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NAMI Orange County News & Views

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Reflections on modernizing our public mental health system: Translating vision to reality

Verla Insko, North Carolina House of Representatives

I have come to believe we are not so much "reforming" North Carolina's public mental health system as we are "modernizing" it.

The word "reform" has developed negative connotations that may reinforce perceptions of problems rather than reminding us that the system needed modernization. There is widespread agreement on the vision and goals, and we are moving forward. So much has happened since the current system was formed in 1974 – a full 30 years ago- it was time to take a long look at the existing system and compare it to what would be possible using recognized best practices.

Terms we use to describe a modernized system are: community-based; best practice treatments; person-centered planning; recovery model; outcomes-based treatment plans, accountability, collaboration, a uniform system statewide, county involvement, strong public management and yes, greater use of private sector providers (divestiture) and downsizing state institutions.

Creating the vision of an up-to-date system took a full year of intense effort by individuals and groups representing diverse interests. That task, though demanding, was easier than the challenge we now face: *translating the vision to reality*.

Because we always hear about the *problems*, I decided to build the February meeting agenda of the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse around *successes*. The Committee heard CenterPoint Area Program representatives describe a positive partnership between the staff at CenterPoint and the Consumer and Family Advisory Committee (CFAC). They spoke of the energy, creativity and advocacy the CFAC has brought to reform efforts. We heard from representatives of Wake County CFAC and the newly created Community Provider Advisory Committee (CPAC), who explained the successful integration of Dix Hospital elderly clients into the community, and described new community-based services developed with funding that followed Dix clients. The Committee also heard from four consumers associated with the Wellness Recovery Action Plan (WRAP) at the Neuse Center. WRAP is a self-administered tool for consumers and families that complements traditional treatments. It is based on the concept that recovering means having an identity that is separate from your diagnosis. It enables one to have a productive life in the community and empowers people to take control of their own lives. Consumers spoke of the profound effect the program has had on their lives, the empowerment, hope and achievements they have experienced in education, employment and life. WRAP will be featured at the NAMI NC spring conference in a workshop, Friday, April 23.

Clearly we are hitting bumps on the road to modernizing the system. Problems I hear about the most: building community capacity, giving LMEs time to gain experience in their new roles of management and oversight, and keeping the state focused on its role of creating the foundation for reform and ensuring all the pieces fall into place on time. As we move forward with modernizing our system, we will have to address each of these problems. We must find the energy and determination to stay on track.

Representative Insko can be reached by email verlai@ncleg.net or phone: 929-6115

A Consumer Views Mental Health System Reform….. from a Small Business Perspective

By Edward Wright

Recently I spoke on North Carolina's mental health reform at a forum sponsored by NAMI Orange County. Having participated in Adult Day Treatment services for four years, and as a member of the Consumer and Family Advisory Council, I was able to present the views of a mental health consumer.

Of particular interest to me is the attempt by those designing reform to base changes on small business principles. A primary goal of reform is moving from a large system that directly supplies most services, to developing small independent ventures that compete to be the most effective providers. The hope is that free enterprise will offer consumers more options at a lower price.

The ideals of the current reform are the same that attracted me to running my own business. Having built a retail and wholesale picture framing business over the last thirty years and participated in a family development company, I have direct experience with the opportunities and the challenges of small initiatives. The ability to freely choose resources and work out one's own plan of action is basic to effective business development. Similarly, a focus of mental health reform is to give consumers the opportunity to develop their own ways of working toward recovery, with the hope that the new system will allow us to find providers that specifically meet our needs.

A critical aspect of my mental health recovery has been my ability to bring together providers that meet my specific needs. Through rigorous examination, I've found therapists that work well with me, I've designed a daily schedule of exercise and balanced nutrition, I've structured contact with friends and groups that provide essential support, and I have been able to structure a supportive work environment. As in my business, it has been necessary to bring a diversity of talents and resources to achieve success. I have worked hard and creatively to use the resources available to me. I have received tremendous support in this effort. I am encouraged by the focus of current reform on supporting consumers to take more responsibility for their own recovery. The challenge, however, is to provide adequate resources, and for consumers to recognize the strength of their own skills.

