

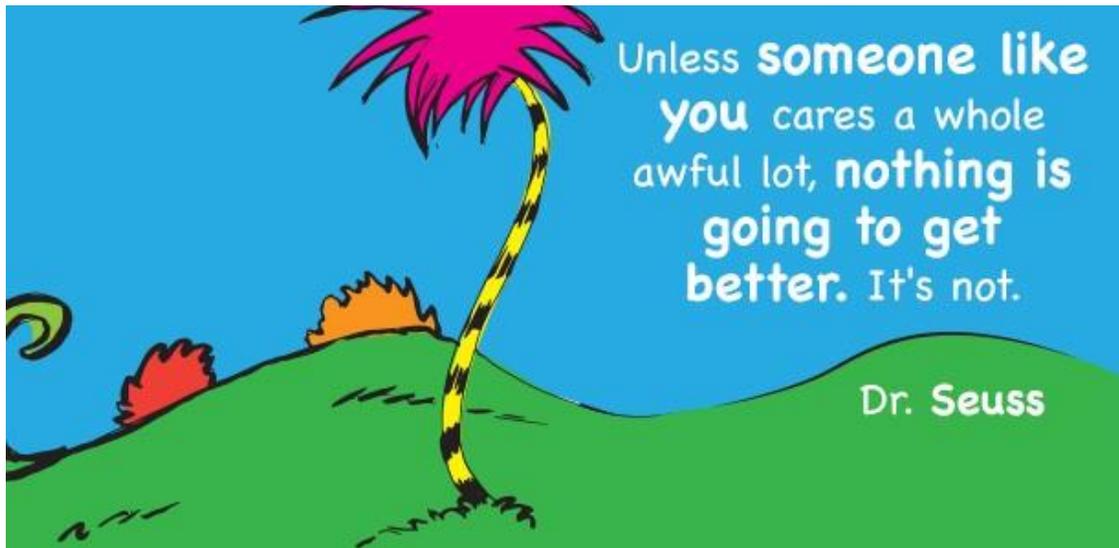
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## Stories - A Part of Teaching About Mental Illness

### **NAMI Greater Des Moines is involved in Crisis Intervention Team (CIT) Training for Law Enforcement.**

A key piece of the training is personal stories of living with mental illness. The stories are told by a panel of **persons with mental illness**, a panel of **family members** of persons with mental illness and a panel of **veterans** living with PTS (post traumatic stress) and/or TBI (traumatic brain injury). After the stories are told - the officers in training have an opportunity to ask questions of the panel.

Each person on the panel would tell their story in 5-7 minutes and include a description of any interaction with law enforcement - good or bad. Each time of participation would involve around 2 hours.

If you want to be part of a panel for CIT training and tell your story, please email [here](#) with your name, email address, phone number and on which panel you want to participate.

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### **Another piece of CIT is the "Hearing Voices That Are Distressing" simulation training.**

If you would like to assist in presenting the training, please send an email [here](#). It would involve 2-4 hours of your time depending on the size of the class receiving the training.

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### **How Culture Shapes your Mind — and your mental illness**

The patient, a man in his early 20s, was clearly distressed. There were insects, he said, crawling around under his skin.

The graduate student doing the initial assessment was immediately concerned and went straight to her

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advisor, Dr. Brian Sharpless, a clinical psychologist and professor at Argosy University in Virginia. The patient sounded psychotic — possibly schizophrenic, she said, and she wanted to know what to do.

“Is he by any chance Nigerian?” Sharpless asked. “Yes!” she replied. “How did you know?”

“He’s not psychotic — that’s Ode Ori,” Sharpless responded. “He’s having a panic attack.”

Read the full story at [BostonGlobe.com](http://BostonGlobe.com).

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## Child ER Utilization Rising

*Open Minds Executive Briefing 12-1-18*

At the national level, recent findings presented at the American Academy of Pediatrics National Conference & Exhibition showed that 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), and that PED visits for mental health problems were twice as high for minority children than non-minorities.

