



NAMI GREATER DES MOINES

AFFILIATE AND SUPPORT GROUP NEWSLETTER

January 2007
“Support, Education, and Advocacy”

<u>Education</u> Meetings are generally the 1 st Sunday of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room . Dates on Sundays other than the 1 st Sunday of the month are due to holidays or other special scheduled events. Caring and sharing will be held after the educational speaker has finished. See inside the newsletter for support groups.		<u>Business and Committee</u> Meetings are the 2 nd Thursday of the month at 4 P.M. at the NAMI-Iowa Office. <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Business</td> <td style="width: 50%;">5. Advocacy</td> </tr> <tr> <td>2. Marketing and membership</td> <td></td> </tr> <tr> <td>3. Support</td> <td>6. Fundraising</td> </tr> <tr> <td>4. Education</td> <td>7. Special Events</td> </tr> </table>		1. Business	5. Advocacy	2. Marketing and membership		3. Support	6. Fundraising	4. Education	7. Special Events
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4. Education	7. Special Events										
Sunday, Jan. 7	The topic will be eating disorders. Marvita McCown from Mercy Psychiatric Services will be our speaker.	Thursday, Jan. 11	We will be discussing and planning around 7 topic areas.								
	Wednesday, Feb. 1 Mental Health Advocacy Day at the State Capitol – There will be displays from a variety of organizations and agencies regarding mental health. You have an opportunity to talk to your legislators about mental health issues.										
Sunday, Feb. 4	The topic will be children and adolescent mental health disorders. Carolyn Hejtmanek from Orchard Place will be our speaker.	Thursday, Feb. 8	We will be discussing and planning around 7 topic areas.								
Sunday, March 4	The topics will be an overview of Mental Health Disorders and the Mobile Crisis Unit – Larry Hejtmanek, founder of the Mobile Crisis Unit will be our speaker.	Thursday, March 8	We will be discussing and planning around 7 topic areas.								
	Thursday, March 8 NAMI Family to Family educational course begins. Call Teresa at 274-6876 or the NAMI Iowa office at 254-0417 to sign up.										
Sunday, April 1	Recovery and Schizophrenia – and – U. of Iowa Research programs Speakers will be Nancy Hale and her son, Courtney	Thursday, April 12	We will be discussing and planning around 7 topic areas.								



Volunteer opportunities abound in our organization. We do not have paid staff so we rely on generous people such as yourself to volunteer the time you feel is available to help out with the activities which are most important to you.

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

2-3 hours per month

- Sunday affiliate meetings - help with the set up and take down of resource table, volunteer sign-up and sales table.
- Newsletter committee – collate, staple, and ready the newsletter for mailing.
- Be willing to share your story as part of a presentation to various groups.

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

- For Family to Family educational classes
- For Visions for Tomorrow educational classes
- For Peer to Peer educational classes
- For Provider educational classes
- Support Group facilitator (involves once a month 2-1/2 hr commitment of time)

Committee assignments:

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

NAMI Walks – October 2007

- Fundraising
- Marketing
- A job on the day of the walk
- Committee work



You can e-mail your interest for any of the above to tbomhoff@mchsi.com or leave a voice mail at 274-6876. There will also be sign up sheets at the Sunday affiliate meetings.

Becoming a member of NAMI Greater Des Moines is a great first step. The foundation of our organization will always be membership dues. Have you become a member yet? We need you.

Your help will be most appreciated. Thanks.



CONFUSED ABOUT DUES?

NAMI of Greater Des Moines, NAMI Iowa and NAMI National are separate non-profit organizations even though GDM is an affiliate of the state organization, and the state organization is part of the national organization.

If you pay dues directly to NAMI-National– you only have a national membership.		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	No membership	No membership
When dues are paid to NAMI Iowa – you have a state membership and a national membership		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	No membership
When dues are paid to NAMI Greater Des Moines – you have NAMI GDM membership, a state membership, and a national membership (3).		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	Yes

By paying \$35 for an individual/family membership to NAMI GDM – you help to support all 3 organizations.

NAMI National has a quarterly magazine, the “NAMI Advocate”.
 NAMI Iowa has a quarterly newsletter.
 NAMI Greater Des Moines has a monthly newsletter.

