts in mental health could truly distinguish between patients needing care in mental health settings from others who he called "pseudopatients," people who represented them-selves as mentally ill but who were actually normal people (1973).
- Bill Rhodes posed the question whether the students served as emotionally disturbed in special education were actually better described as emotionally disturbing to others (1963). Various theorists, labeled as counter-theorists, carried this banner forward. Rhodes went on to champion the notion of "celebrate deviance" asserting that our society would be in significant danger if deviance were eliminated.

These seemingly incompatible perspectives presented a challenge for me. On the one hand, mental illness was a creation of our society as a means of coping with behavior that others perceived as unacceptable. On the other hand the behaviors noted above seemed to fall out of the range of normal behavior.

My road towards understanding these challenging thinkers and developing a career in special education then took a sudden and dramatic turn. As I remember, I started having significant problems with sleep. I also began having significant problems in my thought and interpretive competencies. Along with this I became much more assertive in my advocacy work on behalf of the students I worked with and became suspicious that I would suffer consequences from faculty because of such advocacy. Realizing the dangers of such thinking I began to understand that I probably would benefit from some type of mental health help.

But I also saw what had happened on the national scene when Thomas Eagleton, Senator from Missouri had been chosen in 1972 as George McGovern's running mate but was later removed from this opportunity because of his mental health treatment. For me this signaled the unacceptability of receiving any type of mental health treatment as that would likely plague me for my entire life and thus I did not seek such help. I also did not accept help from a good friend to have me meet with the admitting physician at the University Psychiatric Hospital.

This strategy did not work well for me, as I nevertheless ended up being hospitalized for most of the Spring of 1973. When finally admitted, I was diagnosed with various conditions ranging across primary affective disorder, acute atypical psychosis, acute schizophrenia-form psychosis, paranoid state in remission, and reactive agitated depression in remission. Thus, I went from being a promising, up and coming doctoral student to a psychiatric patient with several of the identified conditions described in DSM II (the current version at the time). I was -

- A patient who thought he was being constantly observed even by the television.
- A patient who thought another patient was actually his doctor.
- A patient looking totally drained after being locked in a time-out room for eight hours, which apparently had followed the patient being restrained.
- A patient who could not sit still and had to continually walk.
- A patient who was so medicated that he drooled and could barely stay awake.

During that time I was prescribed the most commonly used interventions of medications for addressing psychotic behavior, Thorazine, aka "a chemical lobotomy" and Stelazine. While these medications were hailed as significant strides in the practices of psychiatry from earlier methods of prefrontal lobotomies there were side effects to cope with. As a side effect of these drugs I became almost robotic in my movements and thus was also given Artane to offset the side effects of the first two.

At other times, I became noncompliant and aggressive; behaviors that were not typical for me. In dealing with this, the hospital staff restrained and secluded me in what was named the quiet room for up to eight hours at a time as a primary intervention. The only interaction with others during this extended time-out were the nurses bringing in my medications.

In viewing the impact of this experience in my life since, I have several thoughts. First, my mental illness experience was a secret to hide most of my adult life. And there is certainly a foundation for doing so. A close friend advised me to *not* share my story. She was particularly concerned that this sharing would lead to adverse effects on my chances of advancing professionally. Fortunately, this same good friend recently advised me of the value of sharing my story with others as one example of moving beyond this experience and doing well professionally.

Secondly, there were also other possible outcomes outside of the hospital that would have had a significant impact on my chances of recovery. First would have been the ending of my assistantship with the university and possibly being excluded from my program in special education. Rather than this, I received total support from the university faculty. They did so even though my behavior leading up to the hospitalization could have easily led this faculty to determine that I was a *threat* to them individually or the program considering my paranoid thought processes leading up to my hospitalization. This could have also led to my exclusion from my intended program. Think about how this plays out with current media and the focus on the danger of violence often associated with persons with serious mental illness; the other world of mental illness and stigma.

A final thought that has emerged through my journey is that I was extraordinarily fortunate to be where I was when my serious mental illness happened. I was new to a state, only having lived in Iowa for six months. The student insurance policy I took out only provided for less serious concerns. Despite this status, all

of my hospital stay was covered by what is known as “state papers.” I have tried to get the actual costs of this treatment and hospitalization but found out that county records, where these would be stored, did not extend back that far. In what was probably my first “outing experience” of sharing my mental illness I shared my experience with the Iowa Mental Health and Disabilities Commission and questioned whether such support would be consistently provided to a student in Iowa in a similar situation today. My fellow Commission members agreed to reconsider the automatic acceptance that such a student would receive the same treatment today and I believe this contributed in further considerations of reforms needed in our mental health system.