In Connecticut, behavioral health-related crisis visits to ERs by Medicaid-covered children has increased 20% from 2014 to 2016, from 12,100 to 14,448, with researchers concluding that the high number of **second visits** (10.4% of the youths made a second emergency room visit within seven days and 25.6% within 30 days) suggests that the youth and/or family needs were not met at the visit, or by services after discharge.

OPEN MINDS Senior Associate Howard Shiffman, who shared his experience of watching the rise in utilization of emergency rooms for mental health reasons for children and youth, and attributed it as a **direct result of the lack of child inpatient mental health/psychiatric services**. He writes:

*We have experienced a national movement to close inpatient hospital mental health services, and as a result there is a lack of quality, available community, child-oriented mental health and acute care services.*

*To compound the problem, there is also a trend occurring nationally to eliminate inpatient services for children and youth experiencing substance use issues. The result is the higher utilization of ER's to address this lack of resources. Other factors?*

*There is a lack of resources available to the children that require stabilization once they enter the ER, and a lack of follow-up treatment when the child is released from the emergency room.*

OPEN MINDS Senior Associate Paul Neitman explained that children, and especially **children in poverty**, are experiencing escalating incidents of protective services and foster care referral due to abuse and neglect, and that the parents of these children often experience their own mental health and substance abuse issues, and these too have been on the increase. He noted:

*The increased use of ER I think can be linked to several issues. In addition to Howard's comments, these issues include:*

- *a scarcity of psychiatrists (especially child psychiatrists);*
- *the continued stigma related to behavioral health issues and*
- *reluctance to seek treatment until it reaches an emergency level; and*
- *a need for improved outreach and community education, especially for minority populations.*

*The effect of these and other issues on our children exposes them to **trauma**, what some are referring to as **adverse childhood experiences** (ACE) and a **general lack of structure and security** (food, shelter, safety) that is critical to positive childhood development.*

*The result is increased behavioral health issues that include depression, substance abuse, suicide*

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ideation/attempts, and behavioral problems in school and the larger community among other issues. These adverse conditions, as has long been the case, also have **disproportionately impacted** children of color and ethnic minorities.

For innovation provider organizations, these don't have to be insurmountable challenges. Mr. Shiffman noted that one solution will come in the form of **states allocating funds for mobile crisis stabilization that include acute care short term hospitalization**. He explained:

*These services are for any child experiencing a mental health issue. It matters not how or if that child has funding for the service. Colorado has such a program, and this has reduced ER visits. At the end of their evaluation or short-term stay, if follow up is indicated a referral is made to the regional mental health organization.*

Additional solutions include:

- *building outpatient, community-located mental health services for children and youth to replace the lack of hospital services;*
- *creating additional availability of substance use treatment programs for children and youth;*
- *having mental health services for children available and integrated into pediatric practices to identify problems early on in the life of the child;*
- *having more school based mental health services integrated into the schools; and*
- *educating the courts and probation to identify mental health issues when working with children.*

Mr. Neitman suggested addressing the safety and security issues being faced by our children, often known as **social determinants of health**. He said:

- *First, the harmful impacts of poverty must be addressed.*
- *Secondly, a clinical premise I have always subscribed to is that the overall well-being of children is intrinsically linked to the overall well-being of their primary caretakers. Consequently, there is a need to address parental health and behavioral health issues.*
- *Thirdly, communities need to assess their need for mental health services and actively address gaps. It would seem local that hospitals might be natural partners to collaborate with as their funding is often tied to reduced usage of ER and other expensive interventions.*
- *Finally, we need to do a better job of community education and outreach to our most difficult to reach communities with more cultural awareness and competency that addresses improved knowledge of options and issues of stigma.*

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Remember, if you want **Amazon to donate to National Alliance On Mental Illness of Greater Des Moines**, you need to **start each shopping session at** the URL <http://smile.amazon.com/ch/42-1333379>. You need to select a charitable organization to receive donations from eligible purchases before you begin shopping. They will remember your selection, and then every eligible purchase you make at smile.amazon.com will result in a donation.

Choose: **National Alliance on Mental Illness of Greater Des Moines**



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