



Greater Des Moines

Box 12174, Des Moines, Iowa 50312

(515) 277-0672 (voice mail)

AFFILIATE AND SUPPORT GROUP NEWSLETTER

July 2008

“Support, Education, and Advocacy”

Serving Polk, Dallas, Warren, and Madison counties

<p>Education Meetings are generally the 1st Sunday of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room. Dates on Sundays other than the 1st Sunday of the month are due to holidays or other special scheduled events.</p>		<p>Business and Committee Meetings are the 2nd Thursday of the month at 5 P.M. at the NAMI-Iowa Office.</p> <table border="0"> <tr> <td>1. Business</td> <td>4. Education</td> <td>6. Fundraising</td> </tr> <tr> <td>2. Marketing and membership</td> <td>5. Advocacy</td> <td>7. Special Events</td> </tr> <tr> <td>3. Support</td> <td></td> <td></td> </tr> </table>		1. Business	4. Education	6. Fundraising	2. Marketing and membership	5. Advocacy	7. Special Events	3. Support		
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3. Support												
<p>Sunday, July 6–2 PM</p>	<p>The topic will be Veterans Issues. Our speaker will be Pat Wilson. She will give us information on the National Guard program “Enduring Families”.</p>	<p>Thurs–5 PM July 10</p>	<p>We will be discussing and planning around 7 topic areas</p>									
<p>Tuesday, July 22 8 AM to 4:30 PM</p>	<p>2008 Iowa “Ticket to Work” Summit Conference - Join Iowa employment providers to learn about the <i>new</i> Ticket to Work, under the Social Security Administration at the Scheman Center Iowa State University, Lincoln Way & University Boulevard in Ames <i>Cost:</i> None <i>To Register:</i> By July 12th, provide name(s) of participants, county of work, agency name, & phone number via email to mary.revoir@iwd.iowa.gov <i>Targeted Audience:</i> Employment Networks, IVRS counselors, community providers, case managers, CPC’s, Centers for Independent Living, those interested in becoming an employment network, and other stakeholders in supported employment.</p>											
<p>Wednesday, July 23 Noon to 1 PM</p>	<p>Lunch ‘n Learn at Mercy Medical Center – East Tower Auditorium. Free lunch provided. Topic is “Breaking the Silence” with the subtitle <i>Living with Mental Illness</i>. An educational program with persons with mental illness, family members, and health care professionals to increase mental health awareness. Please RSVP to the Mercy Nurse at 243-2584 option 3 so enough lunches will be prepared. CEU’s are available. This event is sponsored by the Mercy Hospital Center.</p>											
<p>Sunday, August 3, 2 PM</p>	<p>The topic will be a State-wide Emergency Mental Health Safety Net and Crisis Response System. Our speaker will be Karen Hyatt – an Emergency Mental Health specialist with the Iowa Dept. of Mental Health & Disabilities</p>	<p>Thurs – August 14 - 5 PM</p>	<p>We will be discussing and planning around 7 topic areas</p>									
<p>Tuesday through Thursday August 5-7</p>	<p>The theme of the Iowa Empowerment Conference is “10 Years Celebrating Empowerment & Recovery” – This is a conference for individuals with chronic mental illness, families of children with severe emotional disorders and transition age youth. It will be held at the Best Western Regency Inn, Marshalltown. Conference contact information: Iowa Empowerment Conference, 1 West Grant St., Apt. 109, Marshalltown or – Call Deb at 641-753-7414 or send an e-mail to dwilliams@adiis.net. Scholarships may be available.</p>											
<p>Thursday through Saturday Sept. 4-6</p>	<p>2008 National Lifespan Respite Conference - “Homegrown, Cultivating Caregivers” at Embassy Suites in Des Moines. Contact the Iowa Respite Crisis Care Coalition to obtain more information 515-309-0858. Growing Fields of Knowledge Planting Seeds of Change Watering Hope and Care Nurturing Promising Programs Cultivating Outcomes for Caregivers</p>											
<p>Family to Family class starts</p>	<p>Thursday Sept. 4 through November 20</p>	<p>Family to Family class – at Warren County Board of Supervisors Conference Room #1 – Indianola – To sign up - Call Grace Sivadge at 961-6671 or e-mail rsivadge1@juno.com or call 277-0672 or 254-0417.</p>										
	<p>Friday – Sunday Sept. 12-14</p>	<p>Family to Family Teacher training – If you are interested – please email porch3498@yahoo.com Or call 1-800-417-0417 or 254-0417.</p>										
	<p>Saturday, Sept. 13</p>	<p>Community Days at Merle Hay Mall – NAMI Greater Des Moines will be a vendor at this event. NAMI Walks information for potential participants will be the primary focus of participation.</p>										
	<p>Friday – Sunday Sept. 28-30</p>	<p>Visions for Tomorrow Teacher training – If you are interested please email namiowa@mchsi.com or phone 254-0417 to Jackie Elfmann.</p>										
<p>Sunday, Sept. 7</p>	<p>Legislative forum on mental health issues.</p>	<p>Thursday, Sept. 11</p>	<p>We will be discussing and planning around 7 topic areas.</p>									

Our website is: www.nami.org/sites/NAMIGreaterDesMoines

See yourself as a person, not an illness.

There are many points on the continuum of wellness, and different degrees of recovery that can be reached with medication, therapy, and a strong support system.

CASES

In Delusions of Romance, Genuine Comfort

By Elissa Ely, M.D.

New York Times – May 13, 2008



She was never on time to clinic appointments. Leaving her apartment was not simple when it required pushing aside the furniture she had pushed against the front door the night before, and even the furniture was no protection against the threats

she perceived.

She said strange men burrowed into the apartment after dark, right through the door, the chest of drawers and the armchairs. They entered her body, and then they ate her up from the inside. It took years before she told us this. We might doubt her, but she knew it happened. Numerous expensive anti-psychotics made no difference at all.

She smoked heavily, partly from anxiety and partly because, like many chronically institutionalized patients, she had been bribed into placidity with cigarettes years earlier. Before her first psychotic break, she had been a singer. Smoking was not good for her voice, of course, but under these harrowing circumstances, quitting was impossible.

A few days after an appointment at which she had looked even wearier than usual, she collapsed. In the emergency room, her blood sodium was low. The medical resident decided it was from her psychiatric medication; he discontinued some, decreased others and sent her home.

Three months later, while defensively moving furniture, she had a seizure. Back in the hospital, she still had low sodium, but a scan showed diffuse lung cancer, metastatic to bones and brain. Her problem was not a result of psychiatric medications.

She refused to acknowledge her cancer, but she demanded that everything reasonable and unreasonable be done for the illness she insisted did not exist. When she grew too weak from chemotherapy and radiation to live alone - much less move the furniture - she was transferred to a rehabilitation facility. The consultant there stopped all of her medications except for a low dose of a single antipsychotic. In his view, the drugs increased her fatigue from the medical therapies. In our view, he might as well have been treating a raging pneumonia with a vitamin.

Two months before she died, she came to see us. She arrived in a wheelchair, unable to walk from metastatic fractures, wearing a stylish bandanna. She was hard to recognize physically, and almost impossible to recognize mentally. She was rational, brisk and organized. She told us she had decided to stop the chemotherapy and radiation. "It's cancer; there's no cure," she said, as I recall. She was lucid as could be, on almost no medication at all, with not one molecule of paranoia or a single misconception. We were the ones confused. We were astounded.

Then she told us something else astounding. Love had come into her life.

During the last few M.R.I.'s that tracked the progress of her tumors, a radiology technician had given her headphones to pass the time. Jazz began to play, and then each time, in the M.R.I. tube, a famous singer appeared in the dark.

She recognized him immediately. "I can't tell you who he is," she said, modestly, "because he's married." Still, she couldn't keep good news to herself. "He was singing love songs to me," she said, "and I sang them back to him."

