



# Greater Des Moines

Box 12174, Des Moines, Iowa 50312

(515) 277-0672 (voice mail)

## AFFILIATE AND SUPPORT GROUP NEWSLETTER

"Support, Education, and Advocacy"

Serving Polk, Dallas, Warren, and Madison counties

**May 2008**

**May is Mental Health Month**

<b><u>Education</u> Meetings are generally the 1<sup>st</sup> Sunday of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room.</b> Dates on Sundays other than the 1 <sup>st</sup> Sunday of the month are due to holidays or other special scheduled events.		<b><u>Business and Committee</u> Meetings are the 2<sup>nd</sup> Thursday of the month at 5 P.M. at the NAMI-Iowa Office.</b> <ol style="list-style-type: none"> <li>1. Business</li> <li>2. Marketing and membership</li> <li>3. Support</li> <li>4. Education</li> <li>5. Advocacy</li> <li>6. Fundraising</li> <li>7. Special Events</li> </ol>	
<b>Sunday, May 4 – 2 PM</b>	A presentation will be given by the <u>Iowa Peer Support Training Academy</u> .	<b>Thursday, May 8 - 5 PM</b>	We will be discussing and planning around 7 topic areas
Week of May 4-10 Thursday, May 8		<b>Children's Mental Health Awareness Week</b> <b>National Children's Mental Health Awareness Day</b>	
Friday & Saturday May 9-10		<b>Understanding Attachment Disorders in Children and Adults – the Circle of Security Approach Seminar – U. of Iowa Hospitals &amp; Clinics – for more information contact <a href="http://www.circleofsecurity.org">www.circleofsecurity.org</a> – CEU's available</b>	
Wed., and Thurs., May 21-22		<b>Co-Occurring Disorders &amp; Dual Recovery Anonymous Consumer/Provider Conference</b> Featuring Dr. Kenneth Minkoff, M.D. – national known consultant/trainer on co-occurring disorders – at the Holiday Inn & Suites, 4800 Merle Hay Rd., Des Moines – for additional information, please send inquiries to <a href="mailto:IAMHR07@gmail.com">IAMHR07@gmail.com</a>	
<b>Sunday, June 1 – 2 PM</b>	Presentations will be given by the <u>Rainbow Center and Disability Program Navigators</u> from Iowa Workforce Development.	<b>Thursday, June 12 - 5 PM</b>	We will be discussing and planning around 7 topic areas
Fri thru Mon – June 13-16		<b>NAMI National Convention</b> in Orlando, Florida – You can register on-line at <a href="http://www.nami.org/convention">www.nami.org/convention</a>	
Thurs., June 19		<b>Many Faces of Mental Illness and Intellectual Disabilities</b> – featuring Dr. Kay Redfield Jamison, author of <i>An Unquiet Mind</i> (recently featured on Oprah and Larry King Live) – will be held at the Sioux City Convention Center – for more information – contact Kim Fischer-Culver 712-202-0173. CEU & CME's Available	
<b>Sunday, July 6–2 PM</b>	The topic will be Veterans Issues.	<b>Thurs–5 PM July 10</b>	We will be discussing and planning around 7 topic areas

**When will the next Family to Family class be held?**

In the fall – we have 2 teams of teachers ready to go – which means we can accommodate 20 people in each of the 2 classes. If you would like to place your name on the waiting list – you can call NAMI Greater Des Moines at 277-0672 or call the NAMI Iowa office at 254-0417 or 1-800-417-0417. Family members of ill adults - age 14 and up can attend the class.

*"It is easy to sit up and take notice. What is difficult is getting up and taking action." -- French Author Honore de Balzac*

**When will the next Visions for Tomorrow classes start?**

Visions for Tomorrow classes will be held this summer. If you are interested in attending– give Diane Johnson a call at 273-5054 or call Jackie Elfmann at the NAMI Iowa office 254-0417. This class is for parents and caregivers of children and adolescents with severe emotional disorder or mental illness.

**When will training for Peer to Peer mentors be held?**

Peer to Peer mentor training will be held in early June in Iowa City. To sign up – contact Dawn Olson at [dawnao@iowatelecom.net](mailto:dawnao@iowatelecom.net).

**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.



#### Magazines available at Sunday NAMI GDM educational meetings

The NAMI Greater Des Moines Board of Directors purchases a bulk subscription for *BP* (Bipolar) magazine, and *Schizophrenia Digest*. We receive issues quarterly and offer them for sale for \$1 each at NAMI GDM educational meetings. Many people have remarked they provide a measure of support in their recovery.

We will be donating copies of each issue to each of the 3 inpatient units in Des Moines at Broadlawns, Iowa Lutheran, and Mercy Franklin.

A new magazine for those suffering from anxiety or depression is *Esperanza*. *Esperanza* means “hope” in Spanish.

All 3 magazines have everything from tips for everyday wellness to profiles of everyday people. They have the latest research, quality of life issues, and other important information about anxiety and depression (*Esperanza*), bipolar illness (*BP magazine*), and schizophrenia (*Schizophrenia Digest*). Each magazine strives to deliver hope with every issue.

At the next business meeting, NAMI Greater Des Moines Board members will decide whether to invest in a bulk subscription for *Esperanza* magazine as well.

Hope is a periscope which enables us to see over our present problems to future possibilities.

Don't give up hope. —L. Jackson Brown, Jr.

#### ✓ Facts on Children's Mental Health in America

From NAMI Fact Sheet

The reports by the U.S. Surgeon General and President Bush's New Freedom Commission on Mental Health offer great hope to the millions of children and adolescents living with mental disorders and their families.

Through appropriate identification, evaluation, and treatment, children and adolescents with mental illnesses can embrace the hope of recovery. They can achieve success in school, in work and in family life.

Nonetheless, the overwhelming majority of children with mental illnesses fail to be identified, lack access to treatment, and needlessly struggle throughout their lives. Stigma persists, and as a result, millions of young people in this country are left behind or go without appropriate necessary care.

Children and adolescents in this country struggle with a serious mental disorder that causes significant functional impairments at home, at school, and with peers.

#### Prevalence of Child and Adolescent Mental Disorders

- 21% of our nation's children ages 9 to 17 have a diagnosable mental or addictive disorder that causes at least minimal impairment.
- Half of all lifetime cases of mental disorder begin by age 14. Despite effective treatments, there are long delays – sometimes decades – between the first onset of symptoms and when people seek and receive treatment. An untreated mental illness can lead to more severe symptoms, the development of co-occurring mental illnesses.
- In any given year, only 20% of children with mental illnesses are identified and receive mental health services.

#### Consequences of untreated mental illnesses in children and adolescents

- Suicide is the 3<sup>rd</sup> leading cause of death in youth aged 15 to 24. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.
- Over 90% of children and adolescents who commit suicide have a mental disorder.
- States spend nearly \$1 billion annually on medical costs associated with completed suicides and suicide attempts by youth up to 20 years of age.

#### Failure in school

Approximately 50% of students with a mental illness age 14 and older drop out of high school; this is the highest dropout rate of any disability group.

#### Juvenile and criminal justice involvement

An alarming 65% of boys and 75% of girls in juvenile detention have at least one mental illness. We are incarcerating youth with mental illnesses, some as young as eight years old, rather than identifying their illnesses early and intervening with appropriate treatment and supports.