The failure of most small businesses results from not anticipating the cost of building the foundation. The impulse for independence often prevents one from learning basic skills, building roots, and developing connections. A secure foundation requires investing time and money. Similarly, an approach to mental health care with greater options will initially demand more investment than the prior system.

Another challenge for mental health reform common to business is for those building a recovery system to trust their instincts. I believe that each of us has a sense of our particular way of working. In mental health it can be described as "islands of clarity". In the midst of depression or psychosis there can be moments of insight, and with support from those who value these experiences one can learn to recognize and value them. Similarly, anyone who starts a business receives an impulse or dream. It is unformed and can easily become a delusion, but if one learns to hold to this critical revelation and is balanced by others' direction, the vision can become a reality.

Growing a business can be described as a form of recovery. It's a way to gradually bring form to an ideal, to create balance, to gain security, or to make connections. In business this work can be overwhelming and frustrating. We can choose to approach it as burden or as an opportunity.

Living with the pain of mental illness can be judged a handicap or we can choose to use it as an opportunity for genuine growth. Recovery demands the same kind of discipline and persistence required in business development. I am encouraged that mental health reform draws from standard business development ideals, but it is critical that we apply the same creativity and resources required for success in healthy initiatives. *Edward Wright can be reached at hew50@bellsouth.net*

System Reform Underway: Big Changes Coming

By Tom Maynard, OPC/LME Director

Implementation of System Reform is underway with big changes coming. **Rich Visingardi** has resigned as Director of the Division of Mental Health (DMH). **Mike Moseley**, a longtime DMH employee, will replace him. We do not know how Mike Moseley plans to carry out his responsibilities, but we do expect reform to continue. Most chief goals of reform have broad support and/or federal requirements for change.

Downsizing of the state institutions has begun and with it some increased funding for community services. We have received funding for geriatric services, some supports for long term Umstead residents, and some funding for Murdoch residents. Community placements have begun, too, though the real work remains ahead of us. To reduce our dependence on Umstead, we will need to implement strengthened crisis services and improved community supports. Some of these needed services will be made possible with the state service definitions that were announced in January. We will need funding beyond what is currently available to make a meaningful impact.

CONTRACTS, PERFORMANCE EXPECTATIONS

The Orange Person Chatham Area Program(OPC) recently received a Local Management Entity(LME) contract and proposed funding arrangement for implementation on July 1, 2004. The contract spells out what tasks the LME would be expected to perform and how it would be paid for. The contract spells out in detail how OPC would be expected to carry out administrative responsibilities and establishes indicators by which OPC would be measured. For example, we will be expected to increase the number of people with severe disabilities we serve in our area. We will be held to limits on using state institutions, and we must assure that all citizens requesting services are seen promptly.

FINANCES

OPC will be paid according to a new procedure starting on July 1, 2004. The LME will be funded directly by the state DMH using state and federal funds. Some new federal funding sources will result in a small overall increase in funding to local programs. No county funding of the LME will be required, nor will county match be required for the new federal sources.

In the past, administrative expenses have been included in service payments. Once the new procedure is started, service rates will no longer include administrative expense funds---they will be reduced by some yet to be disclosed amount. On the other hand, service funds after July 1 can only be spent on services and not on administration. Overall, the funding stays the same, apart from the new federal money, but separation of funds is thought to increase accountability and ease the tracking of money.

The rate to be paid to each LME varies with size and most programs have now been given a proposed funding figure. OPC's allocation is tentatively set at $5,049,000. This figure is greater than OPC now spends on administration, but the LME budget will include some activities such as screenings, crisis functions, and "care management" that have been considered services in past budgets. "Care management" includes some activities that up until now have been part of case management. The current case management role will be divided by state rules into two parts: care management and service delivery. The service portions of case management will be included in service funding.