Lessons Learned

First, I think that we need to make our stories public. I hope this article contributes to the collection of stories of the many individuals who have faced mental health challenges and went on to lead productive, self-satisfying lives. At least two studies (Corrigan & O'Shaughnessy, 2007; Mann & Himelein, 2008) suggest that the stories told by persons who have experienced mental illness may have a profound effect in reducing the impact of stigma.

Secondly, think about the circumstances under which we are most frequently exposed to the lives of persons facing mental

health challenges. How frequently are these diagnoses associated with highly deviant, aggressive, or destructive behaviors? As Leys (2010) points out, serious mental health conditions such as schizophrenia are commonly associated with violence and crime when in reality most individuals with this condition lead “quiet, unremarkable lives.”

Another related dynamic is the influence of whether we believe an individual with mental illness can control their behavior. On the positive side, some of us, who believe such behavior is beyond the control for the individual, may be more forgiving. Others may be more pessimistic regarding possible recovery from these conditions if they believe the behavior is beyond the control of the individual (Corrigan, et al., 2005). We also have differing judgments of other people's behavior in contrast to our own. As Aronson (2000) states:

> . . . whenever we observe someone's negative or nasty behavior, we are prone to assume that the behavior is caused by the kind of person they are, rather than the kind of situation they are in. Interestingly, we are almost always more generous in interpreting the reasons behind our own behavior - primarily because each of us is more familiar with the situational pressures under which we are operating (22).

Contrast this perspective with the role models we need of leaders and caring individuals, particularly in these times where blaming often seems to have replaced attempts at understanding.

There are not clear defining lines separating most forms of mental illness from normal behavior. We all may experience certain behavioral manifestations in areas such as depression or anxiety that may be tolerable at certain times and at other times take us over a threshold and shut down our ability to cope and function competently. As Smoller (2012) notes, “By the latest accounting, more than half of all Americans meet criteria for a psychiatric disorder at some time in their lives” (13). It is also important to note that my journey beyond the early hospital experience has not always been smooth. There were times when I was faced with anxiety and panic attacks related to public speaking and phobias triggered by airplane travel or crossing bridges. The criteria or measure of seriousness is the ultimate challenge of whether these have a functional impact on my life. They did and through some pretty good talking cures and medication these were dealt with. I still take a small dose of antidepressant to cope with what seems to be a common malady for people of my age.

This leads to the meaning of the title I chose for this article and what I believe will be one of the most significant barriers we face in reducing stigma. Until the time that most people perceive mental illness as being a part of all of our lives and not just *them*, we will see this stigma persist. To capture the theme of *us* means that we realize that mental illness will affect all of us, particularly as we think of all the people in our extended family.

As Pete Earley (2006) reminds us, we lock up the mentally ill because they frighten us and we believe there is something that caused this insanity. To believe otherwise, Earley believes would open the possibility that this could happen to us. As he contends, “. . . that is such a frightening thought that we quietly search for explanations to prove that the mentally ill really aren't like us and they somehow deserve the torment they suffer” (121-122). To truly impact the stigma of mental illness, for children, adolescents, or adults, we can and must do better. We must adopt an approach that embraces a caring and understanding world of mental illness and belief in the power of recovery.

References

Aronson, E. (2000). *Nobody Left to Hate: Teaching Compassion After Columbine.* New York: Henry Holt and Company.

Corrigan, P.W. & O'Shaughnessy, J.R. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist*, *42*(2), 90-97.

Corrigan, P.W., Watson, A.C., Byrne, P., & K. Davis, K.E. (2005). Mental illness stigma: Problem of public health or social justice. *Social Work*, *50*(4), 363-368.

Earley, P. (2006). *Crazy: A Father's Search Through America's Mental Health Madness*. New York: G.P. Putnam's Sons.

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other inmates.* Chicago: Aldine Publishing Co.

Leys, T. (2010). Des Moines Register, Des Moines, Iowa, March 7, 2010: A.1.

Mann, C.E. & Himelein, M.J. (2008). Putting the person back into psychopathology: An intervention to reduce mental illness stigma in the classroom. *Social Psychiatry and Psychiatric Epidemiology*, 545-551.

Smoller, J. (2012). *The Other Side of Normal: How Biology is Providing the Clues to Unlock the Secrets of Normal and Abnormal Behavior*. New York: Harper-Collins.

Rhodes, W.C. (1963). Curriculum and disordered behavior. *Exceptional Children, 30*(2), 61-66.

Rosenhan, D.L. (1973). On Being Sane in Insane Places, *Science*, 179 (January 19), 250-258.

Szasz, T.S. (1961) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* Boston: Harper & Row.

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