



NAMI GREATER DES MOINES

AFFILIATE AND SUPPORT GROUP NEWSLETTER

July 2007

“Support, Education, and Advocacy”

<p><u>Education</u> 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. See inside the newsletter for support groups.</p>		<p><u>Business and Committee</u> Meetings are the 2nd Thursday of the month at 5 P.M. at the NAMI-Iowa Office.</p> <ol style="list-style-type: none"> 1. Business 2. Marketing and membership 3. Support 4. Education 5. Advocacy 6. Fundraising 7. Special Events 	
<p>Sunday, July 1 2 PM</p>	<p>The topic is Therapy Approaches for Children and Adults. Our speaker will be Jo Kinsinger with Advanced Therapy solutions at Res-Care.</p>	<p>Thursday, July 12 5 PM</p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p>Friday, July 13</p>	<p>NAMI Walks Volunteer/Committee Meeting at NAMI Iowa office, 5911 Meredith Drive, Des Moines – 1:00 P.M. to 2:30 P.M.</p>	
	<p>Friday, July 13</p>	<p>Suicide and Self Mutilation Seminar – at the Holiday Inn Downtown – 1050 6th Avenue – Des Moines - \$179 – registration must be prepaid – Call 1-800-843-7763 – or go to www.pesi.com/credit/ for more information. This event is sponsored by the Polk County Suicide Prevention Coalition. The speaker is Pam Marcus, RN APRN/PMH-BC. She is a board certified Clinical Specialist in Adult Psychiatric Nursing with an active private practice in the Washington DC area.</p>	
	<p>Tues., Wed., and Thursday July 31-Aug. 2</p>	<p>Iowa Consumer Empowerment Conference at the Best Western Regency Inn in Marshalltown. For more information, direct your inquiries to: Iowa Empowerment Conference, 1 West Grant St., Apt. 109, Marshalltown, Iowa 50158 or call toll free to 1-800-525-2495 pin #00 ask for Kathy. Contact the Office of Consumer Affairs at 1-877-338-2767 or email < jholvec@dhs.state.ia.us for more information on stipends to attend the conference.</p>	
<p>Sunday, August 5 2 PM</p>	<p>The topic will be Special Needs Trusts if we can find a speaker.</p>	<p>Thursday, August 9 5 PM</p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p>Friday, August 10</p>	<p>NAMI Walks Volunteer/Committee Meeting at NAMI Iowa office, 5911 Meredith Drive, Des Moines – 1:00 P.M. to 2:30 P.M.</p>	
	<p>Wed., Aug. 15 * * * * *</p>	<p>Kick Off Luncheon for NAMI Walks at the Hilton Garden Inn, just north of the 86th Street exit in Johnston.</p>	
	<p>Tues., Wed., Thurs., Aug 28-30</p>	<p>The Third Annual CIT National Conference will be this August 28th-30th in Memphis, TN. See inside for more details and possible scholarships to attend.</p>	
<p>Sunday, Sept. 9 2 PM</p>	<p>We will be inviting someone from the Des Moines Register.</p>	<p>Thursday, Sept. 13 5 PM</p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p>Nominations due for election in November.</p>		
	<p>Friday, Sept. 14</p>	<p>NAMI Walks Volunteer/Committee Meeting at NAMI Iowa office, 5911 Meredith Drive, Des Moines – 1:00 P.M. to 2:30 P.M.</p>	
	<p>Sept. 14-16</p>	<p>Visions for Tomorrow Teacher Training in Des Moines</p>	
<p>Saturday October 6 * * * * *</p>	<p>NAMI WALKS FOR THE MIND OF AMERICA Des Moines Waterworks Park – 3 mile walk 8:30 AM check-in 10:00 AM Start time</p>	<p>Thursday, Oct. 11 5 PM</p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p>Tues., Wed., - October 9-10</p>	<p>State Mental Health Conference in Ames</p>	
	<p>Thursday, October 11</p>	<p>National Depression Screening Day</p>	
	<p>Nov. 1-4</p>	<p>Training for Consumers to become a support group facilitator for NAMI Connections Support Recovery Groups. The Des Moines area has 1 trained facilitator from the May 2007 training, but we need a minimum of 2 to start a support group. Are you interested?</p>	
<p>Sunday, November 4 2 PM</p>	<p>2008 Elections for Officers & Board Members</p>	<p>Thursday, Nov. 8 5 PM</p>	<p>We will be discussing and planning around 7 topic areas</p>



MARY BETH PFEIFFER IS KEYNOTE FOR NAMI Iowa FALL CONFERENCE

Mary Beth Pfeiffer is a long-time investigative reporter, published journalist, researcher and author, who puts a human face on the national scandal in which thousands of mentally ill people tangle daily with police. In her new book, *Crazy in America: The Hidden Tragedy of Our Criminalized Mentally Ill*, (Carroll & Graf; Publication date: May 22, 2007; \$15.95, paperback)

Mary Beth Pfeiffer tells the stories of six people whose mental illnesses thrust them into the arms of police and into jails, prisons and juvenile facilities that were ill-prepared to care for them. The results were shocking and preventable: Suicide, self-mutilation, death at the hands of frightened and poorly trained police.

Crazy in America is now available in bookstores and on-line. Don't miss this highly acclaimed journalist, and winner of many awards, whose pioneering reports led her to take her message about the failed mental health system nationwide. We are honored to have Ms. Pfeiffer as our Keynote Speaker at our fall conference.

Crazy in America is an upsetting book, which is as it should be.

One feels restless, even impatient, trying to summarize it. Every chapter is keen in detail. Then, suddenly, the lyrics of a Bob Dylan song come to mind, to help capture its essence:

*How many times must a man look up
Before he can see the sky?*

*Yes, 'n' how many ears must one man have
Before he can hear people cry?*

*Yes, 'n' how many deaths will it take till he knows
That too many people have died?*

Drawing from California, Florida, Iowa, New York and Texas, the book uses six case studies to expose the national scandal in which the mental healthcare system keeps failing and the criminal justice system takes over.

The six case studies—each of which constitutes a separate part of the book, with three chapters in each part—shows the scandal up-close and personal. They are not dry recitations of statistics or policy prescriptions.

One study involves the odyssey of a 39 year old woman with a history of 25 hospitalizations who tears out her eyes while in solitary confinement.

Another is about a man who is shot and killed, after a police officer seeks to scold him about urinating in public but doesn't know how to deescalate his terrified response.

Still another involves an 18-year-old boy who hangs himself after being abandoned in a small cell for eight weeks.

"People with mental illnesses lack the basic tools for survival," Pfeiffer notes. "They see things that others don't, yell out to silent voices, think in chaotic patterns. They are often crippled by irrational fears or weighted down by profound feelings of sadness. Yet the hallmark of prison life is regimentation and control. Obedience is expected to be instantaneous and unquestioned."

To be sure, statistics are seeded throughout the book.

Out of 2.2 million prison and jail inmates in America, approximately 330, 000 struggle with mental illnesses. In Florida, so many people are killed by police that one 1998 study said that they account for 20 percent of the nation's total.

Two of the persons profiled in the book were among 24 people in the Tampa Bay area killed during police confrontations from 2004 to 2006. About three dozen police officers were involved. None were criticized for their actions—and the deaths were ruled "justifiable," "appropriate," or "excusable."

In a legal sense, the rulings may have been correct—the officers involved were often traumatized by the experience. But Pfeiffer points out that in 2000, the Tampa Police Department instituted Crisis Intervention Training (CIT). By 2003, three hundred officers took the course. But today, the number has dwindled to only ten to fifteen each year.

The Tampa officer who shot one of the men profiled in the book had not taken the CIT course. Only three hours of her initial police training covered mental illness. In more than 30 training courses taken by her in the four years preceding the tragedy, not one had anything to do with mental illness. This in a state where one in four of the people arrested have a mental illness.