#### Spiraling Higher Health Care Costs

When children with untreated mental illnesses become adults, they generally use more health care services and incur higher health care costs than other adults. Left untreated, childhood illnesses are likely to persist and lead to a downward spiral of school failure, limited or non-existent employment opportunities, and poverty in adulthood. No other illnesses harm so many children so seriously.

#### Early identification, evaluation, and treatment are essential to recovery and resiliency

- Research shows that early identification and intervention can minimize the long-term disability of mental disorders.
- Mental illnesses in children and adolescents are real and can be effectively treated, especially when identified and treated early.
- Research has yielded important advances in the development of effective treatment for children and adolescents living with mental illness. Early identification and treatment prevents the loss of critical developmental years that cannot be recovered and helps youth avoid years of unnecessary suffering.
- Early and effective mental health treatment can prevent a significant proportion of delinquent and violent youth from future violence and crime. It also enables children and adolescents to succeed in school, to develop socially, and to fully experience the developmental opportunities of childhood.

NAMI has 2 educational programs to benefit people who are raising or working with children and adolescents who have behavioral disorders or mental illnesses.

Our website is: [www.nami.org/sites/NAMIGreaterDesMoines](http://www.nami.org/sites/NAMIGreaterDesMoines)

**See yourself as a person, not an illness.**



**Visions for Tomorrow** – 12 workshops are taught over a series of 8 class sessions. There is no charge to attend VFT classes or workshops. Curriculum topics are:

- 1) Understanding how the brain works
- 2) AD/HD, Oppositional Defiant Disorder, Conduct Disorder, Borderline Personality
- 3) Bipolar Disorder, Depressive Disorders, Suicide
- 4) Schizophrenia, Schizoaffective disorder, Autistic Spectrum Disorders, Tourette Syndrome
- 5) Anxiety Disorders, Reactive Attachment Disorder, OCD, Eating Disorders
- 6) Empathy, Sharing Our Unique Life Experiences (SOUL)
- 7) Organization of Data and Record Keeping, Communication Skills
- 8) Problem Management, Coping and Self-Care
- 9) Transitions, Rehabilitation
- 10) Recovery, Detours, Alternative Treatments, Types of Therapy
- 11) Stigma, Advocacy, Judicial System
- 12) Graduation



**Parents and Teachers as Allies** –

a 2 1/2 hour in-service  
**Components**  
 Welcome and Introductions  
 Early Warning signs of mental illnesses  
 Family Response

Living with Mental Illness  
 Group Discussion  
 Closing Remarks and Evaluation

Contact Diane Johnson 273-5054 to request the in-service or to sign up for Visions for Tomorrow.

**Looking for Community Resources?**  
 Phone 211  
[www.211iowa.org](http://www.211iowa.org)  
 Contact Polk County Health Services  
<http://polk.ia.networkofcare.org/mh/home/index.cfm>  
 Go to the visiting nurses website  
[www.vnsdm.org](http://www.vnsdm.org)  
 click on "links" – then click on Community Resource Directory

Each of the 3 levels of the NAMI organization is a separate 501c3 non-profit.

<b>When dues are paid to NAMI Greater Des Moines</b> – you have NAMI GDM membership (local affiliate), a state membership, and a national membership (3).		
NAMI-National	NAMI-Iowa	NAMI-GDM
<b>Yes</b>	<b>Yes</b>	<b>Yes</b>
When dues are paid to NAMI Iowa – you have a state membership and a national membership		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	<b>No membership</b>
<b>NAMI E-Join</b> is a nationwide online membership initiative that began June 20, 2007. E-Join will allow visitors to NAMI's Web ( <a href="http://www.nami.org">www.nami.org</a> ) 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
<b>Yes</b>	<b>Yes</b>	<b>Yes</b>



**Iowa Adds to its "Bottom of the Pile" Statistics**

Iowa was one of 8 states who received an "F" in NAMI's "Grading the States" report regarding its mental health care system.  
 Iowa is 47<sup>th</sup> in # of psychiatrists  
 Iowa is 49<sup>th</sup> in # of psychologists  
 Now we have another to add – 46<sup>th</sup> in # of psychiatric beds



**SEVERE SHORTAGE OF PSYCHIATRIC BEDS SOUNDS NATIONAL ALARM BELL**

*Report Finds US Deficit Of Nearly 100,000 Inpatient Beds; Result Is Increased Homelessness, Emergency Room Overcrowding, And Use Of Jails And Prisons As De-Facto Psychiatric Hospitals*

A new report released today by the Treatment Advocacy Center reveals that for every 20 public psychiatric beds that existed in the US in 1955, only 1 such bed existed in 2005.

According to data cited in "The Shortage of Hospital Beds for Mentally Ill Persons" report, in 1955 there were 340 public psychiatric beds available per 100,000 U.S. citizens. By 2005, the number plummeted to a staggering 17 beds per 100,000 persons. Mississippi was found to have the most beds available in 2005 (49.7 per 100,000 people), while Nevada (5.1) and Arizona (5.9) had the least. For the complete report, state-by-state ranking of beds lost, and list of recommendations visit:

<http://tacenews.c.topica.com/maakBU4abFTg9ckr5Tob/>

"The results of this report are dire and the failure to provide care for the most seriously mentally ill individuals is disgraceful," said lead author, Dr. E. Fuller Torrey, president of the Treatment Advocacy Center. "Our communities are paying a high price for our failure to treat those with severe and persistent mental illness, and those not receiving treatment are suffering severely. In addition, untreated persons with severe mental illnesses have become major problems in our homeless shelters, jails, public parks, public libraries, and emergency rooms and are responsible for at least 5 percent of all homicides."

To determine a minimum number of beds needed, a consensus of experts involved in the study looked at specific criteria such as number of individuals who need hospitalization, length of hospital stay, and current state and federal financing structures. They also were asked to assume that effective community based services and assisted outpatient treatment (AOT) programs are available in all 50 states. Using these criteria, the panel concluded that 50 public psychiatric beds per 100,000 individuals is the absolute minimum number required to meet current needs. Eight states still don't have AOT and many states are in need of additional community mental health services, making 50 public psychiatric beds per 100,000 people a minimum requirement.

"This report confirms what many in the mental health field already know - too many people with severe mental illnesses aren't getting treatment," said report co-author, Dr. Jeffery Geller. "Someone with schizophrenia who is having a psychotic break should not be told they can't get treatment in their own community, nor should they be told to wait and wait and wait for treatment. We are talking about people in need of immediate care."

State Rankings

The states with the fewest beds in 2005 were: Nevada (5.1 beds per 100,000 people), Arizona (5.9), Arkansas (6.7), **Iowa (8.1)**, Vermont (8.9) and Michigan (9.9). The states with the most beds

available were South Dakota (40.3) and Mississippi (49.7). In 32 states the bed shortage was critical or severe, 42 states had less than half the minimum number of beds needed, and six states had less than 20 percent of the minimum beds needed to provide adequate care.

"One small silver lining in this otherwise alarming study is that Mississippi meets the 50 bed standard," said study co-author and Treatment Advocacy Center executive director, Kurt Entsminger. "If the state which ranks 49 in per capita income can achieve the 50 bed standard, then states with greater wealth have no excuse for their failure to do so."

