



THE BELL

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NMHA Responds to Hurricane Ravaged Gulf Coast

Advocates from across the nation join forces to assist victims

NMHA and its 340 local and state affiliate network continue to mount a coordinated mental health response to the thousands of victims of recent hurricanes, which devastated the U.S. Gulf Coast, caused major damage in southern Florida, killed more than 1,000 people, and displaced an estimated 1.3 million people from their homes and communities.

Immediately following Hurricane Katrina, the national office formed a Disaster Response Team that met every day to coordinate response efforts with MHAs working on the front lines. As part of the effort, the team has so far held two conference calls with MHAs to organize our ongoing efforts.

MHAs from states directly affected by the disasters and advocates from across the country are working daily to support evacuees, and assist displaced consumers,

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Medicaid Cuts Still In Doubt As Advocates Say “No!”

Hurricane Katrina not only wreaked havoc throughout the Gulf region, it continues to roil Congress as legislators debate national priorities and the impact of proposed budget cuts on vulnerable Americans. Accordingly, in late November, despite an earlier budget blueprint requiring potentially deep Medicaid cuts, Congress has yet to resolve how to achieve Medicaid savings and how extensive any budget cut would be. The answers to those questions await a Senate-House conference committee, which will have to reconcile the very different paths the two chambers took to budget-cutting.

With NMHA and affiliates working to steer Congress away from deep Medicaid cuts with a “do-no-harm” message, unrelenting advocacy work has temporarily set back efforts in the House of Representatives to enact such cuts. The House leadership, which backed a package that included some \$10 billion in Medicaid cuts (75 percent of which would fall directly on program beneficiaries), postponed a scheduled Nov. 10 vote on the bill because it lacked the votes needed for passage.

Our joint advocacy efforts forced House leaders to re-examine their Medicaid proposals and ultimately to scale back some of its provisions in order to eke out passage of a revised budget-cutting bill on Nov. 18 by a 217-215 margin. The House-passed bill yielded ground in scaling back one of the most egregious of its proposals that would have permitted states to increase cost-sharing from \$3 to

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NMHA Responds to Hurricanes

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children and families. MHAs are out in the field meeting with state health agencies and volunteer organizations to better orchestrate response efforts and services. They are also working with the media to broadcast mental health tips and information on available resources.

NMHA's Federal Affairs staff is working tirelessly to reach out to congressional leaders and key committees, federal agencies and legislators in affected areas to call their attention to the short- and long-term mental health and housing issues so many communities now face. Most recently, NMHA wrote a letter to Substance Abuse and Mental Health Services Director Charles Curie to address the agency's challenges in helping communities and expanding mental health services.

The American Red Cross in October invited NMHA to join a team of other leaders in the disaster response effort to tour hard-hit Mississippi to view the conditions there. Oscar Morgan, NMHA's senior vice president of Policy and Services, joined organizations such as the oil company BP and the Robert Wood Johnson Foundation to see the work being done and discuss potential partnerships with the Red Cross.

Fact sheets designed to address the hardships facing hurricane victims are posted on NMHA's Web site at www.nmha.org/katrina and have been distributed in communities across the country and published by media outlets.

Watch NMHA's Web site at www.nmha.org for updates on the response effort. 



OPERATION HEALTHY REUNIONS
A program of the National Mental Health Association

Through Operation Healthy Reunions and in partnership with military and veterans organizations, NMHA aims to help service men and women who are returning home from Iraq and Afghanistan cope with their lives beyond combat and back at home and work.

Fact sheets cover topics such as reuniting with your family, adjusting after war, depression, and post-traumatic stress disorder. Download materials and find out more about this initiative at <http://www.nmha.org/reunions>.

FIRST PERSON

Teen's Cutting Experience Leads to Opportunities to Educate

by Lori Pede

I started cutting myself when I was 14 years old. I was always depressed, angry and negative about everything. I would hurt my friends at school or my family because I have a tendency to take my problems out on other people when I'm upset or feel helpless. I decided that I didn't want to hurt other people anymore, so I hurt myself instead. I would cut my arms and legs with razors, bang my head into walls, and rip out my hair when I was upset. I never cried and always bottled up my feelings until I felt like I was going to explode. I was turning my emotional pain into physical pain.