She had a look of demure joy, recalling the married Frank or Dean (she couldn't tell us who) crooning to her over the M.R.I. machine. Against all spatial reality, they lay together, singing. "It was very nice," she said. We might doubt her, but she knew it had happened.

She had underestimated us. We would not have dreamed of questioning her. If there is anything fair about psychosis (and there is not), this was the least schizophrenia owed her. Her delusions, unremittingly ugly, had suddenly grown beautiful. In the end, the psychosis was her friend.

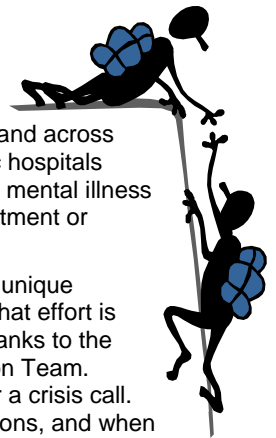
Elissa Ely is a psychiatrist in Boston.

CIT OFFICERS PATROL THE STREETS ACROSS ALLEGHENIES

Laurel Highlands Region

Crisis Intervention Training

WJAC-TV (Johnstown, PA), May 19, 2008



There's a mental health crisis in our state and across the country. Over the decades, psychiatric hospitals have closed, leaving more individuals with mental illness out on the streets, often times with no treatment or medication.

Police officers are finding themselves in a unique position to help fix a broken system. And that effort is under way right here in the Alleghenies thanks to the Laurel Highlands Region Crisis Intervention Team. They're the first responders dispatched for a crisis call. They're forced to make split second decisions, and when confronted with a suspected threat, they're quick to take action to serve and protect. But police officers are finding what sometimes appears to be a disturbing the peace call is something entirely different: A person in distress who really only needs help.

"They're not flawed people," said Peggy McGuirk. "They're not people who are bad. They just have a bad illness."

McGuirk has needed to call on police in the past. She has a loved one diagnosed with schizophrenia.

"You're always afraid that when a police officer comes, if they're needed and a situation is out of their control, you're worried about how they're going to react and you're worried about your loved one's safety," said McGuirk.

A group of about two dozen men and women are the latest to be certified in crisis intervention training. It's a 40 hour, extensive course in which they volunteer to learn how to deal with those who are mentally ill.

Philip Cromwell agreed to share some of the intimate details of his psychosis with the group, from his darkest days of depression to his manic highs, a vicious cycle Cromwell said always seemed to include the police.

Cromwell said, "I've been thrown to the ground, had the knee put in the back of my neck. I've gone to jail many times."

Last year, Johnstown's CIT officers responded to 234 crisis calls. CIT Officer Dan Marguccio was one of the first officers in the state to earn the CIT distinction. Now, he's helping to train others on the force from nearly two dozen departments covering Cambria and Somerset Counties.

Marguccio said, "We're a little different police officer. I can say it's

reducing our injuries. Ya know, if we can talk someone down, rather than hustle with them, I'd rather do that."

CIT training is breaking barriers that often exist between the mentally ill and police.

Wendy Stewart of National Alliance on Mentally Ill Cambria County said "The officers are able to deescalate the situation right on the scene and they don't have to arrest a person and they don't even have to take them to the hospital."

CIT officers are trained to alter their approach. They learn to speak softly, rather than shouting commands. They learn to repeat phrases and keep their distance while always maintaining eye contact. They hit the books, delving into the clinical issues, medication and its side effects. They listen to experts and advocates and to those who this training means the most.

Officer Melanie Kline of the Jackson Township Department said, "I never thought in a million years that they would send a National Guard unit from Johnstown, Pennsylvania right into the front lines. We were losing one, two, three soldiers a day."

Kline is an example of the estimated 20 percent of returning troops who suffer from some form of post-traumatic stress disorder. She lost friends in Iraq and this Jackson Township officer almost gave up.

Kline said, "When I came back, I was sleeping a lot. I was depressed. The guy who I had been engaged to left me. It's 100 percent better now, especially because of my CIT training, I got a chance to talk about my experiences."

Most veterans like Kline get better in six months. But for about 40 percent, it's a lifetime struggle. She's here for those vets who are often misunderstood when experiencing symptoms like flashbacks.

Kline said, "Ask them what's going on or if they're OK. Just throwing in that question may change their whole approach on how they deal with the situation."

Sgt. Phil Staib of the Somerset Police Department said, "A lot of times we find out they're not taking their medication any longer and that's what's creating the problems."

The Laurel Highlands Region program is built on community health care and advocacy partnerships and is based on a nationally recognized model developed by the Memphis Police Department. Since taking root here, officer and mental health injuries are down, arrests are down, and health care referrals are up.

Perhaps most striking of all, officers begin to understand what it's like to be in the grip of a mental illness. Empathy erases stereotypes and misconceptions. These men and women are armed with new knowledge and new friends.

Cromwell said, "We trust them now. We don't panic when we see them coming. We're on a first name basis now. We know these officers. They're like family, like friends."

The Laurel Highlands Region CIT program is taking off. Not only have members of law enforcement been certified, but so has a local 911 dispatcher, a district magistrate, plus hospital security and prison guards.



If you have a mental health crisis in your family and need assistance – call 911. Be clear with the dispatcher what the situation is, that it is a mental health crisis, and you need the DM Mobile Mental

Health Crisis Unit to assist. The goal is to keep everyone safe and to seek the appropriate level of assistance for the ill family member or friend.

The first people to arrive to the situation will be Des Moines 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 Unit is needed.

When DM Mobile Mental Health Crisis Unit staff arrive, a mental health assessment will be done, on-site counseling and problem solving, crisis plan development, coordination with hospitals if transport to a medical facility is necessary, and medication can be administered if necessary. A psychiatrist is always on call to help make those determinations and authorizations.

DM suburbs also use the mobile crisis team services – their officers make the decision whether or not the mobile crisis team is called.

The Mobile Crisis Unit is available 6:30 AM to 2:30 AM – 7 days a week. It is staffed by licensed mental health professionals and registered nurses.

Looking for Community Resources?
Phone 211
www.211iowa.org
Contact Polk County Health Services
218 6th Ave – 243-4545
<http://polk.ia.networkofcare.org/mh/home/index.cfm>
Go to the visiting nurses website
www.vnsdm.org
click on "links" – then click on Community Resource Directory

Community Mental Health Centers

Polk County Child Guidance Center – 808 5th Ave – 244-2267
Eyerly Ball Community Mental Health Center
1301 Center St. – 243-5181
Broadlawns Medical Center- 1801 Hickman Road – 282-6770
Behavioral Health Resources – 945 19th St – 241-0982

Dallas County – West Central Community Mental Health Center
2111 Green, Adel – 515-993-4535

Madison County – Bridge Counseling Center
300 West Hutchings St. – 515-462-3105

When dues are paid to NAMI Greater Des Moines – you have NAMI GDM membership (local affiliate), a state membership, and a national membership (3).		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	Yes
When dues are paid to NAMI Iowa – you have a state membership and a national membership		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	No membership
NAMI E-Join is a nationwide online membership initiative that began June 20, 2007. E-Join will allow visitors to NAMI's Web (www.nami.org) site to join online, using a credit card, for a universal dues rate of \$35/annually. The money is sent to the state and local affiliate.		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	Yes

SUPPORT GROUP MEETINGS for Family Members

Third Sunday of the month -7/20/08 Family members, if you are interested in participating in a NAMI family support group, please contact Glenn Hobin lowaGH@aol.com or call 965-9799 - or contact Grace Sivadge 961-6671. Meetings are at Eyerly-Ball Community Mental Health Center, 1301 Center St., Des Moines – 2:30 – 4:00 P.M.

First Monday of each month -6:30 – 8 PM – 7/2/08 - a support group for **parents and caregivers** of children and adolescents with severe emotional disturbance (SED) or mental illness – meets at the Child Serve Center – 5406 Merle Hay Rd, Johnston. For more information – call Diane at 255-8157.