The decline in Tampa's CIT program points to a key sickness: the lack of sustained leadership and commitment by those in authority and power to do what's necessary and right, rather than simply look for "quick fixes."

Pfeiffer offers a "Top 10 List" of reforms to keep people with mental illnesses out of the criminal justice system:

1. Stop building prisons.
2. Invest in special prison units for those people with mental illnesses who do belong in prison.
3. Train prison corrections officers to work with and respect people with mental illnesses.
4. Invest in prison rehabilitation programs to curb recidivism.
5. Stop putting people with mental illnesses into solitary Confinement.
6. Roll back punitive drug laws; invest in drug treatment programs that allow people to fail and then keep trying.
7. Train police officers how to respond to people with mental illnesses in crisis.
8. Invest in inpatient and outpatient mental healthcare services in the community.
9. Pass insurance parity and extend Medicaid coverage to include stays in state psychiatric hospitals.
10. Invest in housing—and eliminate rules that keep non-violent and reformed felons out of public housing.

None of these are quick fixes. But they will help focus discussion of steps needed to do what's right. It also may be the first list to frankly include stopping the construction of new prisons and repealing punitive drug laws, and instead forcing investment in community services at the front end.

The book may be disadvantaged by similarity in title and topic to *Crazy: A Father's Search Through America's Mental Health Madness*, published last year, which was a finalist for the 2007 Pulitzer Prize, as well as NAMI's 2007 Outstanding Media Award for Advocacy. But they are different book that complement each other. Both should be given to every governor, state legislator and Member of Congress as part of advocacy for reform.

One advantage of *Crazy in America* is that each case study stands alone. Along with the preface and afterword, only one case study, or any combination of them, need be read to get the point.

Yes, too many people have died.



Family to Family Education - Take the 12 week course (1 night/week for 2-2 ½ hours) NAMI Family to Family educational course to obtain coping skills and information about mental illness. Severe mental illness is traumatic to the entire family - you might consider asking other family members to attend with you – a friend, a parent, spouse, a sibling, or one of your children (must be at least 14 years old). Topics include brain biology, schizophrenia, major depression, mania and schizoaffective disorder, anxiety disorders, dual diagnosis, basics about the brain, problem solving skills, medication review, empathy and understanding, communication skills, self-care, recovery, and advocacy. Call the NAMI office to sign up – 254-0417 or call Teresa to sign up 274-6876 tbomhoff@mchsi.com The next class will be in the fall starting Thursday, August 30.



Provider Education

NAMI IOWA and Magellan Behavioral Care of Iowa offer the Provider Education Course - a 10-week training providing behavioral health practitioners with a penetrating, subjective view of mental illness presented through lecture, discussion and handouts.

The Provider Education Course has been completed at Magellan's offices in Des Moines and at the Mental Health Institute at Independence.

The course helps providers realize the hardships that families and consumers endure and appreciate the courage and persistence it takes to find ways to reconstruct lives.

CEU's were arranged for social workers, mental health counselors, marital/family therapists, registered nurses, and certified alcohol/drug counselors.

The Provider Course emphasizes the involvement of consumers in the challenging work of provider-staff training. The teaching team consists of five people: two family members trained as NAMI Family-to-Family Education Program teachers; two consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and a mental health professional who is also a family member or consumer.

The course reflects a new knowledge base, the "lived experiences" of coping with a brain disorder or caring for someone who struggles with this life-long challenge. Including this deeply personal perspective creates an appreciable difference in the program's content. It adds a means of teaching the emotional aspects and practical consequences of these illnesses in addition to the academic medical information in the course.

The Provider Education course is designed for line staff at public agencies working directly with people with severe and persistent brain disorders.

Course components:

- Orientation
- Clinical Bases
- 3 Major Mental Illnesses
- Types/Subtypes of Mood Disorders/Diagnosis of panic Disorder, Obsessive Compulsive Disorder and Co-Occurring Brain and Addictive Disorders, interventions which are effective for Family in Stage 1 Crisis
- Research into the Biological Basis of Mental Illness
- Medication review
- Inside Mental Illness
- Responding Effectively to Families in Stage 2
- Meeting the whole family/problem solving
- Why advocacy?/Helping Families in Stage 3

If you are interested in having the Provider Education course at your business or organization – please go to our website www.nami.org/sites/NAMIGreaterDesMoines and click on educational courses to reach an application form or call the NAMI Iowa office at 254-0417.



Sign up for the next **"Visions for Tomorrow"** class. It is an 8 week course (1 night a week for 2-2 ½ hours) for **parents, foster parents and other caregivers** of children and adolescents who have serious emotional disorders. Curriculum includes types of mental illnesses and emotional disorders as well as instruction on coping skills; dealing with schools; communication; medication; rehabilitation, recovery, and transition; and advocacy. The next class offering will be this fall in September. Call Diane Johnson to sign up – 255-8157 E-mail: itsdianej@aol.com

Parents and Teachers As Allies



This 2 hour in-service program is for Teachers and other school professionals, school nurses, social workers, medical residents, education majors at colleges, juvenile probation officers, court appointed advocates – CASA volunteers, and many others.

The program is presented by an education professional who is also a family member, a facilitator/family member, a parent or caregiver of a child with mental illness, and a mental health consumer that experienced the early onset of mental illness.

Components

- Welcome and Introductions
- Early Warning Signs of Mental Illnesses
- Family Response
- Living with Mental Illness
- Group Discussion
- Closing Remarks and Evaluation

To have this program at your school or organization– please contact Diane Johnson 255-8157 E-mail: itsdianej@aol.com or DLJohnson@magellanhealth.com

Do you know of a conference, school function, wellness fair, or an organization in our community where NAMI Greater Des Moines could make a presentation or attend with resource material?

If you have a request or referral, please e-mail Teresa at tbomhoff@mchsi.com.

We hope you are enjoying the newsletter we are sending you. If you've come to our once a month affiliate meetings, we hope you've obtained useful information.

Please help to support our organization by becoming a member of NAMI Greater Des Moines.

Dues are:	Send to: Don Jayne, Treasurer
	1291 16 th St.
\$35.00 Family/Individual \$ 3.00 Limited income \$50.00 Professional	West Des Moines, IA 50265
	<i>Please make the check payable to NAMI GDM</i>

If you would like to make a **donation** instead of becoming a member, please send your donation to our Treasurer, Don Jayne.

Thanks for your generosity!

RESOURCES – RESOURCES - RESOURCES

911

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. When DM Mobile Mental Health Crisis Unit staff arrive, an assessment will be made whether 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.

Suicide Hotline 1-800-273-TALK (8255)



Volunteer for Bipolar Genetics Study and Major Depression Study at the Univ. of Iowa

You can contact the U. of Iowa directly by calling Nancy Hale at the toll free number (888) 850-8531 if you are interested in participating in genetic studies for either bipolar or early onset depression research programs.

Several Schizophrenia Studies are also at the U. of Iowa

Toll free inquiries may be made at 800-777-8442. Ask for Jane Kerr or Tim Holman.

The University of Iowa Mental Health Clinical Research Center has multiple studies available:

To participate, contact Frank Fleming, BS, BSN

Phone toll free: 1-877-575-2864

The National Institute of Mental Health (NIMH) also has several studies. For more information, go to:

<http://www.nimh.nih.gov/studies/index.cfm>



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://www.together-rx.com) for the **Together Rx Access™ Card**.



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.

Letters to the Editor

You are welcome to send letters to the editor by mail or E-mail. Letters can be sent to: Teresa Bomhoff, 200 S.W. 42nd St. Des Moines, Iowa 50312 or E-mail: tbomhoff@mchsi.com

SUPPORT GROUP MEETINGS

Third Sunday of the month - Family members, if you are interested in participating in a family support group, please contact Glenn Hobin iowaGH@aol.com or call 965-9799 - or contact Grace Sivadge 961-6671. Meetings are at Park Avenue Christian Church, 3219 SW 9th St., Des Moines – 2:30 – 4:00 P.M.