NEW ORGANIZATIONAL STRUCTURE

Our three counties are close to completing an interlocal agreement that will provide the basis for a new organizational structure for Orange, Person and Chatham counties. We are aiming for a July 1 implementation date to implement a new seven member governing board. Each county will appoint two members and the seventh will be the Area Board Chair. The current Area Board will become advisory to the new board.

SERVICE DEFINITIONS

Effective in January of 2005, North Carolina will adopt new "service definitions". The rules and specific terms are very *(continued next page)*

*(Maynard article continued)*important because they shape what services can be delivered and to whom. Since there is not enough money to do everything we might want to do, the service definitions are a big part of establishing priorities.

Service definitions are based on the North Carolina Division of Mental Health, Developmental Disability and Substance Abuse's understanding of "best practice" service models. Federal agencies have pushed states to adopt evidence based service models and to restrict access to non-evidence based models.

Under the new definitions it will become more difficult to access traditional in-office psychotherapy. Crisis services will expand, as will various forms of community support. Clubhouse services and ACTT (Assertive Community Treatment Teams) remain high priorities. Added will be levels of community support that resemble ACTT, with less intensive staffing. The new rules favor services of comprehensive agencies that provide a package of services. Case management is included in the package and services must occur out of the office much of the time.

DIVESTITURE

The single most difficult aspect of reform will be divestiture. Increased client choice will be a good thing, but the rapid pace of change and job uncertainty is causing great disruption in staff morale. Substance abuse prevention, substance abuse treatment in Person County, and work first screenings have all been put out to bid and providers found to implement these services. Divestiture plans are incomplete for the remainder of our services. We are working closely with each of our counties in planning the transition.

INFORMATION, RESOURCES

To request the OPC reform newsletter call **Kenyetta Farrington**, 913-4000, or e-mail kfarrington@opc-mhc.org. The OPC website www.opc-area.w1.com has RFP information, OPC's business plan, service access information, online client feedback forms, and a page devoted to our consumer and family advisory group(CFAC.) *Tom Maynard can be reached at tmaynard@opc-mhc.org*

NOTICE

Opportunity for benevolent investment

The OPC Area program together with the Mental Health Association of North Carolina may be applying for a HUD grant to build either a group home or supervised apartments, a much needed resource, in Siler City. Because of HUD's "site control" requirements, it will maximize our options significantly if we have an investor who is willing to purchase the property and be the interim owner during the HUD application process. Anyone interested in exploring this opportunity to make a benevolent investment should contact **Judith Romanowski**, OPC Support Services Coordinator, at 919-913 4034.

News Brief from NCDHHS

N.C. Department of Health and Human Services Secretary **Carmen Hooker Odom** has announced the appointment of **Mike Moseley** as director of the Division of Mental Health, Developmental disabilities and Substance Abuse Services. "We are entering a new stage in mental health reform" said Hooker Odom. "Today we are putting our plans into action, with the system changing across the state. Mike is the right person for this role".

Mosely has worked in the state's mental health system since 1976 in a number of leadership positions. For the past five and a half years he directed the Caswell Center, a state facility for people with severe developmental disabilities. During his tenure he worked to move clients from institutional care to community settings. He commented, "The days of focusing on big institutions as the only source of care are over. I've seen it is possible to successfully transition people from large residential settings to community care. We must build a mental health system that supports people in their own neighborhoods to the greatest extent possible".

A native of Kinston, Mosely holds a B.A. from the University of North Carolina at Chapel Hill and an M.A.Ed. in special Education-Mental Retardation from East Carolina University.