4th Monday of each month – 5:30 – 7 PM – a support group for Polk County **parents and caregivers** of children and adolescents 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 – please pre-register, if possible – call Dawn at 558-6247. The outreach target is the Sudanese and minority population, but anyone can participate.

Last 2 Monday nights of the month – 6:30-8:30 PM – Perry - a support group for **parents and caregivers** of children and adolescents with severe emotional disturbance (SED) or mental illness – St. Martin's Episcopal Church – 10th Street & Iowa - call Shirley at 515-975-6489 or Kelly at 515-229-4203 or 1-800-649-5423. No child care is provided. The outreach target is the Hispanic and minority population, but anyone can participate.

Friday Noon Lunch n' Learns for **parents and caregivers** of children and adolescents with severe emotional disturbance (SED) or mental illness - Orchard Place, 925 South Porter – call Diane at 273-5054 – to find out when the next lunch 'n learn will be held.

SUPPORT GROUPS for Persons with mental illness

Every Monday evening 7-8:30 P.M. – NAMI Connections – a support group **for persons with mental illness** – facilitated by persons with mental illness – at the NAMI Iowa office – 254-0417 – or 1-800-417-0417 - 5911 Meredith Drive, Suite E, Des Moines. Contact Dawn Olson at dawnao@iowatelecom.net or 641-842-3859 if you have questions. Dawn Olson and Kyle Damman are facilitators.

2nd & 4th Mondays of each month – 7 P.M. – **For depression and anxiety disorders only** – WestView Church, 1155 SE Boone, in Waukee. Call Julie at 710-1487 or E-mail at candlesinthedarkness@mchsi.com

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.

2nd & 4th Tuesday of the month – **New Light Support Group** – 6:30 to 7:30 -for persons experiencing depression or other mental health issues – at Westkirk Presbyterian Church, 2700 Colby Woods Drive, Urbandale, Iowa – 515-253-0330 – Pastor Michael Mudlaff

Every Wednesday afternoon – NAMI Connection Support Group - a support group **for persons with mental illness** – facilitated by persons with mental illness 2 to 3:30 P.M. at **Mercy Franklin Clinics**

- West Conference Room - 1750 48th Street - Contact: Debbie Wallukait (515) 288-4439 or Eddie Lathrop, Jr. - 515-865-1331 legalbound34@yahoo.com

Every Thursday at 2:00 P.M. - **Recovery, Inc.** - a self-help group for people who have nervous and mental troubles – at Central Iowa Center for Independent Living, 665 Walnut St., Des Moines – Call 237-0232 – Mark Grunzweig.

1st and 3rd Thursdays – 5:30 – 6:30 P.M. in Room 213 - The H.E.L.P. Depression Support Group meets at Lutheran Church of Hope, 925 Jordan Creek Parkway, Call 222-1520, ext. 175 or Lisa.davidson@hopewdm.org

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 morning – 10 to 11:15 A.M. – Room 214 - The H.E.L.P. Depression Support Group meets at Lutheran Church of Hope, 925 Jordan Creek Parkway, Call 222-1520, ext. 175 or Lisa.davidson@hopewdm.org

Every Saturday afternoon – 2:00 – 3:30 P.M. – the **Depression and Bipolar Support Alliance** meets at Iowa Lutheran Hospital – University at Penn Avenue – Level B – private dining room. This is a support group for consumers.

Coping After a Suicide Support Group – Polk Co. Crisis and Advocacy Services – Contact: Chris 515-286-3887 Meeting day – 2nd Thursday of each month 6-7:30 P.M. **and** last Saturday of each month 9-10:30 A.M. Meeting place is 525 5th Avenue, Suite H. Victim Services Phone: 515-286-3600

Do you know of other support groups in the Des Moines area that we should list in our newsletter?

Suicide Prevention Lifeline 1-800-273-TALK (8255)
Veterans Suicide Prevention Lifeline 1-800-273-TALK (8255)

What to Look For, What to do

A person may be suicidal if he or she:

- ✓ Talks about committing suicide.
- ✓ Experiences drastic changes in behavior.
- ✓ Withdraws from friends and social activities.
- ✓ Loses interest in hobbies, work, school.
- ✓ Gives away prized possessions.
- ✓ Has attempted suicide in the past.
- ✓ Takes unnecessary risks.
- ✓ Is preoccupied with death and dying.

What you can do:

- ✓ Be direct. Talk openly and matter-of-factly about suicide.
- ✓ Be willing to listen. Allow expressions of feelings.
- ✓ Be non-judgmental.
- ✓ Show interest and support.
- ✓ Don't act shocked.
- ✓ Don't be sworn to secrecy.
- ✓ Offer hope that alternatives are available, but do not offer glib reassurance.
- ✓ Remove means, such as guns or stockpiled pills.
- ✓ Get help. If you or someone you know is in crisis, call 911 or 1-800-273-TALK (8255), the 24 hour National Suicide Prevention Lifeline.

Sources: *Suicide Prevention Action Network (spanusa.org)*
And the American Association of Suicidology (www.suicidology.org).



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.



Assistance with Prescription Cost

Polk County residents without full health insurance coverage can save on prescription drugs under a county sponsored drug discount program. For a complete list of card locations or a list of participating

pharmacies, call 286-3895. **and**

The Partnership for Prescription Assistance - Call 1-888-477-2669 or visit www.pparx.org to see if you may qualify for a variety of programs available. **and**

Patients who lack prescription drug insurance and are not eligible for Medicare - call 1-800-444-4106 or visit the [Together Rx Access Web site](http://TogetherRxAccess.com) for the **Together Rx Access™ Card**.

Research Study

Senior Parent(s) Providing Support for Adult Children with Schizophrenia or Schizoaffective Disorder

The purpose of this research study is to examine the caregiving relationship between senior parents and their adult children with schizophrenia or schizoaffective disorder. The study is to investigate mutual support within family units. A single interview will be conducted with each family member: the parent(s), an adult sibling and the adult child with schizophrenia or schizoaffective disorder. Each interview will last about an hour and a half and will be scheduled at your convenience. No travel is required. Compensation is available. Participation is voluntary.

If you have any questions or would like more information, please contact: James R. Power, MSW, LMSW
 Doctoral Candidate, School of Social Work, U. of Iowa
 319-339-1958 or 515-210-1858
James-power@uiowa.edu

How to contact the Iowa Dept. of Mental Health and Disability Services
 (Established in 2006 via HF 2780 by the Iowa legislature)

Address: Hoover Office Building, 1305 E. Walnut St.
 Des Moines, IA 50322
Phone: 515-281-7277
Website: www.dhs.state.ia.us/mhdd/index.html

Director	Dr. Allen Parks
Assistant to the Director	Barbara Jean Funke
Children & Youth Bureau Chief	Pam Alger
Child/Youth Specialist	Mary Mohrhauser
Child/Youth Specialist	Becky Flores
School Specialist	Laura Larkin
Adults Bureau Chief	Dr. Kelly Pennington
State Payment Program	Lin Nibbelink
Community System Consultant	Julie Jetter
Community System Consultant	Robin Wilson
Emergency Mental Health Specialist	Karen Hyatt
Secretary	Kay Hiatt
Older Adults Program Specialist	Lila Starr
Budgets, Contracts & Grants	Charlie Leist
Accreditation/Bureau Chief	Jim Overland
Accreditation Specialist	Craig Peterson
Accreditation Specialist	Dennis Sibert
Accreditation Specialist	Cheri Reisner

www.supportafriendiowa.com

The website was launched to help young Iowans who have friends struggling with mental illness. There are explanations of mental disorders that frequently impact young adults, a forum to exchange messages, suggestions on how to begin a conversation, and a list of resources.

The website is in coordination with the national "What a Difference a Friend Makes" (www.whatadifference.org) created by SAMHSA.