#### Consequences of Bed Shortage

Because there are so few beds available, individuals with severe psychiatric disorders who need to be hospitalized are often unable to get admitted. Those who are admitted are often discharged prematurely and without a treatment plan. The consequences of the radical reduction in psychiatric hospital beds are evidenced in the following areas:

- Homelessness. A 2005 federal survey estimated that approximately 500,000 single men and women are homeless in the United States at any given time and multiple studies have reported that one-third have a serious mental illness. A study in Massachusetts found that 27 percent of patients discharged from a state psychiatric hospital became homeless within six months of discharge; in a similar study in Ohio, the figure was 36 percent.
- Jails and Prisons as Psychiatric Hospitals. Since the radical reduction in public psychiatric hospital beds there has been a massive increase in severely mentally persons in jails and prisons. Conservative estimates have placed the number at 7 to 10 percent of all inmates, but some studies have put the figure at 20 percent or higher. The three largest de facto psychiatric institutions in the United States are the Los Angeles County Jail, Chicago's Cook County Jail, and New York's Riker Island Jail.
- Hospital Emergency Room Overflow. Emergency rooms are often used as waiting rooms for people in need of a psychiatric bed. This backs up the entire hospital system and compromises other medical care. In Arlington, Virginia, county officials had to call 31 hospitals before finding one that would accept a patient.
- Violent Crime. Studies have shown that between 5 to 10 percent of seriously mentally ill persons who are not receiving treatment will commit a violent act each year. Such individual are responsible for at least 5 percent of all homicides.

#### Recommendations

The present severe shortage of public psychiatric beds should not be tolerated and can be ameliorated in the following ways:

- ⇒ Holding state governors and mental health officials responsible for the shortage.
- ⇒ Utilizing Programs of Assertive Community Treatment (PACT) and assisted outpatient treatment (AOT), both of which have been proven to decrease hospitalization. These are alternatives to hospitalization and have excellent track records for success.
- ⇒ Modifying federal and state regulations to allow more flexibility in the utilization of alternatives to psychiatric hospitalization.
- ⇒ Making the public aware that the current severe shortage in public psychiatric beds is in part responsible for the increase in homelessness, number of mentally ill persons in jails and prisons; persons with mental illness in emergency rooms; and

the increase in violence, including homicides in untreated individuals.

"There's no question we need more public psychiatric beds, but the consequences of the severe bed shortage can also be improved with wide-spread utilization of PACT and AOT," said Dr. Torrey.

"Both of these outpatient treatment options are proven successful ways to treat people with severe mental illnesses in the community. AOT has proven to reduce psychiatric hospitalizations by more than 70 percent."

A group of mental health professionals, led by Treatment Advocacy Center President E. Fuller Torrey, MD, completed the report - "*The Shortage of Hospital Beds for Mentally Ill Persons.*"



#### Depression: Out of the Shadows

(a documentary)

This is a 90-minute documentary, premiering May 21, 2008, at 8:00 pm CST (check local listings). By weaving together the science and

treatment of depression with intimate portrayals of families and individuals coping with its wide-ranging effects, the film raises awareness and eliminates the stigma surrounding this prevalent disease, underscoring the fact that whether we are battling it in our families, our workplaces, or in our own minds, depression touches everyone.

Following the film, broadcast journalist Jane Pauley will host a 30-minute roundtable discussion titled *TAKE ONE STEP: Caring for Depression*, with Jane Pauley in which nationally acclaimed experts will offer advice on recognizing and treating depression.

#### **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](http://www.nami.org/advocacy)

NAMI Greater Des Moines **legislative priorities (a more detailed version)** were in the **January newsletter**. Go to our website to view the January newsletter at

[www.nami.org/sites/NAMIGreaterDesMoines](http://www.nami.org/sites/NAMIGreaterDesMoines)

#### **NAMI Greater Des Moines 2008 legislative priorities were:**

##### 1. Assure there are basic services for mental health care.

- ⇒ Address the mental health workforce shortage crisis.
- ⇒ Stop the closing of acute care beds and take steps to increase the number of beds available.
- ⇒ Retain "open access" for mental health medications.

##### 2. Adequately fund a mental health system in Iowa.

- ⇒ The state should appropriate additional mental health dollars to restore services, eliminate waiting lists, and support building a mental health system in Iowa.
- ⇒ Allow the counties who choose to – the flexibility for alternative methods of generating additional MH/DD funds.
- ⇒ Expand the mental health parity law.

##### 3. Build a mental health system which consists of programs and methods which are a wise investment of taxpayer dollars.

- ⇒ Fund Assertive Community Treatment Services (ACT teams)
- ⇒ Establish a statewide emergency response system for persons in a mental health crisis – a safety net.
- ⇒ Develop a jail diversion system for persons with mental illness.
- ⇒ Reform how jails and prisons treat the mentally ill.

We'll have a recap of how much progress was made in the 2008 legislative session toward our legislative priorities in the June newsletter.

To find who your legislators are: <http://www.legis.state.ia.us/>

Home and State Capitol contact information is available.

**To write your legislators:**

Sen. (insert name) or Rep. (insert name)  
State Capitol, Des Moines, Iowa 50319

**To call your state legislators:**

515-281-3221 (Representatives)  
515-281-3371 (Senators)

Only those who risk going too far can possibly find out how far one can go. – T.S. Eliot

**How Do You Contact the  
Iowa Dept. of Mental Health and Disability Services?**

**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](http://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



**“I’m Not Sick, I Don’t Need Help”**  
by Dr. Xavier Amador

“I’m Not Sick, I Don’t Need Help” has been a highly recommended book for NAMI families since being published. It is a guide for practical

communication.

"My older brother Henry developed schizophrenia and our relationship suffered terribly because we got into "I'm right, you're wrong" arguments about whether he had a mental illness," Amador explained.

Fifty percent of all patients with schizophrenia and bipolar disorder do not believe they are sick," a clinical condition known as agnosognosia. Lack of insight is caused by the illness itself.

"Meanwhile, millions of doctors and family members are dead certain they are sick and need help."

The LEAP method helped Henry, as well as many other persons who were in denial about their mental illness, to nonetheless take their medication—helping to restore insight and move into more effective treatment.

LEAP is different from other conflict resolution or negotiation methods because it shows people how not to argue. Instead, people step aside in order to get what they need—while agreeing to disagree.

The LEAP method is —listen, empathize, agree, partner—for overcoming conflict, based on individual dignity, respect, and trust.

1. Don't insist you're right—being adamant only makes the other person more stubborn.
2. Don't engage in insults or name-calling—it only makes the other person angrier and more rigid.
3. Pick the right time—pay attention to whether you or the other person are too angry, defensive, stressed or tired to be receptive
4. Don't use absolutes—people become more rigid or defensive in the face of absolute claims such as "you always" or "you never."
5. Don't throw in the kitchen sink—bringing up past conflicts or transgressions only makes another person angrier and more rigid and derails attention to the issue at hand.
6. Listen without defending—let the other person feel that they are being heard or understood, which reduces defensiveness.
7. Reflect back what you hear—one of the most effective ways to "lower the temperature" of an argument and open up the other person to your own point of view.

**Co-Occurring Disorders & Dual Recovery  
Anonymous Consumer/Provider Conference –  
May 21-22**



The goal of this conference is to bring together individuals dedicated to co-occurring Disorder Recovery to participate in a forum that is both educational and collaborative. The conference is designed to facilitate discussion among presenters, providers, and consumers in order to promote system change and consumer empowerment.