I was a fairly happy child growing up in the eyes of my parents, but that was because I always kept secrets from them. I was bullied and harassed in elementary and middle school. But, I always put on an act around my parents and they didn't know how depressed I really was. I remember writing in my diaries when I was in 8th grade that I thought I had a depression disorder and I wanted counseling. I asked my parents for counseling, but because I always appeared happy to them, they saw no reason for it. In their eyes, I was perfectly normal. I was constantly on the phone or outside with friends. They had no idea what was going on.

Everything went further downhill when I entered the 9th grade. I began cutting myself every day. I would stand in front of a mirror and tell myself how ugly I was and how much I hated myself. The school counselor got wind of my cutting, told my parents and recommended a counselor. My parents were shocked. My mom took it really hard. She kept asking me, "What did we do wrong?" "Did I fail you as a mother?" But, it had nothing to do with her. No matter how many times I told her, she would continue to blame herself. My parents took the school counselor's advice and put me in counseling. Until now, my parents

had never seen any reason for counseling unless someone was "deeply troubled." I remember my first counseling session with my parents and counselor, Phil. Phil asked me what I thought about my parents' reaction. I looked at him and said, "Everyone thinks Lori's ok. But, Lori's not ok." When my mom heard me say that, she FINALLY realized I really needed help. That I was not just acting and something was wrong.



Lori Pede, right, and her friend, Emily Rose, accept 2005 NMHA mpower awards.

A lot of my problems went back to my childhood. My dad was a truck driver for four years. He was only home one or two days a week. I was 9 years old when he went on the road. I had always been a big daddy's girl. So when he left I was devastated. There were more issues than just my dad. I was insecure about my hair, my teeth, my nose, my body. I had my first boyfriend in 8th grade. He constantly put me down. It was during that period that I started cutting myself. He would tell me I was crazy and make fun of me. He dumped me after two months. I started dating a guy named Will when I was a freshman, three months before I turned 15. He knew about my cutting and encouraged me to stop. Between Phil, my parents and Will, I eventually stopped. I cut for nine months. But I did other forms of self-mutilation for another year and a half. I would rip out my hair, bang my head into walls, punch walls and bruise my fists.

When I was a sophomore, I became friends with Emily Rose. She was also a cutter and had been hospitalized most of her freshman year. We were in the same history class and our teacher assigned our class a history project that was due at the end of the year. We decided to be partners. After doing some research, we selected a topic that was personal to the two of us: self-mutilation.

Emily and I worked on our history project for a few months and I briefly mentioned it to Phil in one of my counseling sessions. He became so excited and offered to do anything he could to help. He took time out of his day to come to our school and work with us in the library. Our teacher never thought we'd be able to relate it to history—but we did. We got a 100 percent on the project.

Phil told numerous people about our little history project, and we were asked to do our presentation at the

2003 Zarrow Mental Health Symposium. This was our first professional invitation, and we presented during our junior year when we were 16. After that, we got numerous invitations. Mike Brose, the executive director for the MHA in Tulsa, asked Emily and me to start a youth advisory board. On January 8, 2004, we started PYRS, Productive Youth Rendering Safety.

During our research for our various presentations, I stumbled upon a man's personal story of how he overcame self-mutilation. He talked about how he had trust issues and that until he could learn to trust himself not to hurt himself, he would never be able to form meaningful relationships. His description of self-mutilation is that his body cried through blood rather than tears. That's the perfect description. When a person bottles their feelings up, they're incapable of crying. When someone cuts himself or herself, it's the same feeling of relief as when they cry. But, their body's crying blood instead of tears.

I read his story when I was a sophomore and it inspired me to stop all of my self-mutilating behavior. I've always had trust issues with people, especially men, because I was molested when I was five. I learned from his story that I couldn't trust others until I could learn to trust myself. On June 26, 2003, I decided that I would never intentionally hurt myself again. I have kept my word to this day. I use his story in all of our presentations hoping that it will inspire someone else.

Our presentations consist of personal interviews with friends from school that cut, and with people we talked to on the Internet in self-mutilation chat rooms. We combine our experiences

“ I know I will never have to feel like I need to hurt myself to deal with my problems ever again.”

with stories from people we've talked to. Our presentations include the 2004 Oklahoma State Suicide Prevention Conference, at schools, and to conferences of counselors and social workers. We've lost count. Emily and I graduated from Broken Arrow High School in May. We both received the Education Award from the Mental Health Association in Tulsa in November 2004 and NMHA's mpower Award in June 2005.