MH/MR/DD/BI Commission - The Iowa Mental Health/Mental Retardation/Developmental Disabilities/Brain Injury Commission -- was created in the 2004 Iowa Code as the state policy-making body for the provision of services to persons with mental illness, mental retardation or other developmental disabilities, or brain injury.

Iowa Mental Health Planning and Advisory Council – The council was created in federal law. Its duties are:

1. To participate in the development of and subsequently review mental health plans for Iowa and submit recommendations for modifications to the plans to the State of Iowa.
2. To serve as an advocate for adults and children with serious mental illness or severe emotional disturbance.
3. To monitor, review, and evaluate, the allocation and adequacy of mental health services within Iowa, and
4. To collaborate with groups, organizations, and professional associations and, specifically, to join the National Association of Mental Health Planning and Advisory Councils.

NAMI Greater Des Moines Board of Directors
Effective January 1, 2008

President - Diane Johnson	255-8157
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Cece Arnold	276-7871
<i>E-mail:</i> cece.arnold@mchsi.com	
Heather Thomas	<i>E-mail:</i> heatherjoythomas@hotmail.com

H.E.L.P. Depression Support Group Monthly Presentations

10 AM to Noon - Lutheran Church of Hope
 SE corner of Ashworth and 925 Jordan Creek Parkway, WDM

July 5 – What is NAMI? What is stigma?
 August 2 – Stories of Hope

Room 214 – Free - For more information, contact Lisa at 222-1750 ext. 176 or lisa.davison@hopewdm.org

Federal Legislative Issues

www.nami.org/advocacy

Contact information for members of Congress
Capitol Switchboard 1-202-224-3121

Contact via E-mail can be made directly through their web sites.

<http://grassley.senate.gov/> <http://harkin.senate.gov/>

<http://www.house.gov/boswell/> <http://www.tomlatham.house.gov/>

<http://www.house.gov/steveking/> <http://www.braleigh.house.gov/>

<http://www.loeb sack.house.gov/>

Check out our updated Explore the Candidates web page at www.nami.org/election2008/candidates and learn how presidential candidates are responding to NAMI's questionnaire on issues of importance to persons living with serious mental illness and their families.

To find the NAMI National federal policy agenda - go to www.nami.org/election2008



For Women Warriors, Deep Wounds, Little Care

By Helen Benedict, Op-Ed Contributor
May 26, 2008

This Memorial Day, as an ever-increasing number of mentally and physically wounded soldiers return

from Iraq, the Department of Veterans Affairs faces a pressing crisis: women traumatized not only by combat but also by sexual assault and harassment from their fellow service members. Sadly, the department is failing to fully deal with this problem.

Women make up some 15 percent of the United States active duty forces, and 11 percent of the soldiers in Iraq and Afghanistan. Nearly a third of female veterans say they were sexually assaulted or raped while in the military, and 71 percent to 90 percent say they were sexually harassed by the men with whom they served.

This sort of abuse drastically increases the risk and intensity of post-traumatic stress disorder. One study found that female soldiers who were sexually assaulted were nine times more likely to show symptoms of this disorder than those who weren't. Sexual harassment by itself is so destructive, another study revealed, it causes the same rates of post-traumatic stress in women as combat does in men. And rape can lead to other medical crises, including diabetes, asthma, chronic pelvic pain, eating disorders, miscarriages and hypertension.

The threat of post-traumatic stress has risen in recent years as women's roles in war have changed. More of them now come under fire, suffer battle wounds and kill the enemy, just as men do.

As women return for repeat tours, usually redeploying with their same units, many must go back to war with the same man (or men) who abused them. This leaves these women as threatened by their own comrades as by the war itself. Yet the combination of sexual assault and combat has barely been acknowledged or studied.

Last month, when the RAND Corporation released the biggest non-military survey of the mental health of troops since 2001, it unwittingly reflected this lack of research. The survey found that women suffer from higher rates of post-traumatic stress disorder and depression than men do, but it neglected to look into why this might be, and asked no questions about abuse from fellow soldiers.

Terri Tanielian, the project's co-editor, told me that RAND needs more money to explore these higher rates of trauma among women.

As the more than 191,500 women who have served in the Middle East since 2001 return home, they will increasingly flood the Veterans Affairs system. To ask those who need help for post-traumatic stress disorder to turn to a typical Veterans Affairs hospital, built in the 1950s and designed to treat men, is untenable. Women who have been raped or sexually assaulted often cannot face therapy groups or medical facilities full of men.

At the moment, the Department of Veterans Affairs operates only six inpatient post-traumatic stress disorder programs specifically for women. And although all 153 department-run hospitals will treat women, only 22 have stand-alone women's clinics that offer a full range of medical and psychological services.

This number of clinics may seem adequate for the 1.7 million female veterans currently at home, especially since they represent only 7.2 percent of all veterans at the moment, but it isn't. Many clinics are miles from where soldiers live, and many more are open only a few hours a week and lack staff members trained to deal with sexual assault, let alone assault combined with combat trauma.

The Department of Veterans Affairs says it plans to open more clinics for post-traumatic stress disorder, but how many will be only for women remains undecided.

Women are the fastest-growing group of veterans, and by 2020 they are projected to account for 20 percent of all veterans under the age of 45. Not all of these women will have suffered sexual assault, but many will have medical or psychological needs that conventional department hospitals cannot meet.

The Department of Veterans Affairs must open more comprehensive women's health clinics, designate more facilities for women who have endured both combat and military sexual trauma and finance more support groups specifically for female combat veterans. The best way to honor all of our soldiers is to do what we can to help them mend.

Helen Benedict, a professor of journalism at Columbia, is the author of the novel "The Opposite of Love" and the forthcoming "The Lonely Soldier: The Private War of Women Serving in Iraq."



Soldier suicides could trump war tolls: US health official

May 5, 2008 - WASHINGTON (AFP)
Foreign Policy in Focus

Suicides and "psychological mortality" among US soldiers who served in Iraq and Afghanistan could exceed battlefield deaths if their mental scars are left untreated, the head of the US Institute of Mental Health warned Monday.

Of the 1.6 million US soldiers who have been deployed in Iraq and Afghanistan, 18-20 percent -- or around 300,000 -- show symptoms of post-traumatic stress disorder (PTSD), depression or both, said Thomas Insel, head of the National Institute of Mental Health.

An estimated 70 percent of those at-risk soldiers do not seek help from the Department of Defense or the Veterans Administration, he told a news conference launching the American Psychiatric Association's 161st annual meeting here.

If "one just does the math", then allowing PTSD or depression to go untreated in such numbers could result in "suicides and psychological mortality trumping combat deaths" in Iraq and Afghanistan, Insel warned.

Our website is: www.nami.org/sites/NAMIGreaterDesMoines

See yourself as a person, not an illness.

More than 4,000 US soldiers have died in Iraq since the US invasion of 2003, and more than 400 in Afghanistan since the US led attacks there in 2001, of which some 290 were killed in action and the rest in on-combat deaths.

"It's predicted that most soldiers -- 70 percent -- will not seek treatment through the DoD or VA," Insel said at the meeting, at which the psychological impact of war is expected to top the agenda over the next four days.

Left untreated, PTSD and depression can lead to substance abuse, alcoholism or other life-threatening behaviors.

"It's a gathering storm for the civilian and public health care sectors," Insel said.

He urged public-sector mental health caregivers to recognize the symptoms of psychological troubles resulting from deployment to a war zone and be ready to provide adequate care for both soldiers and their families.

Other items on the agenda at the meeting, set to be attended by some 19,000 psychiatrists and mental health practitioners from around the world, include violence in schools, the psychology of extremism, and more light-hearted topics such as how music affects mood.



Excerpts from **The Truth About Veteran Suicides** by Aaron Glantz

Eighteen American war veterans kill themselves every day. One thousand former soldiers receiving care from the Department of Veterans Affairs attempt suicide every month. More veterans are committing suicide than are dying in combat overseas.

