Greater Des Moines

NAMI — National Alliance on Mental Illness

AFFILIATE AND SUPPORT GROUP NEWSLETTER

January 2008

"Support, Education, and Advocacy

Education **Meetings are generally the 1st Sunday of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room.** Dates on Sundays other than the 1st Sunday of the month are due to holidays or other special scheduled events.		***Business and Committee*** **Meetings are the 2nd Thursday of the month at 5 P.M. at the NAMI-Iowa Office.** 1. Business 2. Marketing and membership 3. Support 4. Education 5. Advocacy 6. Fundraising 7. Special Events	
	Sat., Jan. 5	**"Healing from Life's Hurts and Coping with the Many Changes in Life as We Grow Older"** – 10 AM to Noon - Lutheran Church of Hope – Ashworth and Jordan Creek Parkway, SE Corner, West Des Moines, Iowa – Room 214 – Free	
Sunday, January 6, 2008 – 2 PM	The topic will be **"Treatment for Psychosis"** – Our speaker will be Darla Krom, from Golden Circle Behavioral Health.	**Thursday, January 10 5 PM**	We will be discussing and planning around 7 topic areas
	Thursdays starting January 10, 2008	**Visions for Tomorrow classes start at 2 locations –** contact Diane 255-8157 for more info. 9 AM - Child Serve, 5406 Merle Hay Rd, Johnston and at 6:30 PM - Orchard Place, 925 SW Porter, Des Moines. This is the educational course for parents and caregivers of children or adolescents with severe emotional disorder. The e-mail to contact is itsdianej@aol.com.	
	Sat. and Sunday, Jan. 26-27, 2008	**Treating Mental Illness in Primary Care Settings** – A conference for primary care physicians to better recognize, understand and treat psychiatric illnesses such as mood, anxiety, and psychotic disorders. Sponsored by NAMI, Medical University of South Carolina Institute of Psychiatry. On-line registration at www.muschealtlh.com/psychevents or call Liz Puca at 843-792-7340 or pucalm@musc.edu. Registration fee is $295. The event is at the Hilton Oceanfront Resort 1-800-HILTONS www.hiltonheadhilton.com $99/night.	
	Tuesdays starting February 5, 2008	**Family to Family class -** Dennis and Diane Banasiak will be the co-teachers – please contact at diban@aol.com or call 334-5159 to sign up – Class will be held at St. Francis of Assisi Church, 7075 Ashworth Road, West Des Moines – in the large meeting room from 6:30 to 9:00 P.M.	
	Fri thru Monday June 13-16	**NAMI National Convention in Orlando, Florida,** at the Rosen Centre Hotel. See inside for hotel contact information. You can register on-line at www.nami.org/convention	

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.

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.
http://www.legis.state.ia.us/
www.nami.org/advocacy

NAMI Greater Des Moines 2008 Legislative Priorities

Keep in mind these two quotes:
1. "America's mental health service delivery system is in shambles." --President Bush's New Freedom Commission on Mental Health, 2002
2. In 2006, the National Alliance on Mental Illness gave Iowa an "F" in a report card on mental health care. --Grading the States, 2006.

There have been steps taken to improve Iowa's mental health system and a lot of planning, but the hard decisions and the action needed to improve it have still yet to be done.

NAMI GDM's legislative priorities are in 3 major areas:

1. Assure there are basic services for mental health care.
2. Adequately fund a mental health system in Iowa.
3. Build a mental health system which consists of programs and methods which are a wise investment of taxpayer dollars.

Within each of the 3 major areas are steps which can be taken to reach each priority.

NAMI Greater Des Moines Legislative Priorities

1. Assure there are Basic Services for Mental Health Care

Address Mental Health Workforce Shortage Crisis

The current demand for psychiatrists (positions which could be filled if a qualified psychiatrist were available):

Full time	Adult	50
Part time	Adult	14
Full time	Child	13
Part time	Child	6

Only about 20 of 650 physicians assistants (PA's) specialize in psychiatry in Iowa. Iowa has 2 post graduate PA training programs – Cherokee and U. of Iowa offer training. The person who started and was running the program in Cherokee recently retired. The U. of Iowa program was funded by the legislature and allows for the training of 1 trainee per year.

In 2005, the Iowa Dept. of Public Health reported there were over 200 psychiatrists in Iowa, of those 147 were in private practice. As of 2007 – that number continued to decline.

State records show two-thirds of Iowa's counties have no private-practice psychiatrists.

We are hearing stories from families being turned away from Des Moines area hospitals because psychiatrists are no longer taking additional patients.

Iowa has 6.6 practicing psychiatrists for every 100,000 residents, according to 2001 statistics, the latest available, from the U.S. Department of Health and Human Services. That ratio is worse than in all but three other states: Idaho, Nevada, and Mississippi.

Iowa's numbers fall short of the 10 psychiatrists per 100,000 residents in the Midwest and 14 psychiatrists per 100,000 in the U.S. population. Iowa is 49th in the nation in psychologists and 47th in the nation for number of psychiatrists.

Patients are experiencing a 2 month time delay in scheduling first follow-up appointments after release from psychiatric hospitalization.

Based on age, about 50% of the currently practicing psychiatrists will retire within the next 10 years.

The training program at the University of Iowa cannot keep pace with the attrition of psychiatrists so the current work shortage is becoming increasingly acute.

Talking points with your legislator:

- ✓ There are an insufficient number of mental health professionals to treat Iowa's population.
- ✓ Expand the number of psychiatric residency positions at the U. of Iowa with accompanying incentives for them to remain in Iowa upon graduation.
- ✓ Expand programs for psychiatric physician assistants, psychiatric nurses, senior level clinicians as well as other psychiatric direct care workers.
- ✓ Scholarships, loan forgiveness, job location incentives, job benefit incentives, and other programs need to be targeted toward individuals seeking careers in this field and to attract individuals to this field.

Stop the closing of acute care beds and take steps to increase the number of beds available.

Nationally

State psychiatric beds
1955- Over 500,000
1990 to 2000 - 98,000 to 59,000
Private psychiatric beds
1990 to 2000 – 45,000 to 27,000
----from SAMHSA

In a 3 year period, the 4 Iowa mental health institutions' beds have been reduced by 43%. During the same time, the prison population has increased from under 3000 to just under 9000.

Des Moines has approximately 110 acute care beds in hospitals for psychiatric patients. Woefully short sighted for a community of an estimated 400,000 persons. Families, health professionals, crisis response teams, law enforcement, and the court system are all alarmed at the **lack of acute care beds.** It is not only a Polk County problem, but also a statewide concern.

The number of state hospital beds is also decreasing which is worsening the crisis.

It is not unusual for families utilizing the commitment laws to seek assistance for their loved one to find there are no beds available in Iowa.

Admittance requirements to access a hospital bed are becoming narrower. It has been reported that it is no longer enough to be suicidal – they must also have a plan for committing suicide before they can be admitted for treatment.

Talking points with your legislator:

- ✓ The number of beds in Polk County should be increased for acute care and for recovery purposes (for ex: dual diagnosis, substance and drug abuse).
- ✓ The limited time allowed for hospitalization should be expanded to allow for patient stabilization, to determine medication efficacy, and allow for illness education for the consumer and family along with recovery information.
- ✓ Create a standard for admittance to a hospital which isn't totally dependent on the element of imminent dangerousness.