2007 NAMI Greater Des Moines

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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). Call the NAMI office to sign up –254-0417. **The next Family to Family class will be in the spring starting March 8.**

SUPPORT GROUP MEETINGS

Family members, if you are interested in participating in a support group, please contact our Vice-President – Dr. Bobby Dickerson
 Work phone: 288-1914 Cell phone: 979-8390
 E-mail: bdickerson@paccdisciples.org – The next support group meeting is Sunday, Jan. 28, from 2-3:30 PM at Park Ave. Christian Church – 3219 SW 9th St., Des Moines.

🕒 **First Monday of each month – 6 – 8 PM** - a support group for parents and caregivers of children with severe emotional disturbance (SED) or mental illness – meets at the Child Serve Center – 5406 Merle Hay Rd, Johnston. For more information – call Diane at 255-8157 or Mary Ann at 883-8014. For newsletters, go to <http://www.iffcmh.org/newsletters.htm>

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

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

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

Every Tuesday morning – 11 AM to Noon- A consumer support group – Wellness Recovery Action Planning – meets at the Res-Care Hope Center at 602 E. Grand. Call Deborah 283-1230 for more information.

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

Every Thursday from 1 PM-2PM – Procovery Circle – a support group for persons with severe mental illness – meets at Res-Care Hope Center at 602 E. Grand. Call Gina Shelley 283-1230.

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

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

Every Saturday morning – 10 A.M. A group of people who have depression will meet at Lutheran Church of Hope, 925 Jordan Creek Parkway, Call 222-1520, ext. 175.

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

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

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

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



The Mental Health Advocacy Coalition is asking for Your Help.

We would like to compile stories that illustrate mental health issues. These can be anecdotes or human interest stories which help to identify important mental health issues and problems – stigma, lack of access to services, your story and struggle in dealing with mental illness, mental health problems of returning soldiers, importance of the right medications, lack of funding, etc – real stories of Iowans.

Copies of your stories should be sent to CeCe Arnold at ncrlcca@mchsi.com. The person sending the story should “de-identify” information in the story for replication purposes but still provide attached identifying information to Cece in case she needs to contact you. Anyone with writing skills who would like to help with this project should send an E-mail.

www.nami.org/travel



NAMI now has its own travel web site. This new service is like having our own Expedia. You get access to the same airlines, hotels and rental car companies, cruises, and vacation packages you find on all the other major travel web sites – and low travel prices. Every time you use a travel web site like Expedia, the travel companies pay big commissions for your reservation. Now, if you book through NAMI, 40% of the commissions will help to improve the lives of people living with mental illnesses.

2007 NAMI National Convention



The 2007 Annual NAMI Convention will be held at the [Town and Country](#) Resort in [San Diego](#), CA June 20 – 24. Online registration is now open. Find out more at www.nami.org/convention!

NAMI Members are eligible for a special First-on-Board rate of \$175 if they register by December 31! If you would prefer to register by mail, a registration form will be printed in the fall issue of *The Advocate*, which has been mailed out in November 2006.

Hotel reservations can be made by calling 1-800-772-8527. You must make your reservation by May 18, 2007 and tell the reservations clerk you are attending the NAMI Annual Convention to receive this special convention hotel rate.



NAMI Teams Up With New Online Community HOTSOU.P.com

HOTSOU.P.com is a forum where people like you can voice your opinions on issues that matter. Join national and grassroots leaders from across the country in meaningful and constructive dialogue.

NAMI is among the first to be part of this just-launched online community, along with Bill Clinton, Lance Armstrong, Mary Matlin, John McCain, Donna Brazile, Jon Bon Jovi, and countless others.

With your participation, we hope to use this platform to raise the profile of mental illness as a national issue, and ensure that the voices of those affected by mental illness are part of the national dialogue.

Come take part in NAMI's Issue Loop – Mental Illness and Society. Weigh in on topics such as "Is mental illness ever funny? Where does humor stop and stigma begin?", "How would you rate mental health care in your state?" and "How big a role does faith play in healing?"

HOTSOU.P.com offers: panels featuring well-known community members discussing today's hot issues, an interactive section that contains polls and opinions, and much more. Just go to <http://www.hotsoup.com/>, click the "Sign in" link, and you're on your way to discussing and publishing what matters most – your opinion. Simply search for "NAMI".



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**.



\$4/generic prescription at Target & Walmart in Iowa

Target Corp.'s announced Nov. 20 that it will offer its own \$4 generic prescription-drug program at all of its 1,287 pharmacies nationwide.

Wal-Mart has accelerated its program to sell 30-day supplies of 314 generic drugs for \$4 each. The program, started in Tampa, Fla., on Sept. 21, now covers 38 states and 3,009 pharmacies, or roughly 75 percent of Wal-Mart's stores nationwide.