These are statistics that most Americans don't know.

In fact, they never would have come to light were it not for [a class action lawsuit](#) brought by Veterans for Common Sense and Veterans United for Truth on behalf of the 1.7 million Americans who have served in Iraq and Afghanistan. The two groups allege the Department of Veterans Affairs has systematically denied mental health care and disability benefits to veterans returning from the conflict zones.

The case, officially known as Veterans for Common Sense vs. Peake, went to trial last month at a Federal Courthouse in San Francisco. The two sides are still filing briefs until May 19 and waiting for a ruling from Judge Samuel Conti, but the case is already having an impact.

"Shh!"

That's because over the course of the two-week trial, the VA was compelled to produce a series of documents that show the extent of the crisis affecting wounded soldiers.

"Shh!" [begins one e-mail](#) from Dr. Ira Katz, the head of the VA's Mental Health Division, advising a media spokesperson not to tell CBS News that 1,000 veterans receiving care at the VA try to kill themselves every month.

"Our suicide prevention coordinators are identifying about 1,000 suicide attempts per month among the veterans we see in our medical facilities. Is this something we should (carefully) address ourselves in some sort of release before someone stumbles on it?" the e-mail concludes.

On May 6, the Chair of the House Committee on Veterans Affairs, Bob Filner (D-CA) convened a hearing titled "The Truth About

Veteran's Suicides" and called Katz and VA Secretary James Peake to testify.

"That e-mail was in poor tone but the content was part of a dialogue about what we should do about new information," Katz said in response to Filner's questions. "The e-mail represents a healthy dialogue among members of VA staff about when it's appropriate to disclose and make public information early in the process."

Filner was nonplused and accused Katz and Peake of a "cover-up."

"We should all be angry about what has gone on here," Filner said. "This is a matter of life and death for the veterans that we are responsible for and I think there was criminal negligence in the way this was handled. If we do not admit, assume or know then the problem will continue and people will die. If that's not criminal negligence, I don't know what is."

A Pattern

It's also part of a pattern. The high number of veteran suicides weren't the only government statistics forced to reveal because of the class action lawsuit.

Another set of documents presented in court showed that in the six months leading up to March 31, a total of 1,467 veterans died waiting to learn if their disability claim would be approved by the government. A third set of documents showed that veterans who appeal a VA decision to deny their disability claim have to wait an average of 1,608 days, or nearly four and a half years, for their answer.

Other casualty statistics are not directly concealed, but are also not revealed on a regular basis. For example, the Pentagon regularly reports on the numbers of American troops "wounded" in Iraq (currently at 31,948) but neglects to mention that it has two other categories "injured" (10,180) and "ill" (28,451). All [three of these categories](#) represent soldiers who are so damaged physically they have to be medically evacuated to Germany for treatment, but by splitting the numbers up the sense of casualties down the public consciousness.

Here's another number that we don't often hear discussed in the media: 287,790. That's the number of returning Iraq and Afghanistan war veterans who had filed a disability claim with the Veterans Administration as of March 25th. That figure was not announced to the public at a news conference, but obtained by Veterans for Common Sense using the Freedom of Information Act.

Why all the secrecy?

Unpleasant Facts

According to an April 2008 study by the Rand Corporation, 300,000 Iraq and Afghanistan war veterans currently suffer from post-traumatic stress disorder or major depression. Another 320,000 suffer from traumatic brain injury, physical brain damage. A majority are not receiving help from the Pentagon and VA system which appear to be more concerned with concealing unpleasant facts than they are with providing care.

In its [study](#), the RAND Corporation wrote that the federal government fails to care for war veterans at its own peril – noting post-traumatic stress disorder and traumatic brain injury "can have far-reaching and damaging consequences."

"Individuals afflicted with these conditions face higher risks for other psychological problems and for attempting suicide. They have higher rates of unhealthy behaviors – such as smoking, overeating, and unsafe sex – and higher rates of physical health problems and mortality. Individuals with these conditions also tend to miss more

work or report being less productive," the report said. "These conditions can impair relationships, disrupt marriages, aggravate the difficulties of parenting, and cause problems in children that may extend the consequences of combat trauma across generations."

"These consequences can have a high economic toll," RAND said. "However, most attempts to measure the costs of these conditions focus only on medical costs to the government. Yet, direct costs of treatment are only a fraction of the total costs related to mental health and cognitive conditions. Far higher are the long-term individual and societal costs stemming from lost productivity, reduced quality of life, homelessness, domestic violence, the strain on families, and suicide. Delivering effective care and restoring veterans to full mental health have the potential to reduce these longer-term costs significantly."

Congress has the power to stop this problem before it gets worse. It's not too late to extend needed mental health care to our returning Iraq and Afghanistan war veterans; it's not too late to begin properly screening and treating returning servicemen and women who've experienced a traumatic brain injury; and it is not too late to simplify the disability claims process so that wounded veterans do not die waiting for their check. As the Rand study shows, this isn't only in the best interest of veterans, it's in the best interest of our country in the long run.

Do's and Don'ts in Helping Your Family Member or Loved One

Parts adapted from When someone you love has a mental illness by R. Woolis (1992) and Trust after trauma: A guide for relationships for survivors and those who love them by A. Matsakis (1998)

Helpful Do's

Communication Do's:

1. Be respectful and calm.
2. Stick to one topic at a time.
3. Keep a positive attitude.
4. Be honest with yourself and with your family member.
5. Use humor (when appropriate).
6. Communicate openly and often with the doctors.

Building family member's self-esteem DO's:

1. Genuinely praise and compliment your loved one frequently, even for day to day behaviors.
2. Work together to create short-term goals.
3. Stay active – plan and engage in activities together.

Dealing with difficult behavior DO's:

1. Accept the fact that the person has a legitimate illness.
2. Set and discuss clear limits, rules, and expectations for family member's behavior.
3. Be consistent and predictable.
4. Keep a log of the patient's symptoms, responses to various medications, hospitalizations, etc.
5. Pay attention to warning signs of possible relapse, worsening of symptoms, etc.
6. Give your family members space when they ask for it (as long as they are not dangerous to themselves or others).

Taking care of yourself DO's:

1. Stay in contact with your support system.
2. Educate yourself about mental illness.
3. Talk to other people who are struggling with similar situations (such as meetings of NAMI)
4. Remember that you are not alone.
5. Take one minute at a time.

Helpful Don'ts

Communication Don'ts

1. Don't tease your family member about their symptoms.
2. Don't yell or shout at your family member.
3. Don't argue with your family member about his/her symptoms (e.g. don't try to talk them out of their delusions or hallucinations).
4. Don't get stuck in talking about the past - stay in the present.

Dealing with difficult behavior DON'Ts

1. Don't take the symptoms or illness personally.
2. Don't tolerate abuse of any kind from your family member.
3. Don't blame all of your family member's undesirable behaviors on the mental illness.
4. Don't always interpret his/her emotional distance as reflective of something about your relationship.

Dealing with the fact that your family member has a mental illness DON'Ts:

1. Don't let the illness run your life.
2. Don't try to be your family member's therapist.

Enhancing your family member's self-esteem DON'Ts:

1. Don't make all of the decisions for your loved one – allow them to make as many decisions for themselves as possible.
2. Don't tell your family member to just "get over it" or to "get a life".
3. Don't call your family member names (e.g. psycho, cry baby, etc.)

*Support and Family Education: Mental Health Facts for Families
Michelle D. Sherman, Ph.D.*



Iowa Path

Projects for Assistance in Transition
from Homelessness

Information from a power point presentation given to the Iowa Mental Health Planning Council at their March 2008 meeting.

There were 29,075 people homeless in Iowa in 2006. That's equal to the entire population of Mason City, our 15th largest city.

One half of homeless adult individuals report a long term disability.