Retain "open access" for mental health medications.

Talking points with your legislator:

- ✓ NAMI supports the "open access" language that is available for all psychiatric medications for those that are on Medicaid
- ✓ Requiring prior authorization for mental health medications will interfere with patients receiving the treatment that their physician/health care provider has determined to be most appropriate.
- ✓ Requiring a person with mental illness to try less effective medicines before receiving the medicine that is right for them will extend that person's suffering, place them at greater harm, and will in some cases increase hospitalization rates (at higher cost and in a system with inadequate in-patient treatment options).
- ✓ Limiting access to achieve a short term line item cost reduction will carry with it a high risk of higher overall treatment and social service costs.
- ✓ The Preferred Drug List (PDL) committee should have adequate representation from consumers, advocates, and mental health professionals. At the present time, the PDL committee is composed only of pharmacists.

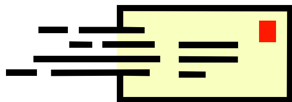
2. Adequately fund a Mental Health system in Iowa.

The state should appropriate additional Mental Health dollars to restore services, eliminate waiting lists, and support building a mental health system in Iowa. Polk County has a waiting list of over 250 people. Award winning programs were cut for lack of funds.	While both county and state levels of government share funding, the state is bearing an increasing percentage of the load, primarily because it is the only source where growth is allowed. There is not enough money in the system for present needs nor for systemic change. Increases in state funding and an expansion of services eligible for Medicaid reimbursement have helped to cover the increasing need for services during the last decade, since county property taxes were frozen. But they have not been sufficient to cover all the need. There was a reduction of $18 million ($23-24 million in today's dollars) in state funding in 2002. The state has restored about half of the reduction in funding from 2002. In the meantime, some counties have significantly reduced or eliminated services and/or have implemented waiting lists. The Division for Mental Health and Development Disabilities has been created to be a statewide leader for a mental health system in Iowa. 6 workgroups of stakeholders were mandated by the state legislature in FY 07's session to assist them in making recommendations for establishing a mental health system in Iowa. A mental health system cannot be created without additional dollars to support it. *Talking points with your legislator:* ✓ Restore the balance of state funding cut in 2002 to help restore services and eliminate waiting lists. ✓ Fund the necessary steps which need to be taken to establish a mental health system in Iowa.
Allow the counties who choose to - the flexibility for alternative methods of generating additional MH/DD money.	Counties are responsible for assisting persons with mental health care who do not qualify for Medicaid and do not have health insurance. Each county has a management plan for MH services they will offer. SF 69 was the legislation in 1996 that froze the county property tax dollars for MH/DD. No county can raise money for MH beyond the specific dollar amount authorized in 1996. That was 12 years ago. No other levy mandate (except for MH/DD) is expressed as a specific dollar amount, but rather is a cost/$1000 of valuation. In Polk county, this limit in dollars for MH has meant that people in need have been turned away for assistance and services available have diminished. The waiting list for services has grown to over 250 people. A very conservative estimate is that at least $4 million dollars worth of services statewide are not being provided this year because some counties do not have enough resources available to meet the expressed needs of their citizens. *Talking points with your legislator:* ✓ Establish a mental health levy range with a minimum and maximum rate (cost per $1000 of valuation) rather than continue to freeze county property tax dollars to a specific dollar amount. The minimum of the range will assure that each dollar of taxable valuation will generate an equal levy amount to support the newly designed mental health system, including all the core services with standard eligibility guidelines. Having a maximum eligibility rate allows those counties that want to provide more than core services to raise the money to do this.
Expand the mental health parity law.	Families should not have to choose poverty to get adequate mental health care through Medicaid. Unfortunately in Iowa, Medicaid often pays for more mental health services than private insurance. Mental illness is a physical illness of the brain. Equal coverage should be mandated under private insurance policies including prevention (early identification and treatment and nutrition strategies), outpatient services, medication, therapy, inpatient stays, and wellness strategies (recovery). *Talking points with your legislator:* ✓ Include coverage for eating disorders, anxiety and panic disorders including post traumatic stress disorder, children and adolescent mental health disorders, and substance abuse. ✓ Extend insurance benefits to cover children of policyholders until age 26. Young adults are the most likely to be without insurance coverage because they age out on their parent's policy and may not have health benefits in the current job market. Most mental health disorders become evident in young people ages 15-25. ✓ Require all health insurance policies sold to Iowa residents to include equal coverage for the "other physical illness" that is still referred to as "mental illness". ✓ Full mental health parity will help to combat stigma and increase the number of people seeking treatment.

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).	***Why Act is Needed -*** People with severe mental illness have multiple needs and have trouble negotiating complex systems. Many find their symptoms are unresponsive or only partially responsive to medications. Community mental health centers and other agencies may not be equipped to meet the needs of persons with severe mental illness. Families can't bear all the burden of care. ***Assertive Community Treatment (ACT)*** is a way of organizing services for a person with a severe mental illness that fosters integration, teamwork, and continuity of care. It incorporates proven treatments for integrated treatment for co-occurring disorders, supported employment, social skills training, appropriate use of medications, and education about the illness. The key features of ACT are: multidisciplinary staff, team approach: daily rounds, integrated care: continuity of care, care is provided in the community, favorable ratio of 7 clients per staff member, assertive outreach to those in need, 24/7 availability for crisis intervention, and time unlimited services. ***How well does ACT work?*** Here are some outcomes: ⇒ Fewer hospitalizations for persons with severe mental illness. ⇒ Improved housing stability for persons with SMI. ⇒ Better quality of life for persons with SMI. ⇒ Better retention in mental health services. ⇒ High satisfaction (patients and families) ⇒ Cost effective (cost neutral to cost savings) Assertive Community Treatment teams provide inpatient care for persons with severe mental illness – in their homes, rather than the hospital. There are 5 ACT teams in Iowa. One of the teams is in Des Moines. More teams are needed. About 500 persons out of an estimated 2000 needing ACT are being served. **More teams are needed.** 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. _Talking points with your legislator:_ ✓ Make Assertive Community Treatment team services a specific Medicaid reimbursable service in Iowa to assist in ongoing funding. ✓ Provide "start up money" for additional ACT teams.
Establish a statewide emergency response system for persons in mental health crisis – a safety net.	To establish an effective statewide emergency response system, the legislature will need to implement the first 2 NAMI GDM legislative priorities – assure there are basic services for mental health care and adequately fund the mental health system. An emergency response system will be extremely stressed with little chance for better outcomes if you have no one or no place to take ill persons for treatment. Invest in a system of mental health care that includes inpatient and outpatient services to support vulnerable people and keep them out of the criminal justice system. _Talking points with your legislator:_ ✓ Establish a statewide training center/program and/or traveling teams to offer Crisis Intervention Team (CIT) training and/or Mobile Crisis Unit organization in local support networks. Train designated police officers to respond to persons in mental illness crisis. Train others such as Community Mental Health Center employees, EMT's, paramedics, emergency room personnel, school employees, jailers as well as others. This will help reduce stigma, increase the likelihood of a safe resolution of the crisis, facilitate the ill person obtaining treatment, and reduce the criminalization of mental illness.
Develop a jail diversion system for persons with mental illness.	To establish an effective jail diversion system, the legislature will need to implement the first 2 NAMI GDM legislative priorities – assure there are basic services for mental health care and adequately fund the mental health system. A jail diversion system will not be workable if you have no one or no place to take ill persons for treatment.