My Brother is Calling Again

By Rebecca Bailey

Reprinted from the Chapel Hill News

My brother is calling again, the third time this past hour. "I'm in trouble up here," he repeats, his voice flat, without urgency. "Up here" is an assisted-living group home in the western half of North Carolina. It is the fifth such home he has tried over the past five years; when things go wrong, as they are apt to do, our parents have been willing to take him back in. But this past year, both parents have battled severe, on-going medical problems. They can no longer care for my brother, who first showed signs of paranoid schizophrenia when he was ten years old.

"This will have to be *it*," my father declared of the current group home. He has said those words before. It is, I believe, the nicest house my brother has lived in: the "housemother" is genuinely caring, the place is kept clean and is located in a semi-residential area. Each of six residents has a private room; meals are eaten communally; meds are distributed; laundry is done once a week.

But my brother, in his fourth month of residency, does not yet have a caseworker and so is unable to participate in the community program designed to teach social and work skills. He was told to be patient because "money is scarce." The idea of attending a daily program is stressful to my brother, but even worse is sitting inside four walls or walking the limited grounds. His fellow residents are significantly older and don't provide the social setting a young adult, ill or not, needs. On one occasion my brother's medication was delayed for 12 hours. He hallucinated, at one point telling my mother over the phone that he was becoming a panther. A fellow resident overheard, and alarmed, tried to have him thrown out.

The lack of community services is nothing new; several articles in the September-October 2003 NC *Medical Journal* discuss this problem. Even when certain services are supposedly in place, administrative oversight or misjudgment can render them useless.

Before my brother went to his current home, he managed to get an apartment through the mental health system in my parents' county. The apartment was our miracle, a dream come true. It was brand new; during construction my entire family would drive out to the building site to watch the progress of insulation, siding, landscaping. We tried to ignore the fact that the building was located in one of the roughest areas of the city; sirens regularly cut through the constant drone of traffic. A brand new van sat in the freshly paved parking lot to ferry residents to planned activities, but the activities never took place. The young woman who was hired to live on site and coordinate events turned out to be a college student; she never had time to provide services yet nothing was done to replace her. A special bus system was supposed to pick up residents at their doors and deliver them to jobs, community-based day programs, or any other spot in the city—but according to a rule, rides had to be requested a week in advance. My brother hated his assigned "program" because it was loud, unruly, and essentially a babysitting service. He applied for a volunteer job and had a promising interview, but somehow the required paperwork from his case manager never made it to the employer. My brother was spending more and more time at my parents' home. He knew he needed to live with other people; otherwise his hallucinations worsened and became unbearable.

After four months, he left his apartment and moved back home. Six months later, in the same week, my father was diagnosed with cancer and my mother with serious heart trouble.

We pin our hopes on the current group home, on the yet-to be-named caseworker, on the untried community support system. There have been good days: upon returning to his group home after Christmas—a difficult holiday— my brother was greeted with a neat stack of wrapped gifts. Now the phone is ringing again, and again I hear my brother's voice. I can tell immediately that he is better; the unspecified trouble, alluded to earlier, seems forgotten. I listen as he describes supper—better than anything I would prepare. "You're in a good place," we tell him. We have to believe it.

Rebecca Bailey, a NAMI-OC member, coordinates our mailings. She can be reached at 929-5818.

Another Perspective

Mental Health Reform: Tragedy in the Making?

By Clay C. Whitehead, MD

I am a psychiatrist and psychoanalyst who has worked part time in public and community psychiatry during my thirty-year career. My perspective is from medicine, public health, and an interest in the common good.

The North Carolina "mental health reform" process has the familiar and ominous predictability of a Shakespearian tragedy. One hopes that this time things will be different, but, of course, they never are.

I have observed this process closely in three previous incarnations. I witnessed the beginning of the trend in California in the early eighties, and saw it replayed in Missouri and Nebraska ten and twenty years later. Recently one of my friends and colleagues came out of retirement to acknowledge that his participation in similar "reform" in California had been an act of professional cowardice and had greatly harmed the state's mental health patients. This was certainly a powerful mea culpa, but had to wait until after retirement to be acknowledged.