Dr. Kenneth Minkoff, M.D. – Harvard Medical School - a nationally known consultant/trainer on co-occurring disorders will be the featured speaker. There will be many other notable presenters.

Topics to be discussed but not limited to are:

- Dual Recovery Anonymous: What is it? How does it work?
- Brain injury, mental health, and co-occurring disorders
- Research developments and applications to clinical intervention
- Consumer driven recovery; it's potential impact on provider services
- Women in recovery
- Federal initiatives and system change in Iowa
- Collaborative System Change

There will also be funds available for persons in recovery who are interested in starting dual recovery anonymous (DRA) groups in their communities. There will be an application process to help with the cost of the conference, meals, and hotel room.

For additional information please send inquiries to [IAMHR07@gmail.com](mailto:IAMHR07@gmail.com)

Do what you can, with what you have, where you are.  
-Theodore Roosevelt



### Looking Ahead to the NAMI National Convention in Orlando

The 2008 NAMI National Convention will be held at the [Rosen Centre Hotel](#) in Orlando, Florida, June 13-16, 2008 (that's Friday through Monday). The banquet is on Monday evening.

Room rates are \$134, plus tax, per night, for a single or double room. You must book your reservation by May 8, 2008 to be eligible for this special convention rate. You can book your reservation by calling 800/204-7234. Be sure to tell the reservations desk you are attending the NAMI convention. Reservations can also be made by clicking on the link for the Rosen Centre Hotel.

The registration fee (if paid by May 16) is \$225.  
The registration fee (if paid after May 16) is \$250.  
You can register on-line at [www.nami.org/convention](http://www.nami.org/convention).

#### 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. 42<sup>nd</sup> St. Des Moines, Iowa 50312 or E-mail: [tbomhoff@mchsi.com](mailto:tbomhoff@mchsi.com)



#### Iowa Empowerment Conference in August

The dates are Aug 5-7 for the Iowa Empowerment Conference. The theme 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](mailto:dwilliams@adiis.net).

#### Educational Classes offered by NAMI - Free

- Visions for Tomorrow* – 8 weeks - for parents and caregivers of children and adolescents with SED – there is also a version for teachers and school professionals
- Parents and Teachers as Allies* – 2.5 hour in-service to educators and parents
- Family to Family* – 12 weeks – for family members of adults with mental illness – must be at least 14 yr old
- Peer to Peer* – 9 weeks - Any person with serious mental illness who is interested in establishing and maintaining wellness

#### Curriculum available for classrooms

- Science of Mental Illness* – from NIMH - lesson plans for the classroom – middle school
- Science of Healthy Behaviors* – from NIMH – lesson plans for the classroom – middle school
- Breaking the Silence* – lesson plans for the classroom – for upper elementary, middle school, and high school-cost \$20 per set.

#### Educational Class offered by NAMI - Cost involved

- Provider Education* – 10 weeks – personnel at agencies or organizations who work with persons with mental illness - CEU's can be arranged for this training

#### Under development

- Hospital Exit Program* – Weekly meeting at each of the 3 hospitals with family members and persons with mental illness about to be discharged from the hospital.

## PLEASE BECOME A MEMBER OF NAMI GREATER DES MOINES

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

Dues are:

- \$35.00 Family/Individual
- \$ 3.00 Limited income
- \$50.00 Professional

Send to: Jim Vandenberg, Treasurer

4114 Allison Avenue  
Des Moines, IA 50310

Please make the check payable to  
NAMI GDM

Dues cover local, state, and national membership.

Donations are welcome.

"Our lives begin to end the day we become silent about things that matter." *Dr. Martin Luther King, Jr.*

#### SUPPORT GROUP MEETINGS for Family Members

**Third Sunday of the month -5/18/08** **Family members**, if you are interested in participating in a NAMI family support group, please contact Glenn Hobin [lowaGH@aol.com](mailto: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 – 5/5/08** - 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.

**4<sup>th</sup> 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 – 10<sup>th</sup> 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](mailto:dawnao@iowatelecom.net) or 641-842-3859 if you have questions. Dawn Olson and Kyle Damman are facilitators.

## SUPPORT GROUPS for Persons with mental illness

**2<sup>nd</sup> & 4<sup>th</sup> 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](mailto: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. 24<sup>th</sup> St., Des Moines – Call 266-2346 – Marty Hulsebus.

**2<sup>nd</sup> & 4<sup>th</sup> 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 48<sup>th</sup> Street - Contact: Debbie Wallukait (515) 288-4439 or Eddie Lathrop, Jr. - 515-865-1331 [legalbound34@yahoo.com](mailto: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.

**1<sup>st</sup> and 3<sup>rd</sup> 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](mailto: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 24<sup>th</sup> 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](mailto: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 – 2<sup>nd</sup> Thursday of each month 6-7:30 P.M. and last Saturday of each month 9-10:30 A.M. Meeting place is 525 5<sup>th</sup> 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)**



**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.



**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.

## Survey for persons with Bipolar Depression

There is a new project to create a global website for people living with bipolar depression. The intention is that the website will be designed by people with bipolar themselves. There is an on-line survey to help design the website.

The survey should take no more than 10-15 minutes to complete. [https://www.surveymonkey.com/s.aspx?sm=HUIsU1tNJVjIkEmdcNGOjQ\\_3d\\_3d](https://www.surveymonkey.com/s.aspx?sm=HUIsU1tNJVjIkEmdcNGOjQ_3d_3d)

The survey hopes to find out:

- (1) What people with BPD think are the most important types of healthcare information for them.
- (2) Other key subjects of importance to people with BPD.
- (3) What people with BPD think sets them apart from other people with a mental health condition.

**The survey is due to close on Monday 30<sup>th</sup> June 2008.**

All responses will be anonymous unless a person wishes otherwise.

The survey is from PatientView, in association with the **World Federation of Mental Health (WFMH)** and **GAMIAN-Europe, as well as** the European family and carer federation, **EUFAMI**, which also welcomes any new initiative for patients which will lead to a better understanding of Bipolar Depression.

The cost of building the Global Bipolar website, and the administrative costs of running this survey, are being funded by an Educational Grant courtesy of AstraZeneca.



**Many thanks to Dawn Olson** for speaking to our affiliate on April 6. Dawn gave us information about the Peer to Peer educational class and the NAMI Connections support group for persons with mental illness. Dawn is truly an inspiration in her recovery and is to be commended for her advocacy and volunteer work with NAMI.

Our website is: [www.nami.org/sites/NAMIGreaterDesMoines](http://www.nami.org/sites/NAMIGreaterDesMoines)

**See yourself as a person, not an illness.**



Many thanks to Shala Wyant for speaking to our affiliate on April 6. Shala gave us information on the Intensive Psychiatric Rehabilitation program.

**What is the Intensive Psychiatric Rehabilitation program?**  
*From a power point presentation given 4-19-07*

Intensive psychiatric rehabilitation is a 2 year program designed to assist individuals with serious mental illness to obtain successful and satisfying roles in the community with minimal professional intervention.

IPR is based on rehabilitation and recovery

Rehabilitation refers to the services and technologies that are made available to disabled persons so that they can develop or recover a valued role, place, and participation in the life of their community.

Recovery refers to the uniquely personal and internal process that is "...a daily striving to achieve a hopeful, contributing and satisfying life while at the same time coping with the symptoms and consequences of mental illness (Deegan, Pat).