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



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

Several Schizophrenia Studies are also at the U. of Iowa

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

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

- Diagnosis and Phenomenology
- Anatomic Magnetic Resonance (MR) Imaging: Brain Structure
- MR Spectroscopy: Brain Chemistry
- Positron Emission Tomography: Brain Blood Flow
- Functional Magnetic Resonance Imaging: Brain Function
- Cognitive Neuroscience: Cognitive Functions
- Clinical Neuropharmacology: Drug Response and Clinical Trials
- Genetics/Epidemiology: Molecular Genetic Studies
- Collaboration with the Mental Illness and Neuroscience Discovery (MIND)

To participate, contact Frank Fleming, BS, BSN
Phone toll free: 1-877-575-2864

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

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

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: bomhoff@mchsi.com



NIMH Study of Schizophrenia Drugs Requires "New Thinking" in Research, Not Restrictions Based on Cost

Statement of Ken Duckworth, M.D., Medical Director, National Alliance on Mental Illness December 1, 2006

The third installment of studies funded by the National Institute of Mental Health (NIMH) on the treatment of schizophrenia with anti-psychotic medications confirms a basic fact that many physicians, consumers, and policymakers already know. "First generation" generic drugs cost less than "second-generation" advancements.

The study's significance lies in its limitations. Where it falls short precisely defines issues that remain to be explored over time.

Previous installments of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) have shown that as a class, the second generation of drugs for treating schizophrenia generally is no more effective than first generation. However, broad findings remain subject to the fact that "one size does not fit all" in choosing the right medication for a patient—which NIMH itself has emphasized.

*In an explicit warning to Medicaid state programs and the managed care industry, CATIE III states: "Treatment decisions must be based on the clinical situation of each individual patient. This study clearly **would not justify** policies that would unconditionally restrict access to any particular medication or that would thoughtlessly force patients or doctors who are satisfied with a current treatment to change to a treatment just because it might be less expensive."*

The American Journal of Psychiatry also chose to publish the CATIE III findings despite what it calls in an editorial "serious reservations" about the study's methodology. They include: CATIE excludes "first episodes" involving the onset of schizophrenia—**the very point in which the initial choice of medication may be most important in minimizing damage and maximizing opportunities for improvement over time.**

The 18-month period of study, although superior to most other clinical trials, is still not long enough to reveal the development of tardive dyskinesia or other serious side effects that may differ from drug to drug.

Methodology is still "too crude" to demonstrate differences between specific medications that are important for individual patients. "Failure to find difference does not mean there is no difference," the Journal's editorial warns.

The Journal editorial also reflects a fundamental concern that NAMI has consistently stated as the CATIE findings have unfolded. The time has come for a third generation of medications for schizophrenia. It notes that second generation drugs "have primarily changed side effects, rather than clinical efficacy." But it is important to understand that in terms of side effects, the choice of first generation drugs runs the risk of permanent, untreatable, debilitating and stigmatizing movement disorders.

The Journal calls for discussion now of what "drug discovery model" can best improve treatment of schizophrenia. Greater scientific research must fuel that discussion. The most important contribution of the CATIE studies lies in stimulating "new ways of thinking" about medication treatment for schizophrenia, and providing a base for the next generation.

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.

1. Mental illnesses are prevalent.
2. Mental illnesses are treatable.
3. Mental illnesses are 'no fault'.
4. FAMILIES are members of the treatment team, and safety-nets for their loved ones who are experiencing first time psychosis, or relapse.



Iowa Federation of Families for Children's Mental Health Website at: www.iffcmh.org - go to library of information then go to resources. Listed below are a few new resources:

--*A Family Guide to Wraparound* (this is a great resource for anyone not just families)

--*Staff Guide for Working with Problem Behaviors* (although this says staff guide it is an exceptional resource for families, teachers and others who work or live with children and adolescents with problem behaviors)

--*Going Places Iowa Residential Educators Directory of Youth Services in the State of Iowa.*

Many more resources are available. Check them out share the information with others who live with or work with children who have mental health needs.