Develop a jail diversion system for persons with mental illness. (cont'd) Mentally ill inmates spend 15 more months on average in state prison, at a cost to the system of an additional $5.7 billion in 2005. --Bureau of Justice (computed using an average annual cost per inmate of $22,650; actual cost for mentally ill inmates can be much higher)	A jail diversion program will help to reduce the criminalization of mental illness. *Talking points with your legislator:* ✓ Expand the use of mental health courts. ✓ Roll back punitive drug laws and invest in drug treatment, giving people many chances to succeed. ✓ Adequately staff intensive case management services for assisted outpatient treatment. ✓ Implement re-entry programs to facilitate access to benefits, meds, treatment, housing, supported employment, other needed social programs, etc., - to decrease recidivism. ✓ Invest in housing and supported employment programs. ✓ Provide for the possibility of long term care in state hospitals, when needed.
Reform how jails and prisons treat the mentally ill. America had the world's highest per capita incarceration rate in 2006: 750 per 100,000 people. Russia placed third with 628. England's rate was 149. In the last decade of the 20th century, 400 prisons were built and 40 mental hospitals were closed in America.	*Talking points with your legislator:* ✓ Invest in special prison units for people with mental illness – for the few mentally ill people who belong in prison. ✓ Train prison officers to work with and respect inmates with mental illness. ✓ Invest in prison rehabilitation programs, which curb recidivism. ✓ Stop putting mentally ill people into solitary confinement, which are psychologically devastating for the sane as well as the sick. ✓ Stop building new prisons, but do provide rehabilitation and renovation to existing out-dated facilities to accommodate the needs of ill prisoners.



Treat mental illnesses quickly

By Peggy Loveless
Guest Opinion

For a change, let's hear some good news. Imagine a serious medical disorder where the current medicines are helpful 80 percent of the time. Imagine that with the proper medication and complementary therapeutic services, successful treatment means many can return to regular life activities, such as attending school, work, and daily life activities. Imagine that early detection and intervention can reduce if not completely eliminate future problems.

Many of those who have or care for those with heart disease, cancer, Alzheimer's, and other major medical conditions would love to hear this prognosis. So what major medical conditions have such a bright prognosis?

The conditions with these relatively wonderful outcomes are real; I am describing brain disorders, often called mental illnesses, such as schizophrenia, bipolar disorder, and major depressive disorder. Surprised?

Most are surprised to hear this because they only see or hear the bad news, the news about those who do not get treatment. That makes sense because many, if not most, of those with these brain disorders go under- or untreated. So, instead we spend millions on the untreated victims of these illnesses.

They don't ask to get sick, and they can get better. Why aren't we treating them quickly and effectively? Why are we waiting until they get so sick they are a danger to themselves or others? That to me shows a complete lack of reason and foresight, which is, by the way, one definition of insane.

We could save so much money and heartache for so many people because one in four families is directly affected by mental illness. That's a lot of people and families. This is a national crisis that has been hidden for too long.

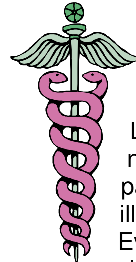
It's time we start talking about it and demanding proper treatments so we can save lives.

How do we start to fix this problem? To save you time, the National Alliance on Mental Illness will do the lion's share of the work.

Just take just a few minutes and write a simple statement such as, "I believe our society should provide full and appropriate treatment and resources for those with mental illness," put your name and address on the statement and e-mail or mail it to your local affiliate of the National Alliance on Mental Illness. (For NAMI Greater Des Moines – mail to 200 S.W. 42nd St., Des Moines, Iowa 50312 – by e-mail - send to Diane Johnson itsdianej@aol.com or Teresa Bomhoff at tbomhoff@mchsi.com).

We will make sure all your messages get to all our legislators and candidates. The few minutes you spend can make a huge difference. You can make these potentially bright futures a reality.

Peggy Loveless is co-president of the National Alliance on Mental Illness (NAMI) of Johnson County and vice president of NAMI Iowa.



RICHMOND'S JAIL: THE SNAKE PIT

Editorial
RICHMOND TIMES-DISPATCH (VA), October 14, 2007

Last Sunday featured what, to some, seems almost old news: an exposé of conditions at the Richmond City Jail, particularly for those inmates who suffer from mental illness. The reporting by David Ress and the photos by Eva Russo told the harrowing story of individuals for whom the jail is something akin to home, as defined by Robert Frost in "The Death of the Hired Man" -- "the place where, when you have to go there,/They have to take you in." The mentally ill, who cannot fend for themselves, have to go somewhere. The jail has to take them in. But it has few resources with which to care for them, which means that it amounts to a warehouse for the disturbed, the broken, and the lost.

How matters arrived at this point is a long story in itself, and one that has been told repeatedly. Nearly a decade ago, E. Fuller Torrey and Mary Zdanowicz summarized it this way: Nationwide, "more than 90 percent of state psychiatric hospital beds that existed in 1960 have been eliminated. Many states have turned over the responsibility for treating severely mentally ill individuals to health-maintenance organizations. Some of them, mostly nonprofits, are doing a creditable job. But for-profit HMOs, with few exceptions, have been disastrous for the severely mentally ill, who are expensive to treat. The newest antipsychotic medications, which

are essential for some mentally ill patients, can cost $400 a month."

The idea behind deinstitutionalization was not necessarily flawed – *(Richmond's Jail – the Snakepit – cont'd)* many individuals, given appropriate treatment outside the walls of mental institutions, could function in society -- but the execution was flawed. Too many of those turned loose were not given appropriate treatment, and the local services meant to serve them never were close to adequate. Nevertheless, Virginia followed the general trend: In the mid-1970s state mental hospitals held roughly 6,000 patients. By the late 1990s the number had declined to 2,000, and it has dropped further since then -- to slightly lower than 1,500 now.

In December of 2001 the inspector general's office for the Department of Mental Health, Mental Retardation, and Substance Abuse released a report on "Outcomes for Patients Discharged From State Psychiatric Inpatient Care." The report was based on only a small sample -- 126 discharged persons, which produced only 12 interviews. But there was a reason: "The majority of the potential discharged sample could not be contacted, even though extensive valid methods for follow-up were used." In short, the state couldn't find them. As for those who could be interviewed: "The majority of the sample is deteriorating in function over time . . . .In each case, but one, where psychotropic medications were changed, the dosage was reduced or discontinued."

Nobody should be surprised that some individuals would deteriorate without follow-up care. Nobody should be surprised that some would end up on the street, where their odd behavior -- or outright criminality -- would require intervention, including forcible confinement. Figures from a Department of Justice report released a little over a year ago show that 64 percent of prison inmates in the United States suffered mental-health problems within the previous year.