The purpose of the PATH program is to improve the quality of life for homeless adults that experience serious mental illness. These are the services offered:

- There is outreach and support to literally homeless individuals: under bridges, in tent camps, living in cars, in emergency shelter, in domestic violence shelter.
- Outreach and support to the near homeless individuals: about to be evicted, sleeping on friend's floors, in transitional housing.

These services can include:

- Mental health screening and diagnosis
- Short term case management
- Habilitation and Rehabilitation
- Community Mental Health Treatment
- Alcohol and/or Drug Treatment
- Primary Health Care
- Housing

In the past year, Iowa effectively used its \$300,000 PATH grant to enroll 832 homeless individuals with mental illness in these services. That's an annual investment of \$360 per person.

(Iowa Path – cont'd) There are also Community links with other programs and resources:

- Basic Needs: Food, blankets
- Veterans Services
- Social Security
- Housing Options

PATH grants come from SAMHSA – the Substance Abuse and Mental Health Services Administration. All Iowa PATH providers have exceeded SAMHSA (federal) expectations to:

1. Increase the number of homeless persons contacted.
2. Increase the percentage of contacted homeless persons with serious mental illness who become enrolled in services
3. Increase the percentage of enrolled homeless persons who receive community mental health services
4. Maintain the average Federal cost of enrolling a homeless person with serious mental illness in services.

There is serious unmet need. Only 832 of 29,075 homeless people could be reached because of limited dollars. Supportive housing is needed. Limited geographic areas have access to the funds.

The PATH provider in the Des Moines area is:

Primary Health Care – Bobbretta Brewton, Development Director
Administrative Office is at 9943 Hickman Road, Suite 105,
Urbandale, Iowa 50322 – office phone # 515-248-1511.

State Legislation

Here are 3 places on the web to access E-mail to figure out who your legislators are, to contact your legislators, get mailing addresses, and phone numbers.

<http://www.infonetiowa.com/> - Has the latest on legislation.

Check out their great newsletters online.

<http://www.legis.state.ia.us/>

www.nami.org/advocacy

Update on Polk County Waiting List

As of the end of May there are now -

- **330** on the waiting list for disability services,
- **240** have chronic mental illness or mental illness
- **71** have mental retardation
- **15** have developmental disabilities
- **4** are unknown
- **110 of the 330** are at risk of hospitalization and/or homelessness
- It is taking an average of **275 days** to get into Polk County health system to receive services.

Polk County is barred by state law (as are all other 98 counties) to raise additional funds for mental health services. County dollars are frozen at 1996 dollar levels.

In a March 14, 2008 report to Governor Culver and Legislative Leaders, the MH/MR/DD/BI Commission reported that over the past year –

- They have reviewed county management plan amendments which were made to reduce or eliminate services in 12 counties containing 36% of the state population..
- A recent survey of counties conducted by the Iowa State Association of Counties found that
---17 counties have either cut services or created waiting lists in the past 3 years,
---3 more counties have done both, and
---another 17 counties are considering creation of waiting lists or cutting services in FY 09.

- State law allows counties experiencing financial problems to access the risk pool. Financial problems are defined in Code as having a fund balance below 20% while levying the maximum allowed. During the current fiscal year, 60 counties representing 72% of the state's population meet that definition.
- As of June 30, 2007, the aggregate fund balance in the 99 counties' MH/MR/DD services fund had dropped 8%.
- 48 counties with 65% of the population have fund balances less than 10%, and 19 have negative fund balances.
- Without sufficient reserves to maintain services, counties will have to make further cuts in the future.

Data prepared by the Dept. of Human Services showed that the county costs for state institutions and Medicaid match had grown by \$26.2 million from FY 05 to 07, yet the allowed growth appropriation from the state legislature to the counties had increased by only \$14.9 million in that same time frame. Since Medicaid match is mandated, counties have had no choice but to reduce other, discretionary services to cover the growing Medicaid bill.

These facts show that the public MH/MR/DD system in Iowa is in a major crisis. Consumers are losing services and are being placed on waiting lists for needed services.

Over the summer – please **talk to your legislators** on the issues that matter to you. Ask them what they plan to do and what you can do to help them. **Not only is there not enough money in the mental health system - we have a public health crisis with an inadequate workforce, inadequate beds and services.**

On May 1, 2008 there was an article in the Des Moines Register – More than 90 percent of the men and women entering Iowa's prisons have had mental illness or an addictive disorder, and 30 percent are at risk for suicide, according to a new University of Iowa study. The most frequent disorders were substance abuse and dependence (90 percent), followed by mood disorders such as depression, psychotic disorders, antisocial personality disorder, anxiety disorders such as panic, and attention-deficit hyperactivity disorder. What follows are solutions other states are implementing.

Getting HELP: Special court designed to help mentally ill

By Stephen Gurr, Gainesville Times, Georgia, April 27, 2008

It took an armed standoff with police to finally get Ron the help he needed for his depression. Suicidal and waving a loaded .357 Magnum in a public place, the bankrupt 46-year-old was certain he would be shot by officers.

"I had lost my faith," he said, after losing his home and watching his marriage slide toward failure. "I saw everything disintegrating around me."

Police did not shoot Ron, though he says he "fully expected" to be shot. They talked him into putting the gun down, handcuffed him, and took him to a mental health facility, where he spent six days. Afterward, his thoughts still fixated on suicide, Ron was booked into the Hall County jail on a pair of misdemeanor weapons charges. It was there that he was given the option of applying for entry into Hall County HELP Court, a treatment court for people whose criminal acts are rooted in mental illness.

Nearly a year after entering HELP (an acronym for Health, Empowerment, Linkage and Possibilities), after attending court-ordered counseling, taking two anti-depressant medications daily and being monitored by a case manager who made home visits, Ron stood proudly in the well of a courtroom on the fourth floor of

the Hall County courthouse, where Superior Court Judge Kathlene Gosselin presented him with a graduation certificate.

"He came in with major depression and had us all worried," Gosselin told the courtroom, where more than 30 active HELP court participants looked on. "He has worked really hard with lots and lots of problems. He's kept on track the whole time."

Ron's wife, standing by his side at the ceremony, managed to say through tears of joy, "he's a lot better, and I'm very thankful."

Said Ron, "The Lord puts people in our lives to help us get through these things. We are all in this program because we made some poor choices. If we stay on track, we can make correct choices."

"Everyone ... has a lot to deal with"

Hall County HELP Court started in December 2004 as one of four accountability courts in the local judicial system, with the focus on people suffering from mental illnesses.

Many of its participants are referred to the court by detention officers or medical workers at the Hall County jail, followed by a clinical interview conducted by a psychologist to determine a diagnosis.

Those diagnosis have ranged from depression to bipolar disorder, schizophrenia and post-traumatic stress disorder.

Prosecutors work with defense attorneys to decide which candidates are right for the program. Offenders who have committed serious violent felonies such as sexual assaults, armed robberies or attacks on police officers are denied entry. More often the charges involve disorderly conduct, domestic violence, drugs, shoplifting, DUIs and other misdemeanors.

Like Hall County's drug court, some HELP participants may have their charges dismissed with successful completion of the program, though not all will. Some may see reduced jail sentences. There are no guarantees, though there is the hope of a healthier, more productive life.

Some will come out of the program with vastly different lifestyles, new jobs and new outlooks on life. In other cases, graduates may never be able to hold down a job or even acknowledge their mental illnesses, but just convincing them to take their medication regularly will be regarded as a success.

Like other accountability courts, the prosecutors, defense attorneys, case managers, treatment providers and judge work as a team in reviewing each case in weekly meetings, determining who has made progress and who has taken a step backward.

In addition to getting treatment and medication through AVITA Community Partners, the local state-affiliated mental health treatment provider, participants must get jobs, if they are able, secure steady living arrangements, and are encouraged to earn General Equivalency Diplomas. Finding meaningful, worthwhile jobs and housing for participants is a huge challenge for people who "live on the margins financially," Gosselin notes.