First Monday of each month -6:30 – 8 PM - a support group for parents and caregivers of children 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 or Mary Ann at 883-8014.

Every Monday evening – 6:30 – 8:00 P.M. – the Support group meets at the Mercy Franklin West Conference Room (enter West side entrance) – 48th & Franklin, Des Moines. This is a support group for both family members and consumers.

Every Monday evening – 7-8 PM – Broadlawn's-1801 Hickman – dual diagnosis support group "Double Trouble and Recovery" – in lower level – Sands Kitchen-call Julie at 282-6793

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.

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.

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 A.M. A group of people who have depression will meet at Lutheran Church of Hope, 925 Jordan Creek Parkway, Call 222-1520, ext. 175.

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?

NAMI GREATER DES MOINES

With a membership to NAMI Greater Des Moines – you help to support all 3 levels of the NAMI organization.

BECOME A VOLUNTEER for NAMI Greater Des Moines

These are some of our volunteer needs for 2007. If you see an opportunity to help out, please e-mail tbomhoff@mchsi.com or leave a voice mail at 274-6876.

Teacher or Support Group Facilitator – would involve a weekend of training to become a teacher as well as teaching at least 2 classes in two years.

- For Family to Family educational classes
- For Visions for Tomorrow educational classes
- For Peer to Peer educational classes
- For Provider educational classes
- Parents and Teachers as Allies team presenters
- Support Group facilitator (involves once a month 2-1/2 hr commitment of time)



Committee assignments:

- Justice issues – would include VHM (Virtual Hallucination Machine) events – help out with events at organization meetings and locations and conferences – normally a day long commitment at a time
- Legislative issues
- NAMI on Campus – DMACC, Drake
- Education – implementing educational courses in the school systems and colleges on mental illness.
- Where Do I Turn to Now? – assembling information for persons with mental illness (and family members) while hospitalized and for use after release.



MENTAL ILLNESS: THE FACTS

From NAMI: In Our Own Voice

Mental illnesses are brain disorders. They are not defects in someone’s personality or a sign of poor moral character or lack of faith. They certainly do not mean that the ill person is a failure. Chemical imbalances in the brain, from unknown or incompletely known causes, are much of the reason for symptoms of mental illnesses.

Mental illnesses are like other organ diseases in which body chemistry changes. The abnormal chemistry of mental illnesses affects brain function the same way that too little or too much of other body chemicals damage the heart, kidneys or liver.

A heart attack is a symptom of serious heart disease, just as hearing voices, mood swings, withdrawal from social activities, or feeling out of control are common symptoms of a mental illness.

Mental illnesses can affect people of any age, race, religion, education or income level. As you read this, five million people here in the United States are dealing with serious, chronic brain disorders.

Major brain disorders include schizophrenia, bipolar disorder (manic-depression), major depression, anxiety disorders, and obsessive-compulsive disorder.

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.



Looking for books to help children better understand their parent’s mental illness? Go to:

www.seedsofhopebooks.com



Mental Health in Early Intervention: Achieving Unity in Principles and Practice – another recommended book by one of our readers.

The authors are Gilbert Foley and Jane Hochman.

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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.braley.house.gov/>

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

The Second Chance Act of 2005

The Second Chance Act of 2005 is federal re-entry legislation designed to ensure the safe and successful return of prisoners to the community. The bill has been introduced in both the U.S. House (H.R. 1704, introduced April 2005) and Senate (S. 1934, introduced October 2005).

The Second Chance Act, which has broad bipartisan support in both the House and the Senate, is the first piece of comprehensive legislation designed to reduce recidivism, increase public safety, and help ensure the safe and successful return of prisoners to the community. The bill authorizes up to \$65 million in grants to state and local governments to develop prisoner re-entry initiatives and a \$15 million re-entry program for community and faith-based organizations to deliver mentoring and transitional services for people returning from prison or jail.



State Children’s Health Insurance Program (SCHIP)

Congress will take up legislation to reauthorize the State Children’s Health Insurance Program (SCHIP) and a bipartisan coalition of Senators is pushing for a new requirement that would ensure that all SCHIP plans meet a standard of non-discriminatory coverage for treatment of mental illnesses.

Advocates are strongly encouraged to contact their Senators and urge them to cosponsor S 1337, the Children’s Mental Health Parity Act of 2007, to require private sector SCHIP plans to cover treatment for mental illness on the same terms and conditions as other illnesses. In addition to urging co-sponsorship of S 1337, advocates should also press their Senators to reach out to Senate Finance Committee Chairman Max Baucus and demand that S 1337 be included in the upcoming SCHIP reauthorization bill.



Male Veterans Have Double the Suicide Rate of Civilians

June 12 – National Institute of Mental Health

Male veterans in the general U.S. population are twice as likely as their civilian peers to die by suicide, a large study shows. Results of the

research by Mark S. Kaplan, DrPH, and colleagues from Portland State University and Oregon Health & Science University were published online June 11 in the Journal of Epidemiology and Community Health and will appear in the July issue.

To date, most studies on suicide among veterans have relied on data from those getting health care from the Department of Veterans Affairs (VA) system. However, 75 percent of veterans do not get their health care through the VA. This study included 320,890 men age 18 and older in the general population, 104,026 of them veterans, whom researchers followed for 12 years.

Veterans who were white, had at least 12 years of education, or whose daily-life activities were limited by health problems were at highest risk. Those who were overweight had a lower risk. By the end of the study, 197 of the veterans had died by suicide. During the same period, the risk of death from other causes was the same in the veterans as in civilian men.

Compared to civilian men who died by suicide, veterans were 58 percent more likely to use a firearm to end their lives.

"Veterans in the general U.S. population, whether or not they are affiliated with the VA, are at an elevated risk of suicide," the researchers reported.

The researchers also note that the number of veterans with daily-life activity limitations – one of the higher risk factors for suicide listed above – is likely to rise. They suggest that clinical and community interventions will be needed, and call for clinicians to be alert for signs that veterans might be contemplating suicide and to assess their access to firearms.

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/> - Also has the latest on legislation and the progress of the Mental Health Redesign.

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

www.nami.org/advocacy

Excerpt from the Infonet

Just because the legislature went home for the summer doesn't mean your advocacy season is done. In fact, it has only just begun.

Believe it or not, now is the time when you have the most impact on legislators. Take some time to contact your Representative and Senator in the next month or two, and thank them for their hard work in representing you. Ask them to sit down over a cup of coffee to talk about the issues you care about.

And it is caucus season, so take advantage of Iowa's first-in-the-nation caucus status and get out and meet the candidates for President. They seem to be underfoot almost daily it seems.

See Iowa's "F" grade at www.nami.org

HF 645 - Let's Not Lose Track of this Legislation

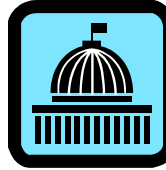
From one of our readers

WHO did a story in May about a bill (HF 645) that Rep. Donovan Olson introduced this past session that would not allow insurance companies to consider a procedure "experimental" (and therefore

not pay for it) if Medicare and Medicaid will pay for it. He said he will be introducing it again next year. Here's a link to the story:

<http://www.whotv.com/Global/story.asp?s=6560901>

Wellmark Blue Cross Blue Shield of Iowa will not pay for Vagus Nerve Stimulation (VNS) for treatment resistant depression because they consider it experimental despite the fact that it has been approved by FDA for well over a year and is covered by Medicare. When I contacted the Dept. of Insurance I was told that there is no definition of experimental and that they can determine anything to be experimental.