The irony of the problem at the Richmond City Jail is that it came about because well-meaning people wanted to prevent simply locking up the mentally ill in snake pits. Virginia's mental-health facilities were the subject of several federal investigations in the 1990s because of neglect and abuse that included tying patients up and pumping them full of drugs needlessly. (The administration of Gov. Jim Gilmore launched a vigorous reform effort.)

It can hardly be considered an improvement, however, simply to have substituted one snake pit for another. Nor is the issue simply a cause for bleeding-hearts. Dealing with the mentally ill diverts from the criminal-justice and correctional systems resources that would be better spent on those individuals society has reason to fear, not those it has a need to treat. Little is gained by running sick people through an endless loop of short-term incarceration.

The city can't resolve the problem of the mentally ill on its own, however. Doing so will take a statewide effort to improve mental-health treatment -- one that already has begun because of the massacre at Virginia Tech. Neither does the issue require a great deal of study; to the contrary, shelves groan under the weight of repeated studies indicating what should be done: Systematize the process of involuntary commitment, provide a wide range of services of varying levels, and improve the continuity of care and housing resources for those being treated on an outpatient basis.

The commonwealth knows what it needs to do. Now it needs the will to act. Absent that, citizens will one day pick up the paper to read yet again about the intolerable plight of the mentally ill being warehoused in a local jail.

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

Iowa Advocates for Mental Health Recovery has received 2 grants.

- $19,000 from Magellan to expand dual recovery anonymous (DRA) support groups in Iowa
- $25,000 from SAMHSA in anti-stigma funds to establish a speaker's bureau

The primary purpose of Dual Recovery Anonymous is to help one another achieve dual recovery, to prevent relapse, and to carry the message of recovery to others who experience dual disorders.

Dual Recovery Anonymous is an independent, nonprofessional, twelve step, self-help fellowship organization for people with a dual diagnosis. Their goal is to help men and women who experience a dual illness. They acknowledge they are chemically dependent and that they are also affected by an emotional or psychiatric illness. Both illnesses affect them in all areas of their lives; physically, psychologically, socially, and spiritually.

If you are interested in being a part of either of the 2 projects – please contact Michael Woods at MHASiouxland@aol.com

CONSUMERS, CAREGIVERS NEEDED

Schizophrenia Digest is looking to create a pool of consumers and caregivers who are willing to be interviewed for future articles on various topics. Interviews can be done by telephone or email.

If you would like to be contacted, please email your full contact info (name, mailing address, telephone number, and email address) to Editor-in-Chief Dianne Duckett at www.schizophreniadigest.com .

Tell just a little bit about your situation; please specify "INTERVIEWS" in your email subject line. If you are interviewed, you will have the option of remaining anonymous.

SCHOLARSHIP APPLICATIONS NOW AVAILABLE

October 1 marked the 10-year anniversary of the Lilly Reintegration Scholarship, and also signaled the first day that applications for the 2008-09 school year are available online at www.reintegration.com.

Since 1997, Eli Lilly and Company has awarded scholarships to people with severe mental illness to help offset their tuition, books, and lab fees. The program is designed to help people with schizophrenia, bipolar disorder, and related schizophrenia-spectrum disorders acquire the educational and vocational skills needed to reintegrate into society.

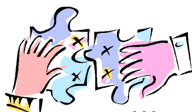
The Lilly Reintegration Scholarship helps people whose lives have been interrupted by severe mental illness reach life goals, said John Lechleiter, president and chief operating officer of Eli Lilly and Company. Since its inception in 1997, the scholarship has assisted hundreds of students in pursuit of a wide range of educational opportunities from graduate degrees to trade certificates. Scholars are selected by an independent judging panel made up of psychiatric care professionals. Since 1997 more than 700 people have been awarded Lilly Reintegration Scholarships. Many are multi-year recipients, allowing them to continue and potentially complete their education.

Thanks to Steve Moats for his presentation on Social Security and the appeal process at our November meeting. If you would like to contact Steve - his contact information is 515-231-2901 and Email address is starman9291@yahoo.com

MTV Wants Young Adults with Schizophrenia

MTV's True Life is a long-running, award-winning documentary series that seeks to have young people share their stories in their own words. The format is first person, without narrators, in which the person is followed by a camera over several weeks. After an initial search this summer, the show is continuing to look for young adults between the ages of 18 and 28 who have been diagnosed with schizophrenia. They are especially interested in talking with persons who are in relatively early stages of recovery from first break. Candidates will be required to provide their doctor's consent to participate.

"Punched in the Head Productions" www.punchedinthehead.com is now producing the schizophrenia episode for the series. They filmed "I Have Autism," a clip of which can be viewed on their Web site. NAMI is not a sponsor of the project, but is circulating this "casting call" for consideration by consumers. If you are interested in learning more, please contact Executive Producer Craig D'Entrone at craig@punchedinthehead.com or 718-422-0704. Please include name, location, phone number and (if possible) a photo.



NAMI Connection Support Groups for Consumers

We now have 2 consumer led support groups in the Des Moines area.

Every Monday 7:00 – 8:30 p.m.
NAMI Iowa Office (1-800-417-0417 or 515-254-0417)
Contact: Dawn Olson (641) 842-3859
dawnao@iowatelecom.net.
Facilitators: Dawn Olson and Kyle Damman

Every Wednesday afternoon 2:00-3:30 p.m.
Mercy Franklin Clinics, West Conference Room
1750 48th Street
Contact: Debbie Wallukait (515) 288-4439
Eddie Lathrop, Jr. legalbound34@yahoo.com
Facilitators: Debbie Wallukait and Eddie Lathrop, Jr.

NAMI Iowa Art Contest for Children and Teens

NAMI Iowa invites children and teens to submit drawings to be considered for the front cover of the *Children's Mental Health Resource Directory*.

The cover will be approximately 8 ½" X 11", but all sizes of drawings will be considered.

Submit artwork by February 29, 2008 to:
NAMI Iowa – 5911 Meredith Dr., Ste. E, Des Moines, IA 50322

Prizes of $50.00 will be awarded to 3 finalists. Winners will be announced by March 31st.

Questions? Contact Jackie at jkelfmann@aol.com or call NAMI Iowa at 515-254-0417 or 800-417-0417.

Thanks to Becky James from Broadlawns for her presentation on "partial hospitalization" for adults age 18 and over at the December meeting. The program at Broadlawns is Monday through Friday from 9AM to 3 PM and requires a doctor's referral. The day is structured for various groups – for example: relapse & recovery, medication and health, weekend safety planning, clear thinking, co-occurring groups, problem solving, ans social skills, stress management, assertiveness, cognitive, group therapy, etc. If you would like to contact Becky – her email address is bjames@broadlawns.org and phone number is 515-282-6926.

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. Curriculum materials are provided by NAMI IOWA. A take home educational packet on PTSD is a new addition to the curriculum.

The next Family to Family class in Des Moines will be starting **Tuesday - February 5**. Dennis and Diane Banasiak will be the co-teachers – please contact at diban@aol.com or call 334-5159 to sign up – Class will be held at St. Francis of Assisi Church, 7075 Ashworth Road, West Des Moines – in the large meeting room from 6:30 to 9:00 P.M.