Lori Reynolds, Executive Director
Iowa Federation of Families for Children's Mental Health
106 South Booth, Anamosa, Iowa 52205
Phone: 319-462-2187 Toll Free: 888-400-6302
Fax: 319-462-6789

Lori@iffcmh.org www.iffcmh.org



Sign up for the next "**Visions for Tomorrow**" class. It is an 8 week course (1 night a week for 2-2 ½ hours) for parents, foster parents and other caregivers of children and adolescents who have serious emotional disorders. Curriculum includes types of mental illnesses and emotional disorders as well as instruction on coping skills; dealing with schools; communication; medication; rehabilitation, recovery, and transition; and advocacy. Call the NAMI office to sign up – 515-254-0417. The class this fall started on Sept. 19. **The next class will be in the spring.**



**From Kevin Concannon,
Director of the Iowa Dept. of Human Services**

I'm pleased to advise that after a search of candidates within the state of Iowa and nationally I have appointed a Director for the Division of Mental Health and Disability Services.

Dr. Allen W. Parks will be joining us fulltime beginning December 1, 2006. Dr. Parks was both my top selection out of the 49 candidates for this position as well as the unanimous first choice selection by the nine members of the interview panel representing the majority of stakeholders in Iowa's mental health and disability services systems.

Dr. Parks is a clinical psychologist by training with broad-based leadership, clinical experience, quality management, and teaching background. He holds a Doctorate degree from Boston University, a Masters degree in Psychology and Counseling from Assumption College in Worcester, Massachusetts; a Bachelor's degree from Calvin College in Grand Rapids, Michigan; and a Master of Public Health degree from the Harvard University School of Public Health.

Dr. Parks has served as a county level director of human services here in the Midwest, served as a Quality Improvement Director at the Mental Health Authority in the District of Columbia, he has worked for a behavioral health managed care entity and has a variety of behavioral health experiences in state government and private, non-governmental organizations.



(Excerpts from) **The Plan to Nowhere**

SEATTLE WEEKLY— March 8, 2006 – by Philip Dawdy

Larry Govea pulled himself off the streets of Seattle and out of homelessness 10 years ago. He was sick of sleeping in his car and of living in high-rise crack houses, as he calls some of the homeless programs in which he's lived. Govea has no better than a sixth-grade education but nowadays reads Plato and Diogenes. But in

three weeks, he faces the prospect of being forced from his small one-bedroom cottage in West Seattle, his home for 10 years, and back onto the streets.

"I don't think I can do it again," he says of possibly sleeping in his old yellow Ford van. "It'd make me crazy. I don't want to go crazy," says Govea, 63, who lives on disability payments and a housing subsidy.

The consolations of philosophy can only take a person so far.

This is not supposed to be happening. Scores of cities and counties around the country have recently adopted plans to end homelessness within 10 years. Yes, end.

King County, Seattle, and other area cities ceremoniously rolled out their version of the plan last summer. It calls for permanent housing for the homeless instead of a mat on the floor of a traditional homeless shelter. Its intent is to prevent people like Govea, who are at risk of homelessness, from ending up on the streets. It's the largest experiment to end homelessness since the latest wave of homeless hit America's streets in the mid-1980s.

For the past 20 years, attempts to end homelessness have been largely motivated by ethics and a general sense that it's shameful for 3 million people to be homeless in the world's richest country. But good intentions in the form of a fragmented, gridlocked system of homeless shelters, transitional housing, and soup kitchens have not fixed the problem.

"The very definition of insanity is to keep doing the same thing over and over again, expecting different results," says Philip Mangano,

executive director of the Bush administration's Interagency Council on Homelessness.

Mangano's definition of sanity is to recognize that it is far cheaper to provide homeless people with permanent housing than to let them bounce from the streets to jail to a hospital emergency room. Housing First, as the approach is known. It's supposed to be better, faster, and cheaper.

Mangano and others argue that, enlightened by potentially billions of dollars in cost savings, policy-makers, Congress, and state legislatures will open the public purse and fund permanent housing projects and medical services. The experiment is broadly known as "The 10-Year Plan to End Homelessness."

But while touting a new approach, crucial cuts are being made to housing and medical programs, especially ones serving the mentally ill, needed for ending homelessness. The city of Seattle, too, is making service cuts. As a result, St. Martin de Porres, a downtown homeless shelter that houses 212 older men each night, will close two days a week—and those men, many disabled, will hit the streets.

Homeless in Seattle, they'll inevitably run into the Seattle police, who are often pressed into service trying to unlock a gridlocked system of social services for them. On a recent night, Seattle police sent a special squad into the streets to coax the most hardened of the homeless into an emergency shelter on one of the coldest nights in years. Led by SPD Sgt. Paul