The road to recovery involves:

- o Acceptance vs. escape
- o Emergence of hope
- o Rebuilt sense of self
- o Empowerment
- o Return to functioning

All services can support recovery if there is the belief - people with mental illness can and do recover. Some services that are specifically based upon recovery principles:

- Intensive Psychiatric Rehabilitation (IPR)
- Wellness Recovery Action Plans (WRAP)
- Peer to Peer and Peer Support Services
- Wellness Management

The IPR initiative started in 1995 through Medicaid "Community Reinvestment" grants through DHS and Magellan.

The IPR philosophy is:

- Persons with mental illness are valuable individuals who have the ability to make choices in their lives.
- People with mental illness can achieve self-reliance and community integration as they develop skills and have access to the appropriate and necessary resources.
- Recovery for person with mental illness does not necessarily imply cure, but does imply that a person can obtain or recover a valued and meaningful role and participate in the life of the community.
- Persons with mental illness should be treated with respect and dignity. We believe that risk-taking, self-advocacy and progress toward goals increase self-confidence and personal growth.

Goals of the program

- o Develop hope for recovery.
- o Achieve motivational readiness for engaging in rehabilitation services as an aid to recovery
- o Achieve improved role functioning, success and satisfaction.

What is expected of participants?

- A commitment from the person to spend 4 to 10 hours per week in IPR.
- The person will need to take responsibility for his/her actions.

Who is eligible for IPR?

The individual must:

- Be between the ages of 18 and 65.
- Have a serious mental illness.
- Be a recipient of Magellan Behavioral Care of Iowa services
- Be a recipient of Medicaid (Title 19); or secure alternative funding (i.e. County, private, etc..)

If you would like more information or have questions – contact Shala at 241-0982.

**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

- May 2 – Health Self Concept
- June 7 – Use of Prayer When Hurting
- 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](mailto:lisa.davison@hopewdm.org)

**Federal Legislative Issues**

[www.nami.org/advocacy](http://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/>

Check out our updated Explore the Candidates web page at [www.nami.org/election2008/candidates](http://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](http://www.nami.org/election2008)

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 INSTITUTIONS EMPTIED OUT AND THE PRISONS FILLED UP**

By Dan Gardner, Times Colonist  
 (Victoria, Canada), February 15, 2008

This month, the Vancouver Police Department released a report that deserved to be front-page news across the country. "More than one-third of all calls for Vancouver police involve people with mental health issues," the report found. "In the Downtown Eastside, it increases to almost one in every two calls."

This report provides real insight into what an effective crime-fighting strategy would look like. And it's a strong indication of what won't work.

What won't work? It's pretty much what the federal government is doing.

Tougher sentences will make thugs think twice before mugging little old ladies, the Harper government insists. More punishment equals less crime. But underlying that conclusion are two assumptions: One, that would-be criminals are aware of the sentencing provisions of the Criminal Code; two, that they factor that knowledge into the rational calculations they make in deciding whether to commit a crime or not. Does the benefit outweigh the

risk? If so, they do it. If not, they don't.

There's plenty of evidence that both assumptions are wrong in most cases. The average criminal isn't a 42-year-old chartered accountant with a newspaper subscription. He's an ignorant and impulsive 21-year-old.

And that's before we factor in alcohol and drugs. Substance abuse is so common among criminals it's actually the sober repeat offender who stands out.

And finally, there's mental illness. What does the threat of a mandatory minimum sentence mean to a frightened man struggling not to hear the voices in his head? If it is silly to expect an ignorant and impulsive 21-year-old criminal to engage in calculation, it is insane to expect it of the insane.

Crime, drugs and mental illness are rarely seen apart.

Why? Lots of us think it starts with the drugs.

In North America, this tends to be the official line, although officialdom will usually admit that, sometimes, mental illness comes first.

That some drugs can cause mental problems in some circumstances is clear. But in most cases, causation runs the other way: Mental illness leads to drug abuse. "Recent research indicates that psychopathology usually precedes drug use," notes the European Monitoring Centre for Drugs and Drug Addiction, a European Union research agency.

Most often, mental illness is the disease. Drugs and crime are the symptoms.

Ignore this dynamic and the policies we adopt to fight drugs and crime almost certainly won't work.

Acknowledge it and new possibilities arise.

The full title of the Vancouver report is "Lost in Transition: How a Lack of Capacity in the Mental Health System Is Failing Vancouver's Mentally Ill and Draining Police Resources." That title would work pretty much everywhere.

The problem goes back to the 1950s, an era when the mentally ill tended to be rounded up and locked away and forgotten in large, soulless institutions. In the 1960s, there was a backlash and the order of the day was "deinstitutionalization" -- which called for the mentally ill to be given the supports and services they need to live in the community. Through the 1960s, 1970s and 1980s, the old institutions closed.

Governments everywhere botched the job. Closing institutions was easy and it saved money. But the supports needed to make deinstitutionalization work cost money, so governments weren't nearly so enthusiastic about that half of the equation.

The institutionalized population declined.

Simultaneously, the homeless, addicted and prison populations rose. Instead of being locked away and forgotten in mental hospitals, the mentally ill were locked away and forgotten in prisons.

The Vancouver police report calls for construction of "a mental health care facility that can accommodate moderate to long-term stays," along with a plethora of new mental health programs and supports. Treat the disease, not the symptoms.

Ah, but democracy intrudes. A politician who tells the angry residents of a neighborhood riddled with crime and drugs that he will increase mental health services is likely to be pelted with

tomatoes. Promise more punishment and they'll throw bouquets.

So more punishment is what we get. And we'll keep on getting it until we start thinking more rationally than criminals.

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"You may think your actions are meaningless and they won't help, but that is no excuse, you must still act." Mohandas Gandhi

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

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Researchers report in *Science* that schizophrenia may not be caused by one or a few genes, but instead is the result of problems in several genes, many of which are critical for brain development and how brain cells communicate with each other. The problems with the genes mean that "you're basically screwing up the way that the regulation of brain growth occurs," said the University of Washington's Jon McClellan, one of the researchers. The identification of the genes might lead to new treatments for schizophrenia, National Institute of Mental Health Director Thomas Insel said. *Reuters* 3/27/08

**Free Poster Fights Stigma: "Know Me as a Person"**

The U.S. Department of Health & Human Services offers free posters to fight stigma and discrimination surrounding mental illness. They are ideal for schools, offices, churches, libraries, community centers, hospitals, and other locations. The poster text is:

*Know me as a person not by my mental illness.*

*We are your friends, neighbors, and family.*

*We improve and recover.*

*We are major contributors to American life.*

*We deserve dignity and respect.*

NAMI Greater Des Moines has a supply of the posters available at the Sunday educational meetings. Please join us.

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The time is always right to do the right thing.

*-Martin Luther King, Jr.*

## MY CRAZY BROTHER

Suicide Can Happen In Any Family, Especially In The West

By Ray Ring

COLORADO SPRINGS INDEPENDENT, April 10, 2008

I used to get mad at my brother for being crazy.

Because some of the time, he wasn't crazy. Or he didn't act crazy. In those good spells, he could be the together older brother, a guy who was good with tools, had a precise pool shot and a talent for massaging brown clay into sculptures of beautiful women. He could take apart the engine of a car or motorcycle, lay out the pieces in neatly labeled envelopes, fix what was broken and put it all back together so it worked. He could talk physics and chemistry and make a good spaghetti. He could see into people and make perceptive remarks.