When one looks underneath the ritualized rationalizations for this "reform" one detects two essential elements: decentralization and privatization. The first, decentralization, is really a euphemism for decapitation, and is sold as deinstitutionalisation. One seeks to remove the key institutions and demoralize the key leaders. When this is accomplished, the entire public mental health care structure almost inevitably begins a drift toward oblivion.

The second strategy, privatization, is really a euphemism for denial of care, and is sold as "competition". Responsibility is delegated to evanescent and greedy managed care operations, which protect the public and the politicians from the painful task of abandoning the weakest among us. The simple fact is that historically the mentally ill poor have always been cared for through charitable and public funding. Had it been a lucrative area, our entrepreneurs would have long ago seized the initiative. Experience has shown that the only money to be made in this area is in the business of withholding services.

Following the closure of the hospitals, promises to support local care are voided, and the County institutions quickly starve. This is the pattern in the thirty or so states where "reform" has been imposed. States promoted by "reformers" as "successes" are rated F" by the national mental health organizations. Any question about a similar fate for North Carolina can quickly be answered by considering the collapse of the Vance County and Durham programs since implementing "reform". No solution is in sight.

What will this "reform" bring? Illusory savings, or windfall real estate sales will soon be forgotten as people realize there is no help. Those in need will end up in the streets, in prisons, in nursing homes, or in an early grave. This may seem unpleasant, but it is well documented to have repeatedly happened around America.

Our "reformers" have imposed a rather sad future on the weakest in our society, and an inattentive public will realize too late the enormous price which has been paid. At this stage, I would ask all of you to join with Margaret Brown, Orange County Commissioner, in her laudable efforts to salvage our local program and to reassert that this community cares for all its' people.

CLAY C. WHITEHEAD, MD
4 Davie Lane Chapel Hill, NC 27514
(919) 942-7009

EDITOR'S NOTE:
NAMI-OC encourages civil dialogue on the reform process, and this edition features several viewpoints on mental health reform. Do you have a perspective and/or experience you'd like to share with readers? Email *News & Views* editor Barbara Nettles-Carlson unikorn@bellsouth.net. or call 942-1393

International Center for Clubhouse Development Unites Clubhouses

By Anne Jackson & Pam Sinel

Housed at Fountain House, the pioneer clubhouse located in Manhattan, the International Center for Clubhouse Development (ICCD) unites clubhouses around the United States and the world. The ICCD mission is "to serve and represent the rapidly growing and dynamic clubhouse community. The vision….. is that men and women with mental illness throughout the world will have access to the respect and dignity offered by clubhouses, and to the full range of clubhouse opportunities, as they rebuild their lives." (www.iccd.org)

Eight intrepid Club Nova members, staff, and a board member journeyed to Minneapolis, Minnesota last October for the ICCD's Twelfth International Seminar, hosted by Vail Place Clubhouse. This whirlwind conference consisted of four days of discussion, sharing and learning among colleagues from clubhouses all over the world. We heard inspiring stories such as a clubhouse in Croatia that started without even a table or chairs and embarked on creating a Transitional Employment program in a nation suffering a 50% unemployment rate. Members gave personal accounts of how the clubhouse experience had forever changed their lives. ICCD representatives spoke on issues such as employment, education and the roles of clubhouse directors, members, staff, and boards.

Club Nova Director **Karen Kincaid Dunn's** presentation was on members becoming employed as full-time staff. Other topics were supported education/supported employment programming, research, innovative funding sources, successful clubhouse newsletters, and the art of engaging members in the clubhouse "work ordered" day.

Club Nova's presence at the Minneapolis Seminar was made possible by a $10,000 grant for training purposes from the Eli Lilly Co. We extend a huge thank you to Eli Lilly Co. for recognizing the importance of clubhouse training and making such a significant investment in our future. With the remaining Lilly grant funds we hope to send staff and members to a three week Colleague Training at one of the clubhouse training bases.