Interesting Facts about the 2007 Iowa Legislative Session

www.infonetiowa.com 6-7-07

2205 bills were introduced this year

222 were sent to the Governor

219 were signed by the Governor

12 bills line item vetoed by Governor

3 bills vetoed by Governor



THIRD ANNUAL CIT CONFERENCE

WORKSHOP The Third Annual CIT National Conference will be this August 28th-30th in

Memphis, TN. The program will examine the

development, implementation, advancement and effectiveness of Crisis Intervention Team training. To learn more about the conference, please visit the [Memphis Police Department](http://www.memphispolice.com) website. NAMI is offering a limited number of scholarships to cover registration and lodging for consumers and family members who otherwise would not be able to attend. For more information about the scholarships, please contact Laura Usher at laurau@nami.org. Regrettably, we cannot accommodate all applicants; however, we encourage eligible consumers and family members to apply.

WATCH



The Iowa Empowerment Conference 2007 **Joining Hands to Help Keep Hope Alive**

The Consumer Conference for individuals with mental illness will be held Tuesday through Thursday July 31-Aug. 2 at the Best Western Regency Inn in

Marshalltown, Iowa. For more information, direct your inquiries to: Iowa Empowerment Conference, 1 West Grant St., Apt. 109, Marshalltown, Iowa 50158 or call toll free to 1-800-525-2495 pin #00 ask for Kathy. **Registration Costs:**

\$230 for registration, meals, lodging

\$150 for registration and meals, no lodging

\$100 for one day only with meals

Can you raise the money on your own? Look into alternative sources for funding. Will your county CPC (Central Point Coordination) or other community organization pay for the conference? If you are denied funding from other sources, there are a limited number of stipends available. These stipends require a \$30.00 co-payment. Contact the Office of Consumer Affairs at 1-877-338-2767 or email < jholvec@dhs.state.ia.us > for more information.



IOWA FIRST TO ADD HCBS SERVICES OPTION TO MEDICAID STATE PLAN

Effective January 1, Iowa became the first state to receive federal approval to add home-and-community-based services (HCBS) option as a permanent feature of its Medicaid plan. The best

news is that adults with mental illness can be targeted very broadly for these services. Although a state cannot explicitly restrict eligibility to individuals with severe and persistent mental illness,

they can reach the same result by tailoring eligibility criteria. In Iowa's case, the Centers for Mental Health Services approved very broad eligibility criteria-i.e. receiving care "more intensive than outpatient care, more than once in a lifetime" or a "history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization." (emphasis added). The criteria include people with a serious mental health problem but do not require a prior psychiatric hospitalization or that adults need a hospital level of care in order to qualify. For more information, please contact TammyS@nccbh.org.

NAMI Walks For the Mind of America

Location	Waterworks Park Des Moines, Iowa
Date	Saturday, October 6, 2007
Distance	3 miles
Check-in	8:30 A.M.
Start Time	10 A.M.

The Walk
Manager is
Jay Brewer
515-321-8051

Each walker who raises at least \$100 will receive a free T-shirt.

We would love to have you join us on Saturday, Oct. 6. The walk will be an anti-stigma event as well as a fundraising event. Can you feel the goose bumps on the back of your neck envisioning hundreds of people openly showing their support by walking together?

Visit the website for more details:
<http://www.nami.org/namiwalks/IA> NAMIWALKSIAMGR@aol.com



Vet to Vet

Are you a veteran who is interested in helping other veterans with mental illness or addiction? If so, Vet to Vet may be of interest to you.

The core components of Vet to Vet are:

1. The principal focus of Vet-to-Vet is the unique experience of veterans, and how they can learn to live with problems posed by mental illness and/or addiction.
2. The Vet-to-Vet has an educational focus, utilizing established materials recognized in the field of psychosocial rehab.
 - The Vet-to-Vet Manual has a list of recommended materials.
 - The meetings use a 'read and discuss' format and all attendees are encouraged to participate.
 - The education is achieved via the materials as well as a mutual learning experience based upon group sharing.
3. The Vet-to-Vet consists of semi-structured curriculum with regular meetings scheduled 2 to 5 times a week.
4. Vet-to-Vet meetings are led and guided by the veterans themselves.
5. Vet-to-Vet is based upon a partnership with the mental health system in which the mental health system provides facilities and support for the program.
6. There is collaborative-clinical supervision through which the mental health professionals and veteran group leaders hold regular consultative meetings that are separate from the actual Vet-to-Vet meetings.
7. Vet-to-Vet meetings are held in facilities made available by the mental health system to provide optimal access to services.

8. The role of the veteran group leaders is independent of the role as receivers of treatment.

Moe is taking direct applications for the Vet-to-Vet. He may be reached by calling: 1-203-623-0731- E-mail is: moeal@verizon.net

Here's a website resources for returning veterans and their families
<http://www.samhsa.gov/vets/index.aspx>



Middle School Teachers for Grades 6-8 <http://science.education.nih.gov/n4a>

Have you ever visited the National Institute of Health website for **free** curriculum supplements? Here are some of the topics:

The Science of Mental Illness
The Science of Healthy Behaviors
How Your Brain Understands What Your Ear Hears
The Brain: Our Sense of Self
... and other topics are available.



More facts about NAMI Walks for the Mind of America

- Started with just 12 sites
 - In 2007, 70 communities will host the Walk
 - NAMIWALKS is in 44 states
 - Over 1,000 businesses sponsor our Walks Across America
 - 55,000 individuals walked last year
- This is the first year we will have a walk in Des Moines.



When Nothing Matters Anymore: A Survival Guide for Depressed Teens

*Bev Cobain, R.N.C.
(Free Spirit Press, revised and updated, 2007)*

This is a book that deserves to be in every middle or high school library, used in every health class, and even given to every adolescent on their 13th birthday—to help them watch out for friends, as well as themselves. For that matter, parents may want a copy, too.

Bev Cobain wrote the original edition in 1998 after losing three family members to suicide, including her cousin, Kurt Cobain, the lead singer of the rock band Nirvana, who endures today as an icon for youth culture. The book provides straightforward information and advice, as well as first-person narratives from 12 teenagers who serve as role models for solving problems rooted in depression.

Kurt Cobain struggled with bipolar disorder, underlying alcohol and drug abuse, and what some called artistic "angst" and inability to cope with success. Ironically, Bev Cobain is a psychiatric nurse—but one who also has struggled with depression. She knows about what she writes.

Part One of the book explores how it feels to be depressed, the causes and types of depression, and connections to alcohol, drug abuse, and suicide. Part Two discusses how to stay healthy, and when to get help.

There are "You Can Say" suggestions to make it easier for teens to open up with adults whom they can trust, as well as common sense "Survival Tips" such as "Have Some Fun" and "Feed the Spirit." Laughter, the first one notes, increases breathing rate, heart rate, and muscular activity," and helps reduce isolation. Feeding the spirit helps reduce feelings of emptiness through creativity or outward-focused activity. The book also includes answers to the Top 10 Questions that teens have asked the author.



MENTAL HEALTH IS IN DARK AGES

Virginian-Pilot Editorial 5-20-07

Here's one image of mental health care in Virginia institutions, circa late 20th century.

Gloria Huntley, a 31-year-old borderline schizophrenic, in and out of hospitals from the time she was 13, died strapped by the arms and legs to a hospital bed at Central State Hospital on June 29, 1996.

Even though her psychiatrist had warned of the danger, Gloria lay spread-eagled in restraints for 300 hours in the last month of her life, including two stretches of 4-1/2 days each.

Here's an image of mental health care in Virginia's more community-driven system, circa early 21st century.

"My son's bipolar, he's off his meds, he has a history of psychotic behavior. You've got to do something! He's sick! Help him please!" Pete Earley, author of the recently published book "Crazy," records a nightmarish attempt to get his mentally ill son admitted to a Northern Virginia hospital.

"Your son is an adult," the physician replies, "and while he is clearly acting odd, he has a right under the law to refuse treatment."

It is only a matter of time until that son breaks into someone's home and faces two felony arrest warrants.

What unites an era of institutions for the mentally ill and an era of deinstitutionalization, in which jails and prisons often wind up as default holding pens? The awareness that mental illness can be hell, no matter when or where.

Think we've progressed far from the era when Dorothea Dix stormed 19th-century America, exposing the abominable treatment of the mentally ill in jails and prisons? Read Earley's account of the psychiatric unit at the Miami-Dade County jail and you'll doubt it.