Most of the time, though, he could barely function. He would hang from a cigarette as if it alone sustained him, and pace back and forth because he couldn't be still and couldn't figure out where to go. He would stare at people and things too long and not answer when spoken to.

In his worst times, he acted completely crazy. Hallucinating, he lined his walls with crinkled aluminum foil to try to block out the voices only he could hear. His movements grew stiff and jerky. His stare seethed with anger.

Or even worse, he would soar on optimism, exuberantly telling me he'd finally cured himself and would be all right from now on - that look lighting his eyes.

I would look at him acting so crazy, and sometimes I thought: Come on, John, knock it off.

You're probably also involved in craziness somehow. The issue cascades through communities and families. Most of us don't talk about it much, because it's too personal. Too burdened with despair and desperate hopes, guilt, blame, feeling sorry for others and ourselves. We're not even supposed to use the word "crazy." It's politically incorrect, but it's the most succinct description I know.

This story needs to be aired because it has meanings beyond vicious fate and one family struggling to cope. It's about people needing help in general, and how that isn't much in fashion these days. And it illuminates dark aspects of Western culture that we prefer to keep hidden.

### One In Six

One out of every six people in this country will suffer a diagnosable episode of mental illness this year. One out of every 17 is seriously mentally ill, a category of disasters that includes bipolar disorder, major depression and schizophrenia.

The National Alliance on Mental Illness, an advocacy group founded in 1979, gives the United States the grade of "D" for our systems of mental health awareness and care - nearly complete failure. Nationwide, we spend more than \$100 billion per year on it. The total keeps rising, and the number of people being treated keeps rising. The wider impacts on society - the annual costs of untreated mental illness - total another \$100 billion.

The only feel-good rush on this issue came during the 1950s to the 1970s, when nationwide reforms freed many people from long-term warehousing in mental hospitals. Now we have one-tenth the number of hospitalized crazies we had back then. But we traded one set of failures for another - we have more mentally ill people in jails and prisons than in hospitals. And in our communities and on the streets, the billions of dollars have fallen short, and mostly we've chosen to look away from the sick rather than set up

adequate treatment and support.

I'm focusing on the deficiencies in our systems of public care, for those who can't afford private psychiatrists and thus fall onto the ragged safety nets. Even for the wealthy, though, there are no easy answers, if there are any answers at all.

For my brother, it worked like this: John was born in 1947 in Tucson, Ariz., where our parents had moved for the healthy, dry air. Then they moved to California, where I was born, and then Indiana, then Illinois, where my younger brother, Mike, was born. Our father, Ray Sr., was an entrepreneur who chased opportunity while suffering physical illnesses and subtle symptoms of craziness, including unpredictable moods and an inability to stay in one place.

As Ray Sr. failed in business, he aimed his demand for perfection and his angry frustration at his first seed. In his eyes, John couldn't do anything right.

Like many crazy people, John probably had his illness encoded into his genes, and childhood stress activated it. From the time he was an infant he rarely smiled. By fourth grade, he had trouble concentrating. He was hearing his own thoughts. Our mother, Kate, took him to his first psychiatrist. More clouds emerged.

When John was 13, Ray Sr. went into the hospital for an operation for symptoms that turned out to be cancer, and John punished himself: He took a baseball bat into his bedroom, locked the door and began smashing his toys. Kate and I stood outside the door listening to the breakage, calling to him, getting no response. Kate didn't know what to do and phoned an Episcopal priest, who came in his black outfit and called through the door, "John, do you know who this is?"

John's voice came through the door, "Santa Claus?" and he kept on with the bat. I remember grinning at his crazy humor.

### Oxymoron Approach

Our father finally killed himself with cigarettes and lung cancer when John was 15, I was 13 and my younger brother was 10. Kate finished raising us, taking a series of jobs, including elementary school teacher, editor of educational materials, real estate agent and finally an adjunct English teacher at a community college. All of this has been toughest on her.

John's path alternated between periods of lucidity and paranoia and hallucinations. He made a few unsuccessful attempts at college, then enlisted for four years in the Army, hoping the structure would straighten him out, serving in the South and Germany as a radar technician. Then he had a few brief civilian jobs. He tried enlisting a second time, but by then he had been diagnosed as schizophrenic, so the Army had no more use for him.

He began what would eventually become hundreds of sessions with psychiatrists and counselors. He tried outpatient treatment and hospitals run by universities, counties, private businesses and the Veterans Administration, the long grind of antipsychotic medications, even shock treatments. At times he wandered the streets incoherently, or landed in jail.

The first years of John's intermittent care were in the Illinois system. Then he and my mother returned to Tucson, where he spent 17 years in the Arizona system. I left Illinois for Colorado, but wound up in Tucson for most of John's crazy years there. I was old enough to be a better witness, and I saw how the Arizona system was itself crazy and sad.

Our family didn't have a lot of money for treatment. John got by mostly on small disability payments from Social Security and the

Veterans Administration, and whatever the public mental health care system could do for him. Arizona's system, like those of the other Western states, is a complicated array of dozens of agencies and companies, some of which operate to make a profit on craziness.

The federal government provides some money through programs such as Medicaid and Social Security disability, but state governments are in the driver's seat. Every year, the legislatures and governors allocate state money for the systems, and it doesn't have much to do with what's needed. The principle is called "managed care," which really means managing costs.

"It's an oxymoron approach," says Chick Arnold, a lawyer who has pressed a class-action suit against Arizona's system since the 1980s, demanding a series of improvements. "The companies (and agencies) get a finite amount of money to provide an open-ended commitment for service for a growing population. They can't do it. ... The system is designed to screen people out, not in. It's all about cost containment."

At most, John would see a psychiatrist for one 15-minute visit per month. He would take meds for a while, stabilize and then stop taking them. He would fly for weeks or months, then crash.

Sometimes when he had bad spells, my mother and I would ally with local prosecutors and go to court, testifying against him, saying he was a danger to himself or others, the legal standard for court-ordered commitment to treatment. The commitment would last for a week or so in a locked hospital ward, then longer periods of follow-up and mandatory meds outside the hospital, sometimes for as long as a year. Always the commitment would end, and then the cycle would begin again. All this is familiar to people who pay attention to crazy people.

When he wasn't in hospitals, John lived wherever Tucson landlords would rent to a crazy person, usually cockroach-infested dives. In the bad spells, he forgot to eat and grew extremely thin. Or he got mad at everything and everyone, sometimes attracting the cops. The busts I know about were for leaping out of bushes and threatening strangers with a hammer, for taking the hammer into a convenience store and causing a disturbance, for tearing the windshield wipers off a parked car, throwing rock salt into the swimming pool in his apartment complex, and for forgetting to show up in court.

Most of the world had no sympathy for him. Banks dunned him with extra charges for bounced checks, and he would struggle to keep track of all his bills, especially the ones from ambulances and other mental health providers, with their complicated deductibles and formulas for benefits. Bills from the phone company, other utilities, car insurance and the dentist often came faster than he could afford.

In desert heat above 100 degrees, he went around in a long-sleeved shirt with a T-shirt under it, and long pants. He wore down the heels of his shoes with his pacing. He loaned money to "friends" and never got it back. He was incapable of bargaining and often got rooked. Now and then, he picked fights with strangers and put up no resistance as the blows began to fall - punishing himself like that.