Visions for Tomorrow

VFT is an educational program for people who are raising or working with children and adolescents who have behavioral disorders or mental illnesses. The curriculum is designed to help parents, foster parents and other caregivers face the day-to-day challenges; learn the facts; and find support, resources, and strategies to cope. The 12 workshops of the parent course are usually taught over a series of eight class sessions. There is no charge to attend VFT classes or workshops. Curriculum materials are provided by NAMI IOWA.

Workshop topics include:

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

Call Diane 273-5054 or Susan 242-7556 or the NAMI office 254-0417 to sign up for the next Visions for Tomorrow class – E-mail: itsdianej@aol.com. Classes will start **Jan. 10 at 2 locations** – at 9 AM - Child Serve, 5406 Merle Hay Rd, Johnston and at 6:30 PM - Orchard Place, 925 SW Porter, Des Moines.

Parents and Teachers As Allies

10% of children and adolescents in the U.S. suffer from emotional and mental disorders so severe that they have trouble functioning at home and in school.

When a child's behavior falls well outside the norm and signals early onset mental illness, families and teachers need to work together to get students the help they need.

This 2 hour in-service program is for parents, 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
1. Welcome and Introductions
2. Early Warning Signs of Mental Illnesses
3. Family Response
4. Living with Mental Illness
5. Group Discussion
6. Closing Remarks and Evaluation

Children with mental illness face a double whammy: they don't get diagnosed soon enough, from fear and misunderstanding. By the time they finally do, a good portion of their childhood may be needlessly lost, and they may be denied the opportunity to live full and productive lives.

Schools are in a key position to identify mental health problems early and to provide a link to appropriate services.

From the Parents and Teachers as Allies course, attendees are given a handbook which gives tips on how to team up to help ensure that students with mental illnesses are identified early and linked with services. It walks school professionals through the early warning signs of mental illness. It also lays the foundation for improving the academic achievement of those students.

Students with mental illness have the highest school drop-out and failure rates of any disability group – clearly they are being left behind.

It can take up to 8 years from the onset of symptoms before a child is identified and gets treatment. Eight years is far too long and the consequences are devastating – not just for families, but for society as a whole. We know that unidentified and untreated mental disorders mean the loss of critical development years, school drop out and failure, involvement with the criminal justice system, and the ultimate tragedy – suicide.

Suicide is the 3rd leading cause of death in children 10 to 14; children of color have the highest rates. And 90% of people who die by suicide suffer from a diagnosable, treatable mental illness at the time of their death.

To have the Parents and Teachers as Allies program at your school or organization– please contact Diane Johnson 255-8157 *E-mail:* itsdianej@aol.com

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 for the **Together Rx Access™ Card**.

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

President - Diane Johnson 255-8157
E-mail: itsdianej@aol.com

Vice-President and Editor of Newsletter
Teresa Bomhoff 274-6876
E-mail: tbomhoff@mchsi.com

Treasurer – Jim Vandeberg 360-1529
E-mail: NAMI-DM@peoplepc.com

Secretary – Sharon Browne 988-5151
E-mail: msrvliving@hotmail.com

Board members
Grace Sivadge 961-6671
E-mail: rsivadge1@juno.com
Glenn Hobin 965-9799
E-mail: IowaGH@aol.com
Diane Banasiak 334-5159
E-mail: diban@aol.com

PLEASE BECOME A MEMBER OF NAMI GREATER DES MOINES

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.

If you've taken one of our education classes, we hope you found the experience valuable.

If you've attended one of our support groups, we hope you found comfort.

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 Vandeberg, Treasurer
4114 Allison Avenue
Des Moines, IA 50310
Please make the check payable to NAMI GDM

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

Thanks for your generosity!

RESOURCES – RESOURCES - RESOURCES

SUPPORT GROUP MEETINGS

Third Sunday of the month -12/16/07 Family members, if you are interested in participating in a NAMI family support group, please contact Glenn Hobin IowaGH@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 - 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.

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

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

Every Tuesday evening – 8-10 P.M. **-** Recovery Inc., a self-help group for people who have nervous and mental troubles – at St. Mark's Episcopal Church, 3120 E. 24th St., Des Moines – Call 266-2346 – Marty Hulsebus.

2nd Tuesday of the month – New Light Support Group – 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

4th Tuesday evening of the month – Presentations on Mental Health issues and topics at Westkirk Presbyterian Church, 2700 Colby Woods Drive, Urbandale, Iowa 515-253-0330 – Pastor Michael Mudlaff

Every Wednesday afternoon – NAMI Connection Support Group - a support group for persons with mental illness – facilitated by persons with mental illness 2 to 3:30 P.M. at Mercy Franklin Clinics - West Conference Room - 1750 48th Street - Contact: Debbie Wallukait (515) 288-4439 or Eddie Lathrop, Jr.legalbound34@yahoo.com

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

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

Every Thursday evening – 7:45 – 9:45 P.M. – Recovery, Inc. - a self-help group for people who have nervous and mental troubles – at St. Timothy's Episcopal Church, 1020 24th St., in West Des Moines. Call – 277-6071-Deb Rogers.

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

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

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

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

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

Did You Know?

NAMI E-Join is a nationwide online membership initiative. E-Join will allow visitors to NAMI's Web 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 on a quarterly basis.

If you haven't renewed your membership – please do so.

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

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.loebsack.house.gov/

Click on the link for an eye opening article. We would have inserted the article in the newsletter but there was not enough space to include it.
The Washington Post, 12/2
A Soldier's Officer
In a nondescript conference room at Walter Reed Army Medical Center, 1st Lt. Elizabeth Whiteside listened last week as an Army prosecutor outlined the criminal case against her. The charges: attempting suicide and endangering the life of another soldier while serving in Iraq.
http://www.washingtonpost.com/wp-dyn/content/article/2007/12/01/AR2007120101782.html
NAMI recently called on the Army to end stigma and discrimination, protesting the Army's prosecution of 1st Lt. Elizabeth Whiteside for the "crime" of mental illness. An Army hearing officer has since recommended against a court-martial, but a final decision is pending. The Army also does not pay for the lodging of family members of soldiers being treated for mental illnesses in Army hospitals, to support recovery, even though it is provided to families of soldiers with physical wounds.

120 War Vets Commit Suicide Each Week
By Penny Coleman, AlterNet
Posted on November 26, 2007,
Printed on November 26, 2007
http://www.alternet.org/story/68713/

Earlier this year, using the clout that only major broadcast networks seem capable of mustering, CBS News contacted the governments of all 50 states requesting their official records of death by suicide going back 12 years. They heard back from 45 of the 50. From the mountains of gathered information, they sifted out the suicides of those Americans who had served in the armed forces. What they discovered is that in 2005 alone -- and remember, this is just in 45 states – there were at least 6,256 veteran suicides, 120 every week for a year and an average of 17 every day.