Attending the International Seminar were **Anne Jackson, Lewis Robison, Taralyn Farell, Pam Sinel, Suzie Aragona, Karen Dunn, Santo Booth and Matt Cox.** Although somewhat overwhelmed, we were excited to come back home armed with new ideas and strategies to strengthen Club Nova. We were so grateful to be able to attend this inspiring and educational event! We look forward to the 13th International seminar, in Helsinki, Finland, in June, 2005.

Anne Jackson & Pam Sinel can be reached at Club Nova, 9686682

Notes on Book Event

A lively crowd gathered March 6 at the Fearrington Barn for a book event honoring the memory of Joshua Seay, son of Lee Smith and James Seay. Josh, a bright spirit who lived with serious mental illness, died in his sleep last October. A thunderstorm with rain battering the Barn's tin roof failed to dampen our spirits and underscored the emotion of the occasion.

Author Kaye Gibbons opened the occasion with her own unique style and humor. Lee Smith spoke warmly on behalf of Josh's parents, Jim and Caroline Seay and Hal Crowther. Featured speaker Virginia Holman interspersed personal comments with moving selections from *Rescuing Patty Hearst*, her memoir about life with her mother. Holman highlighted the family frustration and the sad consequences when the legal and clinical systems prevented getting her mother timely treatment for schizophrenia.

Kudos to the sponsoring independent bookstores that donated booksale proceeds to NAMI-NC (Branch's, QuailRidge, McIntyre's, Regulator, Market Street, Country). Donations at the event totaled over $2000. Nancye Bryan expressed appreciation on behalf of NAMI-NC and Triangle affiliates. Beth Greb ably staffed the NAMI literature table assisted by Susan Spalt, Wadleigh Harrison, Rebecca Bailey and Barbara Nettles-Carlson

Volunteer opportunity

Brain Imaging Study, Social Cognition Study at UNC-Chapel Hill

If you:

- ✓ Have a diagnosis of schizophrenia or schizo-affective disorder
- ✓ Are a male between the ages of 18-35
- ✓ Have no current problems with alcohol or drugs

Then you may be eligible to participate in:

A BRAIN IMAGING STUDY investigating the relationship between social cognition (how one perceives themselves and others) and brain activity in people with and without schizophrenia. In this study you will be interviewed about your psychiatric history, current and past symptoms. You will then be asked to complete tasks that involve thinking and perception skills. You will be asked to do some tasks while in an imaging session. Assessments should take no more than four hours (can be completed over one or two meetings) for which you will be paid $15.00/hour.

A SOCIAL COGNITION AND SOCIAL FUNCTIONING STUDY, investigating social cognition (how we perceive other people) and social functioning among persons with autism and schizophrenia. In this study, you will be interviewed about your psychiatric history, current and past symptoms. You will then be asked to complete tasks that involve cognitive (e.g., memory) and social cognitive skills (e.g., identifying the emotions on others' faces). These assessments should take about 3-4 hours (which can be completed over one or two meetings) for which you will be paid $12.50/hour, for a maximum total of $50.00.

To find out more about these studies contact **Dr. David Penn.** Phone (919) 843-7514 Email: *dpenn@email.unc.edu*

Volunteer opportunity

New Research at Duke Will Test Transcranial Magnetic Stimulation to Treat Major Depression

A clinical depression research trial is beginning at Duke University Medical Center. The principal investigator is **Andrew (Andy) Krystal, MD**.

The procedure used in the study is Transcranial Magnetic Stimulation (TMS). The trial will test a TMS device to evaluate its safety and ability to improve mood in patients with major depression. Trial results will be submitted to the US Food and Drug Administration (FDA).

Persons enrolled in the trial will be randomly assigned to one of two treatment groups. One group will receive the active TMS study treatment and the other group will receive an inactive, or sham, treatment.