I want to become a sexual abuse and self-mutilation counselor. I hope that by telling other people about my experiences that either a fellow cutter will feel less lonely and want help, or that a counselor will be able to better help a client dealing with this issue. I know I will never have to feel like I need to hurt myself to deal with my problems ever again. Between Phil, Mike Brose, Karen LaPlante, my parents, my boyfriend, and of course Emily, I know I will always have all the love and support I will ever need to succeed and accomplish my goals in life and in the mental health profession. 📖

Lori Pedde and Emily Rose, both from Broken Arrow, Okla., were two of the six 2005 NMHA mpower Award winners. Through this annual award, NMHA's mpower program recognizes outstanding young people who have helped change youth attitudes about mental illness, and successfully fought the stigma and prejudice surrounding mental health disorders.

Legislators' Opposition to Screening Misplaced

by Raymond Crowl, Ph.D., vice president of Mental Health and Substance Abuse Services, NMHA

Children are once again caught in the cross-hairs of a political firefight. This time, the issue is the President's New Freedom Commission's (NFC) final report on mental health. In its 2003 report, *Achieving the Promise: Transforming Mental Health Care in America*, the NFC calls for providing mental health screenings to children in a variety of settings—including primary health clinics and schools—to ensure early detection and intervention.

Yet, since the report was released, several state legislators and U.S. Rep. Ron Paul, R-Texas, have proposed legislation to prohibit mental health screening of children in schools. In Alaska, for example, the proposed legislation would not only block screening but would forbid school personnel from discussing mental health issues or recommending that parents consult a mental health professional.

Rep. Paul's bill, which received 90 votes in the last congressional session, cites concerns expressed by anti-mental health groups that the call for "universal screening" is a plot "spawned by the pharmaceutical industry" to medicate America's children. However, the report doesn't call for the "universal screening" of all children and stresses that the main goal of screening is the early intervention of mental health problems, which can halt the progression of disorders and prevent recurrences later.

So what exactly is mental health screening?

Screening commonly refers to the use of one or more brief, structured questionnaires that can help assess the possibility that a person has a mental health problem. Mental health screening tools are not diagnostic tools. They are designed to answer two basic questions: Does the person have signs or symptoms of a mental health problem? If so, should this person be referred to a mental health professional for an assessment?

Although mental health professionals usually administer these screens, they may be administered by trained non-mental health staff from other agencies. Most screens are designed to be fairly brief processes, usually 15 to 30 minutes. Clearly, any efforts to formally screen a child should be done by a well-trained and qualified person.

To be sure, mental health screenings present several challenges. First, there are many screening tools available, but they have not all been equally well-researched. In addition, their validity on diverse cultural groups has not been well-established. These two facts mean that the tools may result in over- or under-referrals for mental health assessment. The degree of subjectivity in the tools may also increase the vulnerability of some cultural groups through bias in administration and scoring.

A separate issue lies in the use of screening tools in school settings. While the NFC does not take a position on who should administer screens in schools, it does note that: "Every day more than 52 million students attend over 114,000 schools in the U.S. When combined with the 6 million adults working at those schools, almost one-fifth of the population passes through the nation's schools on any given



What Advocates Can Do to Promote "Early Identification" Programs in Their Communities

- Monitor their states for potential legislation that would limit efforts to engage in early identification.
- Proactively engage with schools in developing early identification programs with strong privacy and rights protections.
- Provide primary care providers with educational opportunities on mental health screening.
- Engage with the state mental health authority on developing and promoting early identification programs and the support services needed once problems are identified.
- Educate legislators on the needs and benefits of early identification of mental health problems in children.

New York Mental Health Associations Help Pass Geriatric Mental Health Act

by Sara Thompson, senior director, Adult Mental Health Services

Older adults who seek mental health services often face an uphill battle. Insurance coverage is woefully inadequate, services are delivered in mental health centers and not in an individual's home or community, and providers are insufficiently trained in mental health and aging issues. In New York, a new law was recently passed to reverse these harmful trends.

Last summer, New York Gov. George E. Pataki signed into law the Geriatric Mental Health Act. It's the first bill of its kind in the country to help meet the growing mental health challenges of older adults.

The law recognizes the need for innovation in meeting the unique mental health needs of older adults by providing for:

- Services demonstration grants that are designed to foster new approaches to help older adults live in the community; to improve access to, and quality of, mental health services; to integrate mental health, physical health and aging services; to increase the capacity of the mental health system to serve cultural minorities; to enhance caregiver supports; and to build a clinically—and culturally—competent workforce.
- Interagency planning processes that will foster the integration of mental health, physical health and aging services, which is critical for effective service delivery for older adults.