I would get angry at him, wanting him to take his meds, regardless of their side effects - uncontrollable pacing, stiffness of posture, facial grimacing - because the alternative seemed worse to me. Now and then he threatened to commit suicide. I got tired of hearing it. Sometimes I secretly wished for him to die, thinking it was the only way for him to find relief, and also because it would

end my duty.

Then in 1995 at the age of 47, he bought a pistol from a guy he found in the classified ads, took it home to his latest one-room apartment in Tucson, lay down on his bed, and, sometime during the night, shot himself in the head. I do not know the exact date of his death - only that it was sometime in late April or early May - because it took a while for his body to be found. He was that alone at the end.

#### Cataclysmic Sorrows

No one knows exactly what leads up to any person committing suicide, says John McIntosh, a psychology professor at Indiana University South Bend who has studied 50 years of nationwide statistics. But he's one of the experts who've noticed that, collectively, Westerners lead the nation in suicide rates.

Nine of the top 11 suicide states are in the West, a trend that holds year after year and decade after decade. And the degree of the lethal regional difference is stunning: Nevada, Montana, New Mexico, Wyoming, Idaho, Utah, Colorado, Arizona and Oregon range from 19 to 15 suicides per 100,000 people - more than twice as high as New York and Washington, D.C., the healthy end of the scale.

Some 8,000 Westerners will kill themselves this year, a hefty portion of the national total of more than 30,000 suicides. Much of the cause, McIntosh suspects, is embedded in our Western culture.

"Potential contributors," he says carefully, "include the personality or attitudinal or worldview differences across the country."

Patty Limerick, a prominent Western historian at the University of Colorado, frames it more frankly: In the West, "we won't admit our sorrows until they become cataclysmic."

Westerners by nature tend toward transience. The early white settlers came here to escape or find something new and better - that Big Rock Candy Mountain - and the same urge continues today. Waves of migration come from other regions. People bounce from California to Montana to Arizona, thinking nicer scenery will somehow solve their problems, or that they'll find a fresh start in a booming city, or forge deep connections in some small rural town.

When nothing is solved, the beautiful mountains or rivers or deserts become a taunt. And guns, the most popular instrument of suicide, are easily available.

"We encourage people to move here and lie to them about it being paradise," says Arnold, the Arizona mental health lawyer. Western states, exploding with population growth, have flimsy communities. Families are strained or fragmented by the churning. Our frontier mentality makes us suspicious of government and public services. We expect people to tough it out on their own.

"The dream of a freer life, independence, that kind of individualism, works against community and familiar structure," explains Bill Handley, an associate professor at the University of Southern California who studies how Western writers deal with these themes. "There's a whole literature of loneliness in the West."

Among the other cultural factors linked to suicide: Westerners are the least likely to attend church. We're more likely to abuse alcohol and prescription drugs. We have high rates of divorce. A 1992 study even found that country music, with its refrains of loneliness and failure, could contribute to suicide rates.

Sheila Linwood, who runs a suicide-prevention group in Grand Junction, sees high rates of suicide among the young men who work far from their families in the booming construction and oil and

gas fields.

"It's huge isolation," she says. When they suffer depression and other mental illness, she says, "They really do feel like no one else in the world can understand, no one is going to help them out. It's not a healthy atmosphere."

Some suicides never make it into the statistics, she says. "If you're putting up an oil derrick, it's dangerous work, and if you have a mental health condition, you may not take the precautions you need to take."

### Trapped

I don't know whether my brother would've fared better if he'd stayed in the Illinois system. I do know that when he moved back to the West, his chances worsened. But he was a Westerner, in his origin, his conclusion and his transience. He lived in at least six states, two countries, and more than a dozen apartments and houses in Tucson alone, not including hospitals.

I go around with thoughts that I should've done more for John. I also understand how one person's mental illness strains the whole family.

In Tucson, I saw him roughly once a week. On holidays and other special occasions, he came over to the house where I lived with my wife and kids. He tried to interact, but sometimes was too far gone. The kids called him Uncle John, and he was sweet to them, but generally he wasn't good in groups.

So most of the times I was with John in the desert, it was just the two of us (my younger brother took his own path, to New Mexico, Europe and California). We had our routines: I took John out for burritos, or we went to a bar to shoot pool. We went to movies, where he could lose himself in the big screen. He helped me work on my cars. Our best escapes were the hikes we took into the embrace of canyons.

When I decided to leave Tucson, fleeing the sun-baked urban mess - chasing my Big Rock Candy Mountain, headed north to the Rockies and then Bozeman, Mont. - I thought about taking John with me. It seemed close to impossible, on top of moving the wife and kids and facing who knows what changes ahead. My wife thought I was crazy to consider it.

When I told him we would move soon, he took off driving his old Scout, heading north, fully crazy and somehow imagining, I think, that he could prove he could relocate himself. He drove about 120 miles and ended up out of gas and with a dead battery in an old mining community, walking beside the road for hours, hungry and hallucinating.

The cops there scooped him up, thank you, and called me, and my wife and I drove up and brought the Scout back to Tucson. They committed him to a hospital and long-term outpatient meds, again. And we left without him.

The last time he and I talked, about nine months after I moved away from Tucson, it was a long-distance call. My life still felt shaky from the move and I was under more than the usual stress. I picked a fight with him about his driving. He spent too much of his paltry income on gas, insurance and repairs, and for too long I had lived with the fear that he would hurt someone else by driving when he was crazy or acting out his anger. I told him angrily that he should sell that old truck.

Within a few weeks, he did sell it. He used some of the money to buy the gun.

There was a lot of turnover, and his case manager changed four

times during his last year. Tucson had a lousy bus system, like many Western cities, and that also helped kill him: He ended up amid strangers and without wheels, trapped in one place with only his madness. He lost his last shreds of hope.

He pulled the trigger in the springtime, the season of suicide. A few days later, a comedy videotape arrived in my mailbox. He had ordered it for my kids.

### Bearing The Burden

In the 13 years since John killed himself, there have been some improvements in the mental health care system. New medications have fewer side effects. But still there are no cures, and horror stories are legion.

Recent scandals in Western states include physical and sexual abuse, even suicides, right inside hospitals. More changes are needed, but they must be cataclysmic, not just incremental. We must change the way we think about mental health. As Dr. Bruce Kahn, with the nonprofit Valley Mental Health in Salt Lake City, says, "We need a health care policy that would not discriminate based on which organ of the body is afflicted."

When I returned to Tucson for John's funeral, I went hiking in Tanque Verde Canyon - our favorite - at sunset. I found water and went barefoot into it. Walking up the trail out of the canyon, alone in the dusk, I heard a great horned owl hooting. The huge bird was perched atop a tall saguaro cactus silhouetted against the full moon. I watched the owl for a long time. The owl tipped forward to let loose each hoo-hooo-hooo-hooo! with all the volume and force in its body. Hoot after hoot.

On that trip, I also went to the apartment where John killed himself. I felt the terribleness there. Then another strange thing happened: The feeling changed to something golden, like a sunrise coming into the room and into me.

I am not a religious person, but I could feel John in it, telling me he had finally found a better place. I have never felt that feeling again. It is not enough to put my turmoil to rest. But I am proud of how he bore his burden, and I understand that he needed to find a way out.

After these experiences, I know how people can be single-issue voters. There are some who care about nothing except abortion, or gun rights. For me, the need to improve public mental health care outweighs other political issues. A champion of funding for the mentally ill could trash a few rivers and still have my vote.