Like other accountability courts, the judge can impose sanctions if certain requirements aren't met. During one recent court session, a woman who missed a doctor's appointment and a group therapy session had to face the judge. "I have to believe you're not taking this seriously," Gosselin said.

The woman broke into tears, telling the judge, "I'm human. There's a lot on my plate I have to deal with by myself."

"Everyone in the courtroom has a lot to deal with," Gosselin responded. "And while you were in (jail) work-release, you were managing OK."

The judge gave the woman 24 hours in jail. Some get community service, or more time in court. Others have spent days or weeks in jail for not fulfilling their obligations to the court.

Many never will. The graduation rate for HELP court is under 50 percent. Court officials say most drop out or are terminated from the program not because of mental health issues, but because of drug addictions.

More than half the participants are "co-occurring," meaning they struggle daily with drug and mental health problems.

Gosselin hopes HELP's graduation rate will improve after the court recently put co-occurring participants on one treatment track and those with mental health issues only on another.

"I think a lot of people we've lost just couldn't get a handle on their drug problems," she said.

"Not just a job"

Some who come before the judge can hardly hold their heads up or speak during their first day in HELP Court, known as enrollment.

During a recent enrollment session, a young woman was led into court wearing the customary jail attire of jumpsuit, leg chains and shower shoes, took a seat at the defense table and answered the judge's questions tearfully. "We all know you can do this," Gosselin told her.

Later the judge recalled another young woman, this one just 17, who came to the program after a drug arrest, suffering from a severe mood disorder and habitually cutting herself. "You had to almost force her to talk to you the first few months in the program," Gosselin said.

Now, the same young woman is held up as one of the court's successes. Her words of hope are quoted on the back of the HELP graduation program: "I used to hate thinking about the future because I thought that I had nothing to look forward to, but now I know that I have a lot to look forward to," she wrote. "I can be successful in life. I am so glad I have changed. I love the new me."

Ron can remember the turning point for him, while in counseling at AVITA, when he reflected on all the problems he and his wife had endured. "I looked at my depression and realized that no matter what was happening in our lives, we were basically OK," he said. "The structure and support of the HELP system was important as far as keeping me on that track."

Ron has high praise for Gosselin. "Her patience, to me, is just astounding," he said. "She realizes that people are struggling with medical changes and when you're in this state of mind, you're not always the most happy, friendly person."

He also praised his court case workers, who made home visits or checked in by phone to get a feel for how his life was going. "The people in this program really care about the people who are in it," Ron said. "My sense is that this is not just a job for these people, it's a calling."

Rachel Ayers, the clinical case manager for HELP Court, believes it offers community-wide benefits.

"It's so much greater than the one client," Ayers said. "When they get healthier, their family is healthier, their workplace is healthier. It's so far-reaching, the effect that mental fitness can have as opposed to mental illness."

Gosselin said she could point to the statistics that show diverting these offenders from jail saves taxpayer dollars. But in the end, she said, "it's the right thing to do for somebody who's sick."

"All over the country, jails and prisons are dealing with the mentally ill, because we are not dealing with them in other ways," she said. "If it is indeed your mental illness that's causing you to enter the criminal justice system, keeping you in and out of jail instead of getting the treatment you need ... then we should be providing that."



Mentally ill inmates cost \$400M year

Granholm hopes to establish 5 mental health courts to reduce jail, prison crowding and costs.

Gary Heinlein / Detroit News Lansing Bureau

Corrections officials say more than 12,500 of Michigan's 50,000-plus prison inmates -- 1 in 4 -- have a history of mental illness.

Advocates call that shameful. Policymakers trying to get the \$2 billion state corrections budget under control call it expensive.

It costs an average of \$31,325 a year to house a state prisoner, so mentally ill inmates represent a \$400 million annual expense.

That's why Gov. Jennifer Granholm wants \$3.4 million in the coming fiscal year to establish five mental health courts -- pilot projects designed to keep more mentally ill residents from flooding jails and prisons. Mental health courts would parallel drug courts the state set up several years ago to keep some substance abusers out of the penal system.

"Clearly, not taking in prisoners with mental illness, or with significant medical conditions, is one strategy to be able to reduce the prison population costs," Granholm told The Detroit News.

"And, frankly, (it's) a much more humane strategy for dealing with mentally ill inmates who have not committed especially violent crimes."



Better to aid mentally ill outside of jail, report says

By Ann Schrader

The Denver Post - 4/19/2008

One of every five inmates jailed in the seven-county Denver metro area has a serious mental illness, and housing them takes a \$34.4 million annual bite out of the counties' tight budgets, according to a new report by a Metro Area County Commissioners' task force.

Seriously ill inmates spend 5 1/2 times longer in jail than average inmates and cost \$8.28 more per day because they receive more services and may be housed in special units, the report found.

"If we could reduce the number of mentally ill people in jail by one-third, we could cut the jail population in half," said Jefferson County Commissioner Kathy Hartman, chairwoman of the metro group. Mentally ill inmates also revolve in and out of jail more frequently.

The report, "Taking Action for Change," said cuts in mental-health programs and few available psychiatric beds mean jail cells end up as the last resort for people with depression and schizophrenic and psychotic disorders.

Money could be saved by plugging service gaps with community programs, the report said, thereby diverting the mentally ill from the criminal justice system and providing a range of help upon release.

The problem is not new. Since 1991, the percentage of inmates with serious mental illness has increased 1 percentage point each year, according to the Colorado Department of Corrections.

The issue has been trying to find money to pay for state and county programs for the mentally ill. But Hartman said spending money for community-based programs costs one-tenth as much as jail. And for counties such as Jefferson, which is facing a \$150 million jail expansion, the savings could be significant.

In community programs, not only would people receive proper treatment, the report said, but jail bed space would be freed up, inmates would be less likely to return to the criminal justice system, and jail costs would be limited.

"For the first time, mental health (officials) aren't saying this. This is the courts, the sheriffs, people in the community," said task force co-chairman Rick Doucet, executive director of the Community Reach Center in Thornton. "They're saying that this is a problem and we need to address it."

Priorities, the task force said, should include triage centers, mental-health courts, expanded diversion programs, affordable housing, homeless services and access to benefits.

Each county has identified parts of the problem it can work on, whether it's getting ID cards for inmates to use for benefits when they are released, or ensuring Medicaid doesn't drop the inmates from its rolls.

"We're all dealing with the same issues, only we do it a little bit differently," said Adams County Undersheriff Paul Siska, a task force co-chairman. "We have the same goal, and we need to do it all together."

Boulder County's Partnership for Active Community Engagement, or PACE, began in 1999 and has been credited with a 72 percent decrease in overall jail use, saving more than 10,000 jail-bed days each year at a cost of \$61 per bed per day, according to a University of Colorado study.

Another successful program was created in late 2005 by community mental-health and correctional agencies.

The John Eachon Re-entry Program, or JERP, reports 40 percent of the participants work and live on their own, and 35 percent are in school.

Parolees Dave Carter and Scott Urich churned in and out of prison until they linked up with JERP.

Both have schizoaffective disorder, which causes them to hear voices if they don't take medications.

Now 51, Carter served time for stealing cars, robbery and burglary since he was 17. Each time he was released, he had no meds or other help. "If I had stayed in jail, I don't think I would have made changes," said Carter, who has been with JERP for two years.

Urich, 46, took and dealt drugs since his teen years, with spirals into violence and prison. Now, Urich lives on his own and attends community college, hoping to earn a degree in fine arts. "They make sure we don't fall through the cracks," he said. "This is such a vital program."

The problem continues to be money, though some help looms.

A 2004 law allows sheriffs to collect a booking fee, with 20 percent earmarked for mentally ill inmates.