The MHAs of New York City and of Westchester worked tirelessly to ensure the law's passage. Together, the two MHAs created the Center for Policy and Advocacy in 2003 under the direction of Michael B. Friedman, a leading mental health policy expert. The Center mobilizes stakeholders and provides visibility and leadership to help move mental health issues to the top of the state's political agenda. In 2004, the Center established the Geriatric Mental Health Alliance of New York, which has grown into a network of more than 800 individual and organizational members.

The Center is working to see that legislation similar to the New York law is passed by legislatures throughout the country. In fact, staff from the Center recently traveled to North Carolina to strategize with the state MHA there on ways to build an effective mental health and aging coalition, with the ultimate goal of enacting a North Carolina version of the Geriatric Mental Health Act.

For more information about this effort and to learn how to get your state involved, contact the MHA of Westchester at 914-345-5900 or the MHA of New York City at 212-254-0333.

“This landmark legislation will prepare for the vast increase of the number of Americans 65 and older over the next 25 years, from 35 million to 70 million, and the consequent growth of older adults with mental disorders from 7 million to 14 million. Approximately 800,000 of these seniors will reside in New York state.”

—Giselle Stolper, executive director, MHA of New York City

weekday.” This means that mental health problems are most likely to be noted in schools. And, left untreated, they will hamper a child's ability to learn.

There is also considerable concern regarding the potential for screenings to violate a child's privacy and stigmatize him or her. Especially in school settings, care must be taken to ensure that privacy is maintained. And we've all heard concerns regarding potential coercion by schools. Stories abound of parents being told that their child must be medicated to remain in school or that because he or she has a mental illness, they must be transferred. In the end, there remains the perennial question of what to do once you have identified a potential mental health problem. Where are the resources to help the child?

Any effort at early identification and treatment of mental health problems in school settings must take these concerns seriously and work to address them. Because the word “screening” evokes such strong emotional reactions, NMHA prefers the phrase “early identification.” Although this is partly semantics, early identification is a broader frame, allowing for a variety of approaches, including alternatives to screening.

While there is considerable debate about the use of screening, the consequences of failing to identify and treat emotional disturbances in children are clear. Left unidentified and untreated, children are at risk for academic failure, suspension or expulsion for behavior problems, and involvement in the juvenile justice or corrections systems. As we all know, children from diverse backgrounds who have mental health problems are particularly at risk, because they are the least likely to receive appropriate care and are disproportionately overrepresented in our nation's juvenile justice facilities. Failure to identify and address problems early also increases the risk of a variety of negative outcomes for all children, including suicide. ■

NMHA Medicare Campaign Gets Off to a Strong Start

As a leader in the national effort to ensure that the new Medicare prescription drug benefit meets the needs of beneficiaries who have mental illnesses, NMHA has launched its new “Get Educated, Get Enrolled” campaign. Our goal is to get at least 1 million people who have mental illnesses and are eligible for the benefit enrolled by May 15, 2006.

NMHA has organized a series of trainings for MHA community leaders from nearly 40 states to give them the skills and tools they need to educate organizations and communities about the benefit and enrollment process.

Cohosted by the MHA of Greater St. Louis in July and the NMHA in Georgia in August, the events have so far targeted 17 states—with more events planned for Mental Health Planning Councils and other groups. In addition to the training itself, participants use the meetings to brainstorm about creative community enrollment activities and events that will resonate with people in need.

As a result of the events held so far, MHAs are heading up one-of-a-kind initiatives across the country that educate mental health consumers and providers. They are also

partnering with Medicaid agencies, State Health Insurance Assistance Programs and other organizations responsible for enrollment to get the word out.

To help consumers and advocates stay up-to-date with related news as the drug benefit enrollment period nears, NMHA publishes regular e-mail bulletins that will cover updates on community activities, new resources and the latest news on the “Get Educated, Get Enrolled” campaign. To subscribe to the bulletin, or if you have questions about the new Medicare drug benefit, send an e-mail to shcrinfo@nmha.org.

NMHA has published “Get Educated, Get Enrolled: A Workbook for Mental Health Consumers,” a guide to give people the information they need to negotiate their way through the Medicare prescription drug program. Its also a great resource advocates can use to educate their communities. Download a copy of the workbook free of charge at www.nmha.org, or order a printed copy by calling 800-969-NMHA.