Naked prisoners huddled in freezing cells eating food off the floor, then and now.

The April 16 killing of 32 students and faculty at Virginia Tech by a deranged student-gunman is bringing renewed attention to the status and treatment of mentally ill Virginians.

- . What does it take to force treatment?
- . What should that treatment entail?
- . What is the correct balance between honoring the rights of the individual and protecting that individual and society from the harm he might do?

At the first meeting of the blue-ribbon panel appointed by Gov. Tim Kaine to address the Tech shootings, mental illness bubbled to the fore. Kaine confirmed that sense in an impromptu press conference last week.

"Fairly quickly, I felt the mental health issues might come to predominate," he said.

What that panel can most likely provide is a case study in the treatment, or lack thereof, of one young man, Seung-Hui Cho, whose brooding silence apparently intensified during his college years. A more intensive probe of issues will come with a 2008 report from the Commission on Mental Health Law Reform, led by Chief Justice Leroy R. Hassell Sr.

When it was launched last year, that study spawned an unnecessary challenge from lawmakers - most prominently Virginia Beach Sen. Ken Stolle - who thought Hassell was invading their turf. Now, everyone should just be glad the work is under way and that the final report will carry the cachet of some of Virginia's premier minds.

Yes, as Stolle argued, the legislature has conducted study after study of mental illness in Virginia, and the missing ingredient invariably winds up being money.

But timing is everything in politics. No matter how many lofty studies are collecting dust on library shelves, the intersection of the Virginia Tech shootings and the Hassell study means this one will have an audience far beyond the rest.

Moreover, it is starting from the right point - the grim reality that across the commonwealth, as nationally, prisons and local jails are substituting for the mental health hospital beds that no longer exist.

By one reading, America has simply come full circle. In the Colonial era, families cared for their mentally ill as best they could, and jails picked up the slack. Spurred by horror stories, state asylums were born. Generations later, amid new horror stories, asylums began to shut down.

Now we are back to often inadequate family and community-based care, with jails picking up the slack - and more horror stories.

That's a gross oversimplification, of course. Modern medicines, well-run group homes, Assertive Community Treatment (ACT) teams and other innovations all allow scores of mentally ill individuals to live more normal, integrated lives than ever before.

Gloria Huntley and Pete Earley's son present only two faces of care, not the full range.

Still, we deceive ourselves - and badly so - if we continue to shut down hospital wards while tolerating a shortage of community options, or if we dismiss the agony of families forced to watch their loved ones disintegrate into criminals before help arrives.

Anyone reviewing the long history of mental illness in America knows reform never spells panacea. But current conditions are not the best we can do. Freedom that ends in a jail cell is not preferable to custody in a hospital ward.

We can do better, and we must.

-- *Treatment Advocacy Center 5-25-07*



Many thanks to Nancy Williams, our speaker at the May 6 affiliate meeting at Iowa Lutheran. Nancy is a psychiatrist at the U. of Iowa and is the on call psychiatrist for the ACT team

(Assertive Community Treatment). Nancy gave a very informative talk about the history, present situation, and hope for the future of this evidence based practice in Iowa.

Who is ACT for?

- Persons with serious mental illness
 - Primarily schizophrenia, schizoaffective, bipolar and severe depressive disorders
- Persons who are the highest utilizers of health care resources - either through
 - Institutionalization
 - Acute hospitalization
 - Homeless/jailed

Why is ACT needed?

Look at the outcomes for persons with severe mental illness compared with the general population:

- 10X the suicide rate
- 10X the HIV rate
- 3X substance abuse
- 8X violence rate (if severe mental illness & substance abuse)
- 28% of homeless in the U.S. have severe mental illness
- 6-15 year shorter life expectancy
 - Accidents
 - Infection
 - Cardiovascular disease

The origins of ACT

Act began in Wisconsin in the 1970's at Mendota State Hospital. It was originally called "hospital without walls". Outcomes were published in 1980.

Fundamentals of ACT

- Multidisciplinary staff
- Team approach
- Integrated care for co-occurring disorders, supported employment, social skills training, appropriate use of medications, and education about the illness.
- Care is given in the community
- Favorable ratio of 8 clients to 1 staff member
- Assertive outreach to those in need
- 24/7 availability for crisis intervention
- Time unlimited services

Where is ACT in the continuum of care?

- Outpatient care
- Supported community living
- **ACT**
- Residential Care
- Acute hospitalization

ACT outcomes

- Fewer hospitalizations
- Improved housing stability
- Better retention in mental health services
- High satisfaction (patients and families)
- Cost effective

Nationally, ACT is receiving increasing emphasis.

- ACT has been identified as 1 of 6 evidence-based practices by the Robert Wood Johnson Foundation; PORT study recommended ACT for the treatment of schizophrenia.
- Health Care Financing Administration has authorized ACT as a Medicaid reimbursable treatment (in Iowa, Magellan has chosen to include it as Medicaid reimbursable – but ACT still needs to be included in the State Mental Health Plan)

Nationally, ACT is receiving increasing emphasis (cont'd)

- Surgeon General's report on Mental Health endorsed ACT as an essential treatment for severe mental illness.
- NAMI has had a commitment to ACT since the 1980's.
- Olmstead Decision (a Supreme Court decision that disabled persons should be able to live in the community rather than being institutionalized) – ACT assists in helping persons with mental illness live successfully in the community.

How many ACT teams are there in Iowa? – 5

1996 – Iowa City "IMPACT"

1998 – Des Moines "PACT", Cedar Rapids

2004 – Fort Dodge "ACTION"

2006 - Council Bluffs

About 500 persons out of an estimated 2000 needing ACT are being served. **More teams are needed.**

The challenges of developing more ACT teams

Funding and Workforce

Funding

- *Start up costs* - Teams lose money until their census is adequate to cover costs of the program
- *Ongoing funding* -Cost savings for payor of inpatient care
 - For those that are Medicaid/Medicare eligible Medicaid only covers outpatient care (needs to include inpatient). Medicare is the inpatient payor.
- *Multiple funding streams* are needed for start up and ongoing funding

States with

Strong ACT Iowa

Yes	No	Strong "Top Down" support from state Legislature
Yes	No	Significant commitment of State general funds
Yes	No	Significant use of Medicaid Rehab Option

In Oklahoma, the state legislature funds the start up dollars for 2 ACT teams every 2 years and provides ongoing funding to existing teams. From 2000 to 2005 – 8 teams are serving 350 clients with capacity to increase to 600 clients.

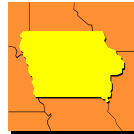
Indiana has 15 teams in operation currently.

Workforce

There is a workforce shortage.

Iowa ranks 47th in the nation in the number of psychiatrists per capita.

PACT of Greater Des Moines serves residents in Polk and Warren County. Office hours are Monday through Friday 8 a.m. to 8 p.m. and 8 p.m. to 4:30 p.m. weekends and holidays. To make a referral or to learn more about the local PACT team, contact the Team Leader at 235-8846.



Iowa Advocates for Mental Health Recovery

A state consumer network organization was formed on April 23 and 24, 2007. A Board of Directors was established – 80% of which must be consumers.

They adopted a mission statement, bylaws, and established 3 committees. The state was divided into 11 districts.

The mission statement is "Develop a more positive image of persons with mental problems by suggesting that they can recover and that friends/peers can aid in that recovery."

The values of the organization are:

1. Everyone should have equal access to mental health treatment regardless of county of legal settlement.
2. Consumers should be accorded basic equal human rights – to be treated with kindness, dignity, and respect to achieve one voice to empower us and to overcome stigma and discrimination.
3. Peer support is essential to mental health.
4. All Consumers can recover.
5. Consumers should organize to become a stronger voice in the transformation of the mental health system.
6. Consumers should represent 51% of all members of committees and boards pertaining to mental health.
7. Consumers can strive in unity in keeping hope alive and educating ourselves and others for positive public policy.
8. Everyone who has contact with us should be required to learn from us, our experience and about our programs we have developed.
9. There is hope for every person.
10. Use your life's pain, use it to guide, encourage, and empower others.