I can't say that better funding would've prevented my brother's suicide. But it might improve the day-to-day lives of others.

If I were in charge, my program for crazy people would include a decent apartment, a good burrito, movies, hikes. And cats and dogs and whores, so the crazy people can touch and be touched physically, without judgment. And a place for hammering things to smithereens, without endangering other people.

My thoughts will not be welcomed by all who are touched by mental illness and suicide. But maybe this story will resonate in your life, offer you some support for decisions you've made, both good and bad. I hope it will also raise awareness.

NAMI has announced there are promotional products through [3dASAP](http://www.nami.org/3dASAP), and the new 3dASAP-NAMI store is accessible through the NAMI Web storefront. Check out the new items available for NAMI affiliates, Walk teams, and others! Items include mugs, pens, jackets, banners, hats, shirts, and other exciting NAMI merchandise. The website location is:  
[http://www.nami.org/template.cfm?section=NAMI\\_Store](http://www.nami.org/template.cfm?section=NAMI_Store)

## Program for Assertive Community Treatment (PACT)

PACT is a rehabilitation and recovery model providing comprehensive care to the most disabled and vulnerable consumers with chronic and persistent mental illness. The model has been validated by research and is an evidenced based practice. PACT provides the care level of an inpatient psychiatric facility within the consumer's home. The research results show that PACT participants have a higher quality of life and spend less time in hospitals when compared to other treatment models for people with chronic and persistent mental illness.

Unique to the PACT model is a multi-disciplinary team of mental health professionals, including a psychiatrist, nurses, social workers, mental health professionals, vocational and addiction specialists that provides care to people where they live. PACT services are intended to be long term. Services and service intensity increase and decrease according to each consumer's needs and preferences. To foster rehabilitation and recovery PACT provides; symptom education, symptom management, case management, individual supportive counseling, individual therapy, psychopharmacologic treatment, medication monitoring, vocational services, addictions treatment, family education and support, and skills teaching.

PACT of Greater Des Moines serves residents in Polk and Warren County. Our mission is to facilitate recovery, foster symptom management skills and promote high quality of life through evidence based practices within a PACT model. These services have been offered to the local community since January of 2000. The program was a result of grass roots community interest that was effectively advocated by NAMI of Greater Des Moines.

Most consumers currently in our program are funded through Title 19. Priority is given to persons living with schizophrenia, bipolar disorder, and other psychotic disorders. They often have significant functional impairments in daily living with high service needs, high use of psychiatric hospitals or emergency services, coexisting substance abuse, high risk or recent history of criminal justice involvement and difficulty maintaining employment or a homemaker role. Title 19 currently requires that PACT referrals funded by Title 19 have a history of at least two psychiatric hospitalizations in the past two years, and have attempted treatment in a less intense treatment program.

Currently, the PACT Team of Greater Des Moines serves 61 consumers and is staffed and funded to serve up to 70 consumers. PACT is available to its consumers 24 hours a day, seven days a week for crisis intervention. 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 please contact the Team Leader, Darla R. Krom, LMSW at 235-8846.

## Suicides Seen Among Vets Treated By VA

WASHINGTON, March 20, 2008

(CBS) There's new information about the risk of suicide for those who have served in the military. Last November, CBS News broke the story of the overwhelming number of veteran suicides nationwide. Now, Chief Investigative Correspondent Armen Keteyian has discovered veterans who get help from the VA are also at risk.

"When you go through war, you're going to change permanently and totally for the rest of your life," said veteran Harold Pendergrass.

Pendergrass knows firsthand the hidden wounds of war. He served two tours in Vietnam.

"I carried a suicide note in my pocket for years," he said.

At 57, the former Army soldier has tried to take his own life three times, constantly wrestling with thoughts of killing himself.

"I sat around numerous times with a .44 in my mouth," he said. "But for some reason, I just couldn't pull the trigger. I don't know why."

Now, CBS News has obtained never-before seen patient data from the Department of Veterans Affairs, detailing the growing number of suicide attempts among vets recently treated by the VA.

The data reveals a marked overall increase - from 462 attempts in 2000 to 790 in 2007.

"This is highly statistically significant," said Dr. Bruce Levin, head of the biostatistics department at Columbia University. Levin is one of three experts who analyzed the data for CBS News.

"I'd characterize it as something that deserves further attention," Levin said. "Overall the data suggests about a 44 percent increase and that is not due to chance."

According to the experts, two age groups stood out between 2000 and 2007. First, ages 20-24 - those likely to have served during the Iraq-Afghan wars. Suicide attempts rose from 11 to 47.

And for vets ages 55 to 59, suicide attempts jumped from 19 to 117.

In both age groups, the attempted suicides grew at a rate much faster than the VA patient population as a whole.

In addition, this VA study, also obtained exclusively by CBS News, reveals the increasing number of veterans who recently received VA services ... and still succeeded in committing suicide: rising from 1,403 suicides in 2001 to 1,784 in 2005 - figures the VA has never made public.

Rep. Bob Filner is chairman of the House Committee on Veterans Affairs. He's been critical of the VA's unwillingness to provide a full accounting of veteran suicides.

"These are incredible figures," he said.

"Does it surprise you that a study like that even exists?" Keteyian asked.

"Well, given the fact that we keep asking for data and they say, 'we don't have any,' yes, it surprises me," Filner said.

It angers Filner. "If we can't get the correct information, we can't do our job. We can't prevent every suicide but you can prevent a whole lot of them and it's our duty as a nation to do that."

The VA declined to speak on-camera about this story, but in an e-mail, said it "takes the issue of veteran suicide very seriously" and "has been doing a thorough data investigation to document the number of patient suicide attempts."

It insists the patient suicides are "...consistent with national trends," despite recent studies that show veteran suicide rates are substantially higher than those of non-veterans.

But Harold Pendergrass worries the VA remains ill-prepared to handle the next generation of veterans who will be fighting the horrors of war, for decades to come.

"If what the VA is doing is not working then they need to change tactics," Pendergrass said. "They need to listen to these guys and listen not only with their ears but also with their hearts."

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We have 3 great new products to share with you.

**The Famous Names Bookmark**

The **Pink Guard Card** – as a gentle reminder of the endearments which are so important to verbalize

The **Do's and Don'ts Card** – Communicating with Someone in Crisis Who Has a Mental Illness

Let us know if we can provide these products to you, your family, your business, or your organization. They are free.

If you would like a speaker to present information about NAMI and mental illness – please give us a call 277-0672.

Let us know if you can volunteer to help us with marketing/media, veterans programming, or if you could be a youth project leader (especially for adolescent support groups and sibling support groups).

We also have note cards for sale designed by persons with mental illness. Small note cards are \$6/ box and large note cards are \$7.50 per box. You can purchase these at our Sunday educational meetings.

**Please join us at our Sunday, May 4 Educational meeting for a presentation by the Iowa Peer Support Training Academy.**



To find out how to participate – go to [www.nami.org/namiwalks/IA](http://www.nami.org/namiwalks/IA) or call Jay Brewer – the walk manager – at 515-321-8051

**SAVE THE DATE - Saturday, Oct. 4, 2008**

NAMI is a grassroots organization. This is the second year for our major fundraiser in the Des Moines area – 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 –or be a sponsor.

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  
10% of the funds will go to NAMI National, and  
the balance of funds – 50% - 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.