Advocates Say “No!” to Medicaid Cuts

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\$5 for beneficiaries with incomes below the poverty level. Yet the House-passed bill would still permit the cost burden on those individuals to increase in line with medical inflation and to increase even more for other beneficiaries. In fact, most of the Medicaid savings in the House-passed bill would come from increased cost-sharing and premiums and reduced benefits for low-income beneficiaries. The House measure poses other dangers by allowing states to restructure their Medicaid programs in the vein of private insurance. It’s important to note that this would also allow states to avoid the Early Periodic Screening Diagnosis and Treatment (EPSDT) requirement, which is so critical to ensuring that children on Medicaid who have mental health disorders receive treatment. In addition, given the discrimination that individuals with mental illness routinely face in the private insurance market, this flexibility to remodel Medicaid after private insurance could lead to discriminatory restrictions on mental health treatment under Medicaid.

The Senate, which narrowly passed its budget measure in early November, lessened the impact on Medicaid by including reductions in Medicare spending. Sens. Gordon Smith, R-Ore, and Olympia Snowe R-Maine, were instrumental in efforts to minimize the magnitude and

impact of Medicaid cuts. The Senate bill would cut Medicaid spending by \$4.3 billion and Medicare spending by \$5.7 billion. Most of the Senate’s Medicaid savings would result from changing the reimbursement to pharmacies for prescription medications and by increasing the rebates paid by pharmaceutical manufacturers. Most of its Medicare cuts would result from reducing reimbursement to Medicare managed care programs.

The Senate bill does provide some good news: it would enable families who have disabled children and incomes below 300 percent of poverty (\$58,050 a year for a family of four) to buy Medicaid coverage for their disabled children. And it would establish a \$218 million demonstration project to enable 10 states to receive waivers to provide home- and community-based care services to children who would otherwise be placed in psychiatric residential treatment centers.

Both the Senate and House budget bills would also provide some assistance to Katrina survivors in authorizing 100 percent federal funding for any state covering Medicaid-eligible Katrina survivors from the hardest hit counties in Louisiana, Mississippi and Alabama. But the bills would not help those who do not qualify for Medicaid regardless of

Research Notes . . .

Many Addicted to Alcohol Receive No Treatment

Despite the promise and effectiveness of new treatments, less than 10 percent of the estimated 20 million Americans who are addicted to alcohol are diagnosed each year and less than one-half of these people receive any treatment, according to researchers at the George Washington University Medical Center in Washington, D.C.

Fewer Teens Are Using Drugs, Survey Finds

Although there was only a slight decline in the number of American adults who used illicit drugs last year (from 8 percent to 7.9 percent), the percentage of teens who used such drugs fell significantly, the annual federal National Survey on Drug Use and Health indicates. Nine percent fewer teens used drugs in 2004 than in 2003.

Early Stress May Lead to Cognitive and Other Problems Later in Life

A study involving young rats placed under temporary psychological stress suggests that early-childhood trauma may lead to memory problems, and mental and cognitive declines later in life. The study, published in the *Journal of Neuroscience*, is believed to be the first to show that such early emotional stress can lead to a slow decline in neuron communication within the brain, particularly in the region associated with learning and memory recall.

Teens Whose Mothers Attempt Suicide Are Prone to Suicidal Ideation

Teens whose mothers attempt suicide are five times more likely to think about attempting suicide themselves and are more likely to attempt suicide at a younger age than other teens, a study published in the *American Journal of Psychiatry* indicates.

income levels (including childless adults) or other individuals who do not meet income-eligibility requirements, which states often set well below the poverty level.

Both the House and Senate rejected a very troublesome administration proposal to limit reimbursement for rehabilitation services that would have prohibited Medicaid coverage if other government programs could potentially pay. But both bills do include provisions to redefine what services qualify for coverage as targeted case management (TCM) under Medicaid. These provisions are said to simply codify current guidance on the types of activities that should qualify for Medicaid funding as TCM, but they also include problematic language regarding third-party liability. We are attempting to win support for changes in that provision to protect Medicaid reimbursement for targeted case management services.

NMHA is an important voice in the fight against any cuts that would harm beneficiaries. In addition to working closely with key members in both the Senate and House, NMHA participated in a Sept. 28 press conference and congressional briefing that highlighted the importance of Medicaid to people who have chronic conditions. The events were organized by the National Health Council and the Georgetown Health Policy Institute, which released a report, "Why Medicaid Matters." NMHA contributed to the report, which included a consumer profile from among the many submitted to us by MHAs.



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To join NMHA and receive *The Bell*, visit NMHA's Web site at <http://www.nmha.org> or call 800-969-NMHA (6642).

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