As the widow of a Vietnam vet who killed himself after coming home, and as the author of a book for which I interviewed dozens of other women who had also lost husbands (or sons or fathers) to PTSD and suicide in the aftermath of the war in Vietnam, I am deeply grateful to CBS for undertaking this long overdue investigation. I am also heartbroken that the numbers are so astonishingly high and tentatively optimistic that perhaps now that there are hard numbers to attest to the magnitude of the problem, it will finally be taken seriously.

Since these new wars began, and in spite of a continuous flood of alarming reports, the Department of Defense has managed to keep what has clearly become an epidemic of death beneath the radar of public awareness by systematically concealing statistics about soldier suicides. They have done everything from burying them on official casualty lists in a category they call "accidental noncombat deaths" to outright lying to the parents of dead soldiers. And the Department of Veterans Affairs has rubber-stamped their disinformation, continuing to insist that their studies indicate that soldiers are killing themselves, not because of their combat experiences, but because they have "personal problems."

Active-duty soldiers, however, are only part of the story. One of the well-known characteristics of post-traumatic stress injuries is that the onset of symptoms is often delayed, sometimes for decades. Veterans of World War II, Korea and Vietnam are still taking their own lives because new PTSD symptoms have been triggered, or old ones retriggered, by stories and images from these new wars. Their deaths, like the deaths of more recent veterans, are written up in hometown newspapers; they are locally mourned, but officially ignored. The VA doesn't track or count them. It never has. Both the VA and the Pentagon deny that the problem exists and sanctimoniously point to a lack of evidence they have refused to gather.

They have managed this smoke and mirrors trick for decades in large part because suicide makes people so uncomfortable. It has often been called "that most secret death" because no one wants to talk about it. Over time, in different parts of the world, attitudes have fluctuated between the belief that the act is a sin, a right, a crime, a romantic gesture, an act of consummate bravery or a symptom of mental illness. It has never, however, been an emotionally neutral issue.

In the United States, the rationalism of our legal system has acknowledged for 300 years that the act is almost always symptomatic of a mental illness. For those same 300 years, organized religions have stubbornly maintained that it's a sin. In fact, the very worst sin. The one that is never forgiven because it's too late to say you're sorry.

The contradiction between religious doctrine and secular law has left suicide in some kind of nether space in which the fundamentals of our systems of justice and belief are disrupted. A terrible crime has been committed, a murder, and yet there can be no restitution, no punishment. As sin or as mental illness, the origins of suicide live in the mind, illusive, invisible, associated with the mysterious, the secretive and the undisciplined, a kind of omnipresent Orange Alert. Beware the abnormal. Beware the Other.

For years now, we have been has been blasted with high-decibel, righteous posturing about suicide bombers, those subhuman dastards who do the unthinkable, using their own bodies as lethal weapons. "Those people, they aren't like us; they don't value life the way we do," runs the familiar xenophobic subtext: And sometimes the text isn't even sub.

The opinion has been expressed that suicide bombers are motivated by despair, neglect and poverty. The demographic statistics on suicide bombers suggest that this isn't the necessarily the case. Most of the Sept. 11 terrorists came from comfortable middle- to upper-middle-class families and were well-educated. Ironically, despair, neglect and poverty may be far more significant factors in the deaths of American soldiers and veterans who are taking their own lives.

Consider the 25 percent of enlistees and the 50 percent of reservists who have come back from the war with serious mental health issues. Despair seems an entirely appropriate response to the realization that the nightmares and flashbacks may never go away, that your ability to function in society and to manage relationships, work schedules or crowds will never be reliable. How not to despair if your prognosis is: Suck it up, soldier. This may never stop!

Neglect? The VA's current backlog is 800,000 cases. Aside from the appalling conditions in many VA hospitals, in 2004, the last year for which statistics are available, almost 6 million veterans and their families were without any healthcare at all. Most of them are working people -- too poor to afford private coverage, but not poor enough to qualify for Medicaid or means-tested VA care. Soldiers and veterans need help now, the help isn't there, and the conversations about what needs to be done are only just now beginning.

Poverty? The symptoms of post-traumatic stress injuries or traumatic brain injuries often make getting and keeping a job an insurmountable challenge. The New York Times reported last week that though veterans make up only 11 percent of the adult population, they make up 26 percent of the homeless. If that doesn't translate into despair, neglect and poverty, well, I'm not sure the distinction is one worth quibbling about.

There is a particularly terrible irony in the relationship between suicide bombers and the suicides of American soldiers and veterans. With the possible exception of some few sadists and psychopaths, Americans don't enlist in the military because they want to kill civilians. And they don't sign up with the expectation of killing themselves. How incredibly sad that so many end up dying of remorse for having performed acts that so disturb their sense of moral selfhood that they sentence themselves to death.

There is something so smugly superior in the way we talk about suicide bombers and the cultures that produce them. But here is an unsettling thought. In 2005, 6,256 American veterans took their own lives. That same year, there were about 130 documented deaths of suicide bombers in Iraq.* Do the math. That's a ratio of 50-to-1.

Penny Coleman is the widow of a Vietnam veteran who took his own life after coming home. Her latest book, Flashback: Posttraumatic Stress Disorder, Suicide and the Lessons of War, was released on Memorial Day, 2006. Her blog is Flashback.

Jere Beery, National Public Relations Director
Operation Firing For Effect www.offe2008.org

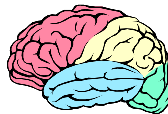
NAMI launches Veterans Resource Center

www.nami.org/veterans

NAMI launched its Veterans Resource Center, an online portal to mental health resources for America's veterans, active duty service members, and their families. In an effort to respond to these issues, NAMI's Veterans Resource Center features a growing compilation of fact sheets, self-help information, online discussion groups, research and policy updates, and links to government agencies and other private organizations. NAMI has made the Center a priority to meet a growing need.

The Center's resources are organized into 12 on-line categories:

- Posttraumatic Stress Disorders
- Traumatic Brain Injury
- Suicide Prevention
- Veterans & Mental Illnesses
- Veterans Affairs & Veterans Integrated Service Network (VISN)
- Families, Children and Spouses
- Women Veterans Resources
- Multicultural Resources
- Homelessness & NAMI's Missing Person's Network
- NAMI Veterans Council
- Online Discussion Groups



20,000 Vets' Brain Injuries Not Counted in Pentagon Tally

From USA Today by Gregg Zoroya

At least 20,000 U.S. troops who were not classified as wounded during combat in Iraq and Afghanistan have been found with signs of brain injuries, according to military and veterans records compiled by USA TODAY. The data, provided by the Army, Navy and Department of Veterans Affairs, show that about five times as many troops sustained brain trauma as the 4,471 officially listed by the Pentagon through Sept. 30. These cases also are not reflected in the Pentagon's official tally of wounded, which stands at 30,327.

[Editor's Note: Sonny Iovino was too sick to be allowed to stay on a street corner, too sick to be welcome on the campus of University of Iowa, too sick for Iowa City's homeless shelter, and too sick to be given the psychiatric medication he requested. After his arrest, Iovino was even too sick for the Johnson County Jail. Yet, Sonny Iovino was apparently not sick enough to be hospitalized and helped. He was, however, sick enough to die.]