Membership is open to adults with mental illness and children with severe emotional disorder. More information will be forthcoming.



State Mental Health Planning Council

The State Mental Health Planning Council is looking for volunteers to serve on the council in the category of parents of children with severe emotional disorder.

Teresa Bomhoff, President of NAMI Greater Des Moines, serves on the council as a parent of adult children with severe mental illness.

If you are interested, please contact Sue Bakker at sbakker@dhs.state.ia.us and ask for the MHPC Application.



MEASURE WOULD ALLOW EARLIER COMMITMENT OF MENTALLY ILL

The State Journal-Register, June 01, 2007

Late yesterday afternoon, the Illinois General Assembly passed a substantial reform of the state's commitment standard - by a commanding vote of 108-6. After a concurrence on a minor amendment by the state senate, which passed the bill unanimously three weeks ago, Senate Bill 234 will head to the desk of Illinois Governor Rod Blagojevich.

SB 234 would expand the scope of Illinois commitment criteria now requiring that a person with a severe mental illness be "expected to inflict serious physical harm" in the near future before a court can authorize assisted treatment. The new standard would permit court-ordered treatment for individuals who, while not presenting a demonstrable threat of immediate physical harm to themselves or others, are clearly in need of psychiatric care and whose condition is likely to create a risk of serious harm to the person or others absent treatment.]

MEASURE THAT WOULD ALLOW EARLIER COMMITMENT OF MENTALLY ILL PASSES

By Laura Camper, Illinois State Capitol Bureau

Family members afraid their loved ones might harm themselves or someone else because of mental illness would be able to have them admitted for treatment involuntarily under legislation that passed the Illinois House on Thursday.

The vote was 108-6, sending it to the governor for his signature.

"This is a very important step, to let parents, especially, intervene on behalf of their loved ones who are suffering serious mental illness," said Rep. David Leitch, R-Peoria, sponsor of the bill.

Family members know the person well enough to recognize when he or she has stopped taking medicine or is heading toward dangerous behavior, Leitch said.

But under current law, they are not able to step in until the loved one has become a danger. Senate Bill 234 would allow family members or friends to act earlier, he said.

"It's virtually the opposite of the way the archaic, expensive and totally ineffective state system functions," Leitch said.

While he admitted that patients do fall through the cracks of the mental health system, Rep. Lou Lang, D-Skokie, argued that allowing someone to be involuntarily admitted for treatment because of "mental deterioration," which is not defined in the bill, was too vague.

"We must not and we cannot resort to constitutionally vague language," he said. "There should be a high bar for us to deprive an individual of their liberty."

Rep. Julie Hamos, D-Evanston, also opposed the bill, saying that while the issue is emotional, it has to be viewed rationally.

"Think ahead about the kind of people who will be snagged in a web which will result in an involuntary commitment, in a sense, an incarceration," Hamos said.

The National Alliance on Mental Illness Illinois supports the legislation.

"Many of the consumers that we work with know that it made the

biggest difference in their lives," Lora Thomas, executive director of NAMI Illinois, said of the forced treatment. "They are productive and have fulfilling lives because someone else had the compassion to get them into treatment."

Because of their illness, Thomas said, patients with disorders such as schizophrenia or bipolar disorder may not be aware of their need for treatment.

"The bill that passed today recognizes families as a safety net, and allows family and friends to get involved in trying to access treatment and support," she said.



OUR VIEW: TREATMENT, NOT JAIL

SPOKESMANREVIEW (Spokane, WA), May 30, 2007

Half a century ago, people who heard voices or plotted paranoid fantasies were likely to wind up living at Eastern State Hospital. Now they're much more likely to wander the streets of Spokane and land in the local jail.

In the 1960s Americans became deeply concerned about the state of public mental institutions. Books like Ken Kesey's "One Flew Over The Cuckoo's Nest" raised the public's consciousness. And facilities such as Eastern began opening their doors and releasing thousands.

The vision then, of mental health programs that could allow patients to live less restricted, richer lives, has never fully come to fruition. While injustices of the old system were corrected, many new horrors were created.

State and local governments never found enough money to give those with mental illnesses the care they need. And where the psychiatric nurses left off in setting limits on irrational behavior, other public servants, particularly police, judges and jailers, were forced to step in.

Last week Spokane-area officials announced welcome news. A group from law enforcement, the courts and the mental health community will spend a year developing a strategic plan. They'll examine ways to improve the criminal justice system's dealings with the mentally ill.

The public has become increasingly aware of the issue. The most notable tragedy was the death last year of Otto Zehm, a mentally ill janitor, who died after Spokane police officers tied him down.

Last September, a U.S. Justice Department report showed that 64 percent of Spokane jail inmates displayed symptoms of a mental disorder.

And last week Spokane Superior Court Judge Linda Tompkins said, **"We face the fact every day that so many of our folks are in jail when they should be on a treatment regimen."**

This new strategic planning process, paid for by a \$50,000 grant from the U.S. Justice Department, offers new hope for Spokane's mentally ill.

The criminal justice system, never designed to replace the psychiatric field, sometimes must do just that. For the collective health of our community, police, judges and jailers must work hard to reduce the insanity here, not compound it.



The National Alliance on Mental Illness has created a promising new blog (<http://blog.nami.org/>)

In the second entry to that blog, NAMI Executive Director Mike Fitzpatrick offers some dynamic comments for treatment law reform.

SOLUTIONS

By Mike Fitzpatrick

In my previous post, I talked about some of the ways that the mental health system in America is broken, and shared some of the real-world consequences experienced by families and consumers. In this post, I'd like to focus on what I see as some solutions.

First, we must invest adequate resources in mental health services that work. The mental health system must be reorganized to more effectively respond before crises occur. Today, it is virtually impossible in many communities across America to get mental health services unless you have been arrested or been determined as dangerous. It is no wonder why our jails and prisons are filled with people with serious mental illnesses. We must make services available to people when they need them.

We must work with colleges and universities to include screening, assessment, and treatment of serious mental illness within the array of health services available to students. As we know, early adulthood is the stage at which a number of psychiatric illnesses, such as schizophrenia, bipolar disorder, and major depression are most commonly diagnosed.

It is essential that states with overly restrictive laws amend their laws to permit court-ordered treatment on an inpatient or outpatient basis without requiring proof of imminent dangerousness. Information and evidence such as past history and input from families and others close to the individual should be incorporated into determinations of whether individuals meet the legal criteria for court ordered treatment. The laws in many states frequently function as impediments to treatment when people need it the most, but may be too ill to recognize their own need.

We must invest in treatment options that are evidence-based and emerging best practices. It is frankly not acceptable that some states have no assertive community treatment teams. There is a very rich body of data showing that these teams are highly effective in helping people with the most severe mental illnesses. What justification can a state provide for failing to fund any assertive community treatment teams? The same holds true for other evidence-based practices, such as integrated dual diagnosis treatment, supported employment, and illness self management.

While perhaps not yet reaching the threshold of being "evidence based", there are a host of emerging best practices such as peer counseling, supported housing, and jail diversion that can have a very positive impact in helping people recover. We must invest in these services as well. Outdated practices that have been shown not to work should not be funded.

MENTAL ILLNESS AND THE PRICE OF 'FREE WILL'

LOS ANGELES TIMES, June 10, 2007

[Treatment Advocacy Center Editor's Note: Although the laws to which she refers and the policies against which she rails both suggest it, Dr. Partovi never explicitly writes in this piece that her patient had a severe mental illness. That is, however, essentially immaterial. For even if the sole cause of Williams' treatment refusals is the effects of his dementia, there are tens of thousands of Americans similarly at risk because of acute psychiatric disorders. Dr. Partovi's impassioned points and William's grievous story relate equally to the plight of those so imperiled.]