- *The trial consists of 30 treatments during a six week period*
- *Treatments are scheduled one per day Monday thru Friday. Treatment takes 45-60 minutes to complete*
- *You will remain awake for the procedure: no anesthesia or medication is required*

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- *All procedures will be done on outpatient basis*
- *You may go about normal activities after a TMS session*
- *Completion of interviews and forms will be required from time to time.*
- *All trial related medical care will be at no cost to you.*

You may be a candidate to enroll in this trial if you have been diagnosed with major depressive disorder and are 18-70 years of age. For details and a prescreening interview, contact **Pamela Smith**, Coordinator Phone 919-681-8750,and fax: 919-681-8744 *email: smith288@mc.duke.edu*

UPCOMING EVENTS

Saturday April 10 NAMI-OC meeting at Church of Reconciliation. 110 N. Elliot Rd., Chapel Hill. Fellowship and sharing 9:30. At 10:30, presentation on Family-to-Family, NAMI's signature educational program. Have you wondered what it's all about? Come and find out when a panel of experienced teachers take us through "F2F 101".

Friday-Sat, April 23-24 NAMI NC Spring Conference. North Raleigh Hilton. Theme: "Reform, Responsibility and Recovery: NAMI North Carolina 20 Years and Going Strong." Registration fee. Information: 919-788-0801

Saturday May 1, Annual Legislative Breakfast, 8:30-10 at the Church of Reconciliation. A forum for dialogue about mental health issues. Keynote speaker **Lanier Cansler**, Deputy Secretary, NC Dept of Health & Human Services, will address system reform issues, followed by a question and answer session with our state legislators.

Tuesday, May 4 Joint meeting with NAMI Durham, 7-9 pm at Watts Street Baptist Church. The program will feature **Beth Melcher**, Ph.D, Director of the Science-to-Service Project. She will speak on "Evidence-based practice, Mental Health Services that work".

Saturday May 22, STEP Symposium, 8:30-2pm, Carolina Alumni Club. Topic: Antipsychotic Drugs and Weight Management. Includes lunch!

Saturday June 12 NAMI-OC affiliate meeting at the Church of Reconciliation. Fellowship and sharing, 9:30. 10:30 program will feature **Dr David Penn**, clinical psychologist, UNC Chapel Hill. He will speak on "Recovery Models: what works".

Jonathan Barker D.Min, LFMT, a NAMI-OC member and author of *Acceptance: An Insider's View of Bipolar Disorder*, will donate 10% of online booksales to NAMI–OC. His website: www.jonathanbarker.com

NAMI Orange County

Board of Directors

Please let us know your comments and concerns. We meet every other month in the Carol Woods conference room, 750 Weaver Dairy Rd. Next meeting: May 16 3-5 pm. Meetings are open.

NAMI-Orange County is a local affiliate of the National Alliance for the Mentally Ill, a non-profit organization for support, education and advocacy on behalf of individuals with severe mental illness and their families.

Information, Support, Referrals

Local Helpline 929-7822
North Carolina Helpline: 1-800-451-9682

Websites

Local: www.namiorange.org
State: www.naminc.org
National ***www.nami.org***

If you are not a member we encourage you to join. Annual dues are $35.00. Open Door membership, $3.00 is available to those with limited income. Your dues give you membership in the Orange County, North Carolina and National NAMI. Make your check payable to NAMI Orange County and mail with this completed form to: NAMI Orange County, PO Box 4201, Chapel Hill, NC 27515

Our membership year begins January 1, 2004

NAME_____ **PHONE:**_____ **EMAIL**_____

MAILING ADDRESS_____

_____Annual membership dues ($35.00 regular or $3.00 open door)

_____Contribution (tax deductible)

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NAMI Orange County

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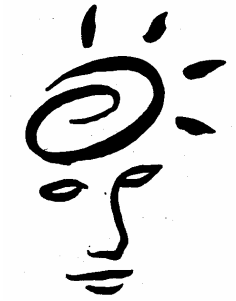

Open Your Mind

Mental illnesses
are brain disorders