HOMELESS VETERAN REFUSED HELP BEFORE DEATH

CEDAR RAPIDS GAZETTE (IA), November 20, 2007

Two days before Sonny Iovino died of exposure, he was released by a Veterans Affairs Medical Center doctor and turned away from the Johnson County Jail after police repeatedly found him behaving erratically and shedding his clothes.

On the advice of a social worker, police didn't try to take Iovino, 55, to a shelter, according to University of Iowa police incident reports The Gazette obtained.

Medical Center spokesman Kirt Sickels told the newspaper Monday hospital officials did all they could.

"If somebody doesn't want to be treated, you can't treat them," Sickels said. He could not disclose details about Iovino's medical history or immediately get information about Iovino's military service.

The nearly naked body of Iovino, a homeless Vietnam-era veteran who had frequented Iowa City for years, was found under the Benton Street bridge around 3:45 p.m. on Nov. 7. An autopsy confirmed he died of hypothermia.

Advocates say there's little the community can do to help if mentally ill people refuse treatment.

"If they don't want to go and if they aren't committed there's nothing anyone can do," said Gene Spaziani, former chairman of the National Alliance on Mental Illness of Johnson County. "They're on their own. That's the way it goes."

Reports The Gazette obtained show that, on Nov. 5, UI police found Iovino at 8:42 a.m. lying on the ground near the corner of Burlington and Madison streets. He wore no shoes, seemed confused and talked constantly as he dug in the mulch, the reports show.

"He was lying near the exhaust vent to keep warm," officer Eric Werling reported. "We asked Iovino to leave and he would not respond to our questions, but kept talking and crawling around on the ground."

Police persuaded Iovino to put on his shoes, cited him for trespassing and told him to move. At 11:29 a.m., they were called back to the UI's Lindquist Center and found an agitated Iovino wearing only pants. Again they got Iovino to dress and leave, reports show.

When police were called again less than two hours later, they took

Iovino to a psychiatrist at the VA center.

Iovino asked the psychiatrist for medication, but the doctor said he first needed an evaluation. When the doctor asked to take his vital signs, Iovino made what reports called an inappropriate comment. "I take that as a no," UI Police Officer Alton Poole reported the doctor as saying. The doctor released Iovino back to police.

A blood-alcohol test showed Iovino hadn't been drinking, but a medical center social worker said Iowa City's Shelter House wouldn't take him in his condition, reports showed.

The officers arrested Iovino and took him to jail, but deputies there wouldn't take him either. Johnson County Sheriff Lonny Pulkrabek told The Gazette the jail won't admit anyone with an immediate medical need. He said the doctor's note indicated Iovino needed hospitalization for mental illness.

Police cited Iovino for criminal trespass and released him with notice to show up for court on Nov. 20. He signed the charge and left the jail, walking south along Court Street - toward the Benton Street bridge, the reports said.

SCHIZOPHRENIA COULD TAKE FRED FRESE FAR AWAY, BUT IT ALSO GIVES HIM A NICHE IN LIFE WHEN REALITY ESCAPES

By Fran Henry, Plain Dealer Reporter
Cleveland, Ohio

On a business trip in 1967, Frederick Frese cracked the code of the universe -- a labyrinth of concepts and beliefs related to the number three. He suspected as much on his way to church, faithfully heeding traffic lights although he was on foot.

At red lights, he'd stop walking, no matter where he was on the block.

When he got to church, he knelt by the priest, and when the priest asked him to leave after Mass, Frese felt a change come over him. He barked like a dog, then grunted like an ape. He fell to the floor and writhed like a snake. A few life forms later, he became a tritium atom -- the kind used to build a hydrogen bomb -- and knew he was going to be split, triggering a nuclear blast to start World War III.

God, he believed, had chosen him for the mission.

"I was the instrument that would wipe out the universe," Frese said dryly, slouched in a lawn chair on the patio of his Hudson home.

He remembered blacking out at the altar. When he came to, he thought he'd triggered Armageddon and was in heaven.

In fact, he was strapped to a table in a psychiatric hospital. His elaborate delusions were born of schizophrenia, a brain disease characterized by the loss of contact with reality. The cause of schizophrenia is unknown, but thought to be an interaction of genetics with life experiences. The disease is treated with medication.

It wasn't Frese's first psychotic break, nor was it his last. He cycled in and out of mental hospitals for 10 years, escorted by men in white coats. And the respected professional would like everyone to know.

"I refuse to hide in the shadows and be ashamed," he said, a bit of his Texas childhood in his voice. "There's tremendous discrimination against [the mentally ill]. You can't put us in the back of the bus' in mental hospitals."

The mental health industry is built on confidentiality, he said, and secrecy only reinforces the stigma.

"It's so obvious to me that the people who say they are protecting us are perpetuating the shame. . . . The professionals shouldn't assume the patient is ashamed of the illness."

He speaks from the perspective of both patient and mental health professional.

Frese, 66, was unemployed for a year after his psychotic break in Milwaukee, his master's in international management useless with his medical history. When a friend suggested he could help him get a job in the state mental health system, he took the state test to be a certified psychologist. It was 1968, when a psychology degree was not required to take the test. He began working with the mentally ill in prison.

The work agreed with him, and he decided he'd need a doctorate in psychology to gain credibility in the field. He earned the degree in 1978, and was director of psychology at Western Reserve State Hospital, a now-defunct psychiatric hospital, for 15 years before he retired.

"I was able to keep a job," he said, ripping apart an onion bagel. "Isn't that amazing?" He buttered a bit, and chewed it thoughtfully. "If they hadn't come up with these wonderful pills, I'd still be hospitalized."

Frese is certain his illness gives him a better understanding of people with schizophrenia, and that his openness makes him a role model for others with the disease. He travels about half the year, giving speeches nationwide -- more than 2,000 so far. He's testified at congressional hearings and appeared on ABC's "Nightline" four times "when they needed a schizophrenic with a Ph.D.," he said, quite amused.

Changing attitudes about illness

Frese's speeches benefit mental health professionals, too, said Nancy Little, training director of Thresholds Institute, Chicago's largest mental health agency. "We were amazed that this person had an advanced degree and a high position in mental health. He totally changed our view of what people with schizophrenia could do."

And he has a one-of-a-kind ability to convey the experience of schizophrenia with humor, said Mark Munetz, chief of the Summit County Alcohol, Drug Addiction, and Mental Health Services board, where Frese works half-time coordinating recovery groups.

In fact, Frese delights in calling himself a stand-up schizophrenic. "That's my gig!" he said. "When I started speaking, people couldn't believe a schizophrenic could talk."

Actually, people thought schizophrenics could talk, but only to themselves on street corners. Frese was delighted when the 2001 film, "A Beautiful Mind," challenged that tired stereotype with the story of John F. Nash Jr. Nash, a mathematician with schizophrenia, won the Nobel Foundation's Sveriges Riksbank Prize in Economic Sciences in 1994.

"The movie resonated," Frese said. "We weren't portrayed as monsters like Hannibal Lecter or Norman Bates. I thought, Heh-heh, we schizophrenics aren't all useless after all.' "

Finding love, building a life

He hasn't been hospitalized since he met a Franciscan Sister of Penance and Christian Charity in 1976 at a meeting of Charismatic Catholics at Ohio University.