A bill passed by the Colorado Senate and assigned to the House Judiciary and Appropriations committees earmarks \$279,000 from the general fund for training to assist inmates in accessing health care, housing and job benefits. It also sets up grants for two-year county pilot projects.

40% - Estimated percentage of Colorado's inmate population that has some type of mental disorder--about 35,000.

\$34.4 million - additional amount spent annually to care for 5500 seriously mentally ill metro county inmates

1484 - average daily number of seriously mentally ill people jailed in the Denver metro area

\$6000 - \$8000 – annual cost of treating a mentally ill person in the community

\$60,000 -annual cost of incarcerating each mentally ill person.

92 days – additional time each seriously mentally ill inmate spent in jail

\$6249 – cost of that additional time per inmate

\$599 million – what the Colorado state legislature spent on corrections in 2007

\$37.5 million – what the Colorado state legislature spent in general fund money on community mental health services for the medically indigent.

Ann Schrader: 303-278-3217 or aschrader@denverpost.com

Triage centers planned for mental-health care

Mental-health care experts on the Front Range have a \$12 million idea: They hope to open three 24-hour mental-health triage centers in the seven-county Denver metro area to take a huge burden off the justice system and emergency rooms.

The centers, the first of which could be open by the end of the year, would support a crisis phone line and would have professional staff who can assess and treat mental and behavioral health problems for up to three days, said Carl Clark, executive director of the Mental Health Center of Denver.

There are strict legal limits on the kinds of services that can be provided by either emergency rooms or police, Clark said, "so sometimes, no one gets help."

Supporters of the Triage Project include Mental Health America of Colorado, local hospitals, providers, advocates and law enforcement leaders.

The project's steering committee, which includes first lady Jeannie Ritter and Golden Police Chief Bill Kilpatrick, is searching for appropriate space to house the first center, said Heather Cameron, Triage Project director with Mental Health America of Colorado.

And the committee is looking for money, Cameron said.

Cameron estimated it will take about \$12 million annually to fund three crisis centers, an information technology infrastructure and a call center.

Half of that might come from reimbursements by health insurance, she said, and the remaining \$6 million, "well, that's minuscule compared with the cost of emergency care and what we're doing now."

The project's initial planning has been funded with about \$220,000 from regional hospital owners Cent-ura, Exempla and Health One, she said.

The Colorado Health Foundation kicked in another \$300,000 last month, Cameron said, and in early May, Triage Project members will hear whether they'll be awarded \$500,000 from the Robert Wood Johnson Foundation — with expected local matching funds.

"I really believe this is going to happen," Kilpatrick said. "This project has the backing of a lot of people."

- The time is always right to do the right thing.

-Martin Luther King, Jr.

A PLACE ON EARTH FOR THEM

By Robert Fleming -- Publishers Weekly, 4/21/2008

In the 1960s, the severely mentally ill began to be turned out of public hospitals—too often with tragic consequences. In The Insanity Offense (Reviews, Apr. 14), E. Fuller Torrey explores the issues.

What sparked you to write this book?

The immediate impetus for the book was the daily printout of what we call "preventable tragedies," which we collect from newspaper clippings at the Treatment Advocacy Center [in Arlington, Va., which Torrey heads]. The long-term impetus was the 1989 Tate case, with which I open and close the book. It seems to exemplify everything that is wrong with the system.

Why are so many mentally ill homeless and imprisoned?

Many end up homeless because they are paranoid or delusional, and afraid to stay in shelters, or because they are too psychotic to be able to apply for public assistance or housing. Many end up in jail because of psychosis-related behavior, such as exposing themselves in public or assaulting a stranger.

How much of a threat do severely mentally ill Americans on our streets pose to themselves and the community?

The magnitude of the threat is directly proportional to whether or not they are being treated. At any given time, at least half of those who are dangerous are not being treated. They pose a major threat to themselves through suicide and accidents, and to others through violence and homicide.

Wasn't outpatient care supposed to replace institutionalization?

Outpatient care has failed because most community mental health centers and other clinics failed to give priority to the sickest patients. Resources went to providing psychotherapy for the "worried well" instead.

What would you say to those who resist changing the law to allow involuntary commitment?

They do not understand what it is like to be psychotic. I tell them to spend a few hours on the streets or in a public shelter with severely mentally ill individuals.

There are very few funds earmarked for treatment and research of this crisis. What can we do?

Money is, of course, an issue, but it is not the most important answer. Surveys we carried out found very little relationship between how much any given state was spending on mental health services and the quality of services available. In some states, there is enough money in the present mental health budget to deliver good services if it were being spent wisely and prioritizing the most seriously mentally ill individuals.

Why don't elected officials tackle this crisis?

This is not a sexy issue. The patients and their families are not an important political constituency. Perhaps most important is that most officials, like most members of the public, do not understand the problem and are not aware that it is fixable.

Other Books by E. Fuller Torrey:

Out of the Shadows: Confronting America's Mental Health Crisis

Surviving Schizophrenia – A Family Manual (1988)

Surviving Schizophrenia – A Manual for Patients, Families and Providers (2006)

Freudian Fraud: The Malignant Effect of Freudian Theory on American Thought (1999)

Schizophrenia and Civilization (2001)

Surviving Manic Depression: A Manual on Bipolar Disorder for Patients

The Invisible Plague: The Rise of Mental Illness 1750 to Present

Schizophrenia and Manic Depressive Disorder: The Biological Roots of Mental Illness As Revealed by the Landmark Twins Study

Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill

Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals

National Alliance on Mental
Illness of Greater Des Moines
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Coping With Mental Illness

What Family Members Can and Cannot Do

What Family Members Can Do:

1. Talk about your feelings and encourage other family members to do the same.
2. Talk to others who are also dealing with mental illness in the family (for ex: support groups)
3. Learn about mental illness.
4. Choose your battles carefully. Prioritize what is most important to you.
5. Pay attention to your own needs.
6. Remember that all family members are affected and that "well" family members also need your attention. Avoid making the patient the focus of all of the family's attention.
7. Strive to respect the coping strategies different family members may adopt.
8. Seek to improve the mental health system so that treatment options are available.
9. Acknowledge the admirable courage your family member has in coping with the illness.
10. Separate the person from the illness. Love the person even if you hate the disorder.

What Family Members Cannot Do:

1. Can't make the mental illness go away.
2. Can't meet the patient's needs all of the time.
3. Can't lessen the impact of the illness by not talking about it.
4. Can't do the grieving (mourning) process for others. Grieving involves many steps, including denial, sadness, anger, and

acceptance. Everyone must do this process in their own way and at their own pace.

5. Can't take away peer and societal stigma and judgments.
6. Can't make the family member seek help (or take medications) if they are in the denial stage (unless they are dangerous).

Support and Family Education: Mental Health Facts for Families
Michelle D. Sherman, Ph.D.



To find out how to participate – go to www.nami.org/namiwalks/IA
Of call Jay Brewer – the walk manager – at 515-321-8051.

SAVE THE DATE - Saturday, Oct. 4, 2008

NAMI is a grassroots mental health organization. This is the second year for our major fundraiser in Des Moines – the *NAMI Walks for the Mind of America*. We hope you will decide to help us out by walking with us – and perhaps making a donation.

When you donate to the walk - if you choose to designate the NAMI Greater Des Moines local affiliate –
40% of the funds will go to NAMI Greater Des Moines
15% of the funds will go to NAMI National, and
45% - will go to NAMI Iowa

If NAMI Greater Des Moines is not designated – we will receive no funds from your donation.

We would be most grateful if you would choose to designate NAMI Greater Des Moines so all three levels of our organization can benefit from your generosity.

Funds are needed for our continued operations and to continue with our projects – from the newsletter to the educational programs and the proposed hospital exit program – as well as other projects waiting in the wings. Thank you.

Our website is: www.nami.org/sites/NAMIGreaterDesMoines

See yourself as a person, not an illness.