Are Laws Protecting The Right To Refuse Psychiatric Treatment Doing More Harm Than Good?

By Susan Partovi

Susan Partovi is a staff physician at the Venice Family Clinic and

an assistant professor at UCLA's David Geffen School of Medicine. She is also the medical director for Homeless Health Care Los Angeles.

THE PHONE RANG at 3 a.m. "Dr. Partovi," the person on the line said, "I'm calling to let you know that William expired this morning."

I'd first met William about six months earlier in May 2006 at the Venice Family Clinic after his release from a hospital where he was treated for congestive heart failure. I still remember his loud, childlike voice: "No, no . I'm not going to the hospital!" he shrieked when I told him that I wanted to refer him to Harbor-UCLA's cardiology clinic.

William - I'm calling him that because medical privacy rules don't allow me to use his real name - was 61. Six feet tall with gray hair, he dressed in T-shirts and pants that were a little too big. He lived alone in an apartment in Brentwood and had a sister in Canada and a niece in New Jersey.

Three years earlier, he'd had a heart attack and a stroke, and he now suffered from dementia, likely as a result of the stroke. It was quickly obvious to me that William could not take care of himself anymore. He spoke like a whining toddler. He was very stubborn, and his judgment was extremely limited. "My memory's not good," he'd huff if he couldn't answer a question.

But one's inability to care for oneself is not a criterion to receive involuntary treatment for the mentally impaired. And for many mentally impaired people without family nearby to rely on for housing, food and help in managing their medical care, the result can be disastrous.

A recent study of adults with serious mental illness who were treated in eight states' public hospitals and clinics found that they died, on average, at age 51 - 25 years younger than the average American. The study's lead author, Dr. Joseph Parks, director of psychiatric services for the Missouri Department of Mental Health, said that about three out of five died of preventable diseases.

William's heart failure was very treatable, but only if he would take his medications appropriately.

I continued to see him every two weeks or so at the clinic. At first he was brought by a female friend, and then after she disappeared, by a new friend, Mike. Mike kindly made sure that William had food, checked that his bills were in order and put his medication into daily pill boxes. When, after a few months, Mike confessed that he'd met William only recently when buying one of his boats and couldn't continue to be this involved, I understood.

I asked one of the clinic's volunteer psychiatrists to see William, and she chatted with him for a bit during his regular clinic appointment with me.

Though he seemed to like her, he would never go to her office at the Edelman Westside Mental Health Center, a county clinic, and neither of us could make him go. I also called the county office that handles elder services - which investigates impaired adults to learn whether they suffer from abuse, isolation or neglect - but he kicked the social workers out. "He's got a personality problem," one of the social workers said to me afterward. "We can't help him."

William's health deteriorated, and he landed in the emergency room with abdominal pain - most likely angina related to his heart failure. I asked for a psychiatric consultation; if William were deemed incapable of making his own decisions, we could try to get him placed in a long-term care facility.

But the hospital psychiatrist claimed that William knew his name and where he lived - and that he was very insistent on not being placed.

"But he can't take care of himself, he doesn't have food, he can't pay his bills, he won't take his medications," I replied.

"It's his free will to not take his medications." Thus, he was deemed "fully competent."

A woman who'd been assigned by the hospital to sit with William in his room took it upon herself to become his home health caretaker after he was released. She cleaned his apartment - which she described as unlivably filthy - washed his clothes, stocked the fridge. But it lasted only three days. He became so verbally abusive that she left.

Mike called a few days after that. He'd found William naked on the couch, claiming that he couldn't find anything to wear.

I thought that he should go to Harbor-UCLA Medical Center, where I could try to get another psychiatric consultation. Mike agreed to take him, but William refused to go.

He'd still come to his now-weekly appointments at the clinic, but he stopped taking the drugs that controlled his blood pressure, cholesterol, fluid levels and agitation. He would only say, "I promise, Dr. Partovi, I'm going to do better," like a 3-year-old promising not to hit his sister.

The next phone call came from his landlord. "William looks very sick," she said, "but he won't go to the hospital."

When I called to check on William, he sounded breathless. Yet, when I mentioned the hospital, he slammed down the phone.

I called the county's psychiatric emergency team but was told that its members couldn't force themselves into someone's house, and I knew William wouldn't let them in voluntarily. The unit recommended asking the police to do a courtesy check. But the police said they weren't allowed to force entry either.

William had gained more than 50 pounds in fluid. I begged him to go to the hospital, but he vehemently refused.

"Do you want to die?" I asked, exasperated.

"No, no, I don't want to die," he'd squeal in his childish voice. But he couldn't understand that he was killing himself.

The next Monday, he came to the clinic, complaining of chest pain. The attending physician called the paramedics to take him to the hospital. He again refused to go.

"Do you know your name?" one paramedic asked. "Do you know where you are?" These are the standard questions non-psychiatrists ask to assess one's mental state.

"The Venice Family Clinic," William said, sing-songy.

"He's competent," the paramedic said. "We can't take him if he refuses."

A few days later, I got a call from William's new roommate, John. He was in a panic: "Dr. Partovi, William looks horrible. He can't get off the couch, and he's hallucinating. He's barely breathing!"

"Call 911," I told him. I could hear his hesitancy in the silence. "He's going to die on your couch if you don't."

John called 911, and paramedics took William to the emergency room.

"We'll get him tuned up," the ER physician assured me. I could hear William's boyish cries in the background, "No, no, no!"

That night I got my last call about William. The one that came at 3 a.m.

Since the deinstitutionalization of the 1980s, when state laws protecting the right to refuse psychiatric treatment were

strengthened, it has been extremely difficult to involuntarily hospitalize the mentally ill or mentally impaired. Though psychiatrists are the only ones who make legal determinations, other physicians, the police and the paramedics all know the criteria: "If the patient is at risk of harming him/herself or others .

But what is harm? Wasn't William harming himself? And aren't we allowing him to harm himself under the guise of "free will?"

There's a homeless man in Santa Monica who sits on the same stoop all day, every day. He has matted hair down to his hips, long nails and a honeydew melon-sized hernia easily visible under his filthy clothes. He's quite benign, but he refuses anything from me or the outreach workers I go out with. Isn't he harming himself? Isn't it harmful to live in the streets, not bathe, not seek a doctor's attention for a chronic condition?

In the wake of the massacre at Virginia Tech, we've been repeatedly told that we all need to be able to spot the warning signs of mental illness. But it's not rocket science. Seung-hui Cho was severely mentally ill - and there were several attempts to "help" him by his teachers at Virginia Tech, whose efforts were thwarted.

The law allows people their free will to refuse treatment. As someone on the front lines of treating the mentally ill, I would like to see the law take better care of people like William, the homeless man with the hernia and Cho - and, by extension, the 32 people he killed.

Perhaps the issue confronting us is not about free will at all. Perhaps it's about our own disinclination as citizens and taxpayers to fund more treatment facilities, counselors and hospitals for the mentally ill. And perhaps "free will" is the propaganda we've decided to believe instead.



Paxil Pediatric Class Action Settlement – Payments Available

Please be advised of a national settlement in a lawsuit that alleged GlaxoSmithKline, the maker of Paxil and PaxilCR, concealed information about the safety and effectiveness of prescribing Paxil for children.

Under the terms of the settlement, anyone that purchased Paxil or PaxilCR for a minor child or ward is entitled to recover 100% of their documented out-of-pocket costs for purchasing Paxil or PaxilCR. Those who are unable to document their purchases are still able to recover up to \$100.

In order to receive payment, parents and guardians must submit a claim form that must be received by August 31, 2007.

For more information about the settlement or to download a request a claim for, you can visit paxilpediatricsettlement.com or call toll-free (866)494-8404.



Have You Seen the Public Service Announcements?