"I thought he seemed awkward and uncomfortable, so I went up to say hello," Penny Frese recalled. A close friendship developed, but he was slippery about his background, she said. Then one

afternoon, during a walk in the woods, he revealed his psychiatric history.

"Honest to God, I felt like I couldn't breathe," she said. "I'd just walked an hour into the woods with a man who's insane. I asked, Are you violent?' "

She researched schizophrenia, and found that the best predictor of recovery, according to one source, "is a long-term loving relationship." And she took that to include a close friendship. But she soon realized she couldn't envision life without Frese. "I went to him and said, I was thinking of marrying you, and he said, I've been thinking that, too.' And he proposed."

She left the convent, but before their wedding day, he had a psychotic break and insisted they stay in a hotel three days to evade "people" looking for him. "I thought, OK, I can handle this,' " she said. Marrying him, she said, was a leap of faith she never regretted. "I was so in love with him and still am."

They have four grown children, and each has a 10 percent chance of developing schizophrenia. Typical onset is late teens to early 20s for males, and as much as 10 years later for females. The Freses don't worry about the odds. "What if John Nash hadn't been born?" Penny Frese wondered.

Although her husband hasn't been hospitalized since their marriage 31 years ago, he has short periods of two days when he lives on another plane, connecting ideas and concepts, finding extreme significance in certain words, and researching arcane interests until "it all fits in a grand scheme," she said.

She sheltered the children from the episodes when they were small, said son Joe Frese, 29. "Mom would keep him in the bedroom and we weren't allowed to talk to him," he said. That changed after their father took his disease public. "Then he'd be dancing and singing in the kitchen," Joe Frese said.

"It was fun," Penny Frese said.

While the episodes don't reach the level of the psychotic break he experienced in Milwaukee, Fred Frese said they can signal that his mind is going places it might have trouble leaving.

Munetz, of the Summit mental health board, can tell when Frese is entering an episode. "His thinking gets disorganized. It's more grandiose than usual, or he starts wearing a hat."

The hat is what Ray Gonzalez remembers from the late '70s when he and Frese were colleagues at the mental hospital. Executive director of Planned Lifetime Assistance Network of Northeastern Ohio, a social service agency for people with mental illness, Gonzalez said Frese would slouch in the corner at staff meetings, a wool hat pulled down on his head.

"I didn't know he was ill," he said. The only thing that separates Frese from the homeless people with schizophrenia is medication. "They don't take their meds because they don't think they're sick," Frese said.

And he knows for sure that he is. He'd like you to pass it on.

UPDATE

Division of Mental Health and Disability Services

Administrator – Dr. Allen Parks

1. Child & Adolescent Bureau Chief – Pam Alger
   School Mental Health – Laura Larkin
2. Adult Bureau Chief – Dr. Kelly Pennington
   Emergency Services – Karen Hyatt
3. Older Adult Bureau Chief – to be hired

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 March 1) is $195.
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.

NAMI Walks for the Mind of America

SAVE THE DATE - Saturday, Oct. 4, 2008

The Susan G. Komen Race/Walk for the Cure will not be on the same date as NAMI Walks in 2008. NAMI Walks is on October 4 while the Race for the Cure will be October 25, 2008.

Dept of Veterans Affairs Letter from the UnderSecretary for Health

Dear Veteran,

If you're experiencing an emotional crisis and need to talk with a trained VA professional, the **National Suicide Prevention toll-free hotline number, 1-800-273-TALK (8255)**, is now available 24 hours a day, seven days a week. You will be immediately connected with a qualified and caring provider who can help.

Here are some suicide warning signs:

1. Threatening to hurt or kill yourself
2. Looking for ways to kill yourself
3. Seeking access to pills, weapons or other self destructive behavior
4. Talking about death, dying or suicide

The presence of these signs requires immediate attention.

If you or a veteran you care about has been showing any of these signs, do not hesitate to call and ask for help!

Additional warning signs may include:

1. Hopelessness
2. Rage, anger, seeking revenge
3. Acting reckless or engaging in risky activities, seemingly without thinking
4. Increasing alcohol or drug abuse
5. Feeling trapped -like there's no way out
6, Withdrawing from friends and family
7. Anxiety, agitation, inability to sleep - or, excessive sleepiness
8. Dramatic mood swings
9. Feeling there is no reason for living, no sense of purpose in life

Please call the **toll-free hotline number, 1-800-273-TALK (8255)** if you experience any of these warning signs. We'll get you the help and assistance you need right away!

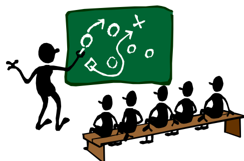
Sincerely yours,
Michael J. Kussman, MD, MS, MACP

It was reported there were 1500 phone calls the first month the hotline was activated. 50 of those calls resulted in rescues.

National Alliance for the Mentally Ill
of Greater Des Moines
5911 Meredith Drive, Suite E
Des Moines, Iowa 50322-1903

NONPROFIT ORG.
US POSTAGE PAID
DES MOINES IA
PERMIT NO. 34

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.



NAMI GDM Strategic Plan

On Saturday, Dec. 8, the Board of Directors and invited guests met to discuss 2008 plans and to finalize a strategic plan.

The strategic plan was finalized and has been posted to our website. To see the strategic plan, go to our website at: www.nami.org/sites/NAMIGreaterDesMoines and click on "About Us". Scroll down to the bottom of the page to find the Strategic Plan.

We also discussed assets, accomplishments, and proposed projects in the areas of organizational development, support, education, advocacy, marketing, special events, and fundraising.

There are some very definite volunteer needs that we have identified for 2008. These are the categories - we need leaders and committee members:

- ✓ Media/marketing person
- ✓ Veterans Liaison
- ✓ Hospital Exit Project Leader
- ✓ Food Systems/Mental Health Education Project Leader
- ✓ Grant Writer
- ✓ Youth Project Leader (Adolescent Support Group Leader/Kidshops)
- ✓ Faith Outreach
- ✓ Sales Table Coordinator
- ✓ Provider Training Team members

In next month's (February) newsletter, we will include a volunteer sheet that you can mail in to us. It will have a complete list of volunteer needs for NAMI Greater Des Moines as well as a list of volunteer needs for NAMI Walks.

Please consider helping us out with your time and talents.

The easiest way to assist us is to become a dues paying member. You can either go on-line at NAMI E-join at www.nami.org - or you can send a check to our Treasurer – Jim Vandeberg, 4114 Allison Avenue, Des Moines, Iowa 50310

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

What is Recovery?

Recovery does not refer to an end product or result. It does not mean that one is "cured" nor does it mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts one's limitation and discovers a new world of possibility. . . Thus, recovery is a process. It is a way of life. It is an attitude and way of approaching the day's challenges." ---Patricia Deegan, *The Conspiracy of Hope*

Essential Components to Promote Recovery

- Access to recovery-oriented mental health services
- Peer and consumer support and self-help groups
- Family and friend support and relationships
- Work, meaningful activity, and interests
- Self-determination
- Elimination of stigma and negative stereotypes about mental illness
- Community involvement
- Educational opportunities
- Access to training and technologies that foster recovery