What A Difference A Friend Makes

The opportunity for recovery from mental illness is more likely in a society of acceptance. Many Americans are misinformed about mental illness and respond negatively when confronted with a friend's mental illness. According to one survey, less than one-third of adults believe a person with mental illness can recover, and about 1 in 4 adults age 18-24 believes a person with mental illness can recover.

To help improve awareness about recovery from mental illness, SAMHSA launched What A Difference A Friend Makes, a national anti-stigma campaign targeted to men and women 18-25 years old. The prevalence of serious mental health conditions among people between the ages of 18 and 25 is almost double that of the general population. Young adults are more likely than the general population to know someone with a mental illness. Yet young people have the lowest rate of help-seeking behaviors. This group has a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on.

What A Difference A Friend Makes focuses on friends as a key component of mental health recovery, and delivers messages to encourage, educate and inspire 18- to 25-year-olds to step up and support friends they know are experiencing a mental health problem.

Education and support from friends not only helps individuals to recover; it also helps to counter discrimination and stigma associated with mental illness. When young adults offer reassurance, companionship, and emotional strength to their friends who have mental illnesses, they demonstrate to other people that it's OK to have friends with mental illnesses. By maintaining the friendship, young adults become part of the "contact approach," sending a powerful message that people with mental illnesses should be supported, not shunned.

What A Difference A Friend Makes includes television, radio, outdoor, print, and interactive elements. Visit the Web site <http://whatadifference.samhsa.gov/> for information on the campaign and to learn how you can get involved.



Another Silver Ribbon Dialogue

On Memorial Day, my family has a reunion in Howard County where we have a Century Farm and decorate 21 graves.

I always ride with the American Legion Auxiliary women, in the small town Memorial Day Parade. My father marched every year, until his death at 88 years of age. He had battle fatigue in WW2 but recovered after six years and picked his life up again. My son who is a veteran, marches also - he continues to cope with his serious mental illness, and is 100% service-disabled. The people of this small town, know of both my father and my son's experiences with mental illness. Three women - about my age - give me updates about their own sons with SMI, every time I come home. This is from one of my friends:

"My son with schizophrenia, had been doing very well on his medicine. He had a low-rent apartment in town, and a job mowing lawns, and shoveling snow in the winter. He was seen on a regular basis by a person at the regional Mental Health Center.

Because he had not been hospitalized for almost 4 years and was doing so well, they told him they no longer had to see him. Within 6 months, he had a mix-up in his meds. He began to deteriorate. He went into a severe psychosis and was hospitalized. He was put into a nursing home, to continue to recover.

During this time, his Medicaid was all confused. I got a bill for the cost of his nursing home, the ambulance bill for his emergency hospitalization and for all of his meds. He is now living 'on his own' again but is not as well as he was, before his relapse.

His neighbors and the people he did lawns for, are afraid of him now. I continue to try to pay the bills.

When a person has an illness such as schizophrenia, it is not

cured, when in recovery. Without the 'anchor' and the stability of a person who can negotiate the system if there is a mix-up in medicines - a person is 'at risk'.

I am worried that 'they' may drop him from care again.

Is there any way to make sure this won't happen?" I am a 74 year-old widow.

--June Judge



Male Depression: Don't Ignore The Symptoms

Mayo Clinic newsletter – Part I

Are you irritable, isolated and withdrawn? Do you find yourself working all the time, drinking too much alcohol, using street drugs or seeking thrills from risky activities? If so, perhaps you're being

chased by what Winston Churchill called his "black dog" — male depression. Churchill attempted to ward off his black dog with compulsive overwork and large amounts of brandy.

For male depression, the coping strategy may be reckless driving, risky sex or shutting yourself off from the world. But none of these can keep male depression at bay for long. Even worse: Men with depression are at increased risk of suicide.

Male depression often undiagnosed

Each year, serious depression affects about 6 million American men and 12 million American women. But these numbers may not tell the whole story. Because men may be reluctant to discuss male depression with a health care professional, many men with depression go undiagnosed, and consequently untreated.

Some men learn to overvalue independence and self-control during childhood. They're taught it's "unmanly" to express common feelings and emotions often associated with depression, such as sadness, uncertainty or a sense of hopelessness. They tend to see illness — especially mental illness — as a threat to their masculinity. So men may deny or hide their problems until a partner's insistence or a catastrophic event, such as job loss or arrest, forces them to seek treatment.

When they visit their health care professional, men are more likely to focus on physical complaints — headaches, digestive problems or chronic pain, for example — than on emotional issues. As a result, the connection between such symptoms and male depression is often overlooked. And even if they're diagnosed with depression, men may resist mental health treatment. They may worry about stigma damaging their careers or about losing the respect of family and friends.

Symptoms of male depression

In both men and women, common signs and symptoms of depression include feeling down in the dumps, sleeping poorly, and feeling sad, guilty and worthless. Men with depression, however, have bouts of crying less often than do women with depression.

Symptoms of male depression often include:

- Anger and frustration
- Violent behavior
- Losing weight without trying
- Taking risks, such as reckless driving and extramarital sex
- Loss of concentration
- Isolation from family and friends
- Avoiding pleasurable activities
- Fatigue
- Loss of interest in work, hobbies and sex
- Alcohol or substance abuse
- Misuse of prescription medication
- Thoughts of suicide

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(Male Depression – Don't Ignore the Symptoms – cont'd)

In addition, men often aren't aware that physical symptoms, such as headaches, digestive disorders and chronic pain, can be symptoms of male depression.

Job stress a common trigger of male depression

Whether in men or in women, the precise cause of depression isn't known. Researchers believe depression is the result of a combination of genetics and brain chemistry, your thought processes and your social environment. Everyone, for instance, is susceptible to depression in the wake of a major life stress, such as the end of an important relationship, the death of a loved one, moving or financial problems.

Some research suggests that for men, job-related stress may also play a very important role in male depression. Some job characteristics that may be associated with male depression include:

- Lack of control over your responsibilities
- Unreasonable demands for performance
- Conflicts with supervisors or co-workers
- Lack of job security
- Night-shift work or excessive overtime
- More time than you'd like spent away from home
- Wages that don't reflect the level of responsibility you bear

When male depression goes untreated

Like other men, you may feel that your depression symptoms aren't severe. You may believe that you should be able to just get over them or tough them out. You may try to deny them, ignore them or blunt them by drinking too much alcohol or working longer hours. But left untreated, male depression symptoms disrupt a person's life in many ways and leave the individual chronically unhappy and miserable.

Depression can also damage your health. For instance, it can keep your stress response continually activated, a state that can damage many organs, including the heart. Depression can even shorten your life.

In a given year, men with depression are more than twice as likely as men without depression to die of any cause. Women with depression also have an increased risk of dying, compared with women without depression, but the difference is not as great as it is in men. Although the reasons for this difference are unclear, men with depression may be more likely to engage in self-destructive behavior — from excessive drinking to reckless driving to suicide — that may contribute to it.

Depression also increases your risk of divorce and your children's risk of developing depression themselves. At work, male depression makes you less productive, limits your earning potential and increases your risk of losing your job.

Part 2 of this article on Male Depression will be in next month's newsletter –Suicide and Male Depression and Treatment and Self-Care for Male Depression.

Please send a big **THANK YOU** to
Cindy Gross and Plaza Printers

6762 Douglas Avenue
Urbandale, Iowa 50322

278-4695 www.plazaprinters.net

For their assistance in helping us print this newsletter.

Steven Morgan, a Peer Specialist working in Vermont has put together an extensive website about mental health recovery. *"It contains many resources available for reading and download. There are over 100 articles, multiple wellness programs and goal-setting packets, an entire section dedicated to the Peer Recovery Center that I work at, links to important sites, information about being healthy, a section for finding work and volunteer opportunities in Vermont, and more. My goal was to create a website that brought together the many resources for mental health workers that are essentially scattered across the Internet. I hope you enjoy!"* Please check it out at www.vermontrecovery.com. To provide feedback, e-mail steven@vermontrecovery.com or call 404-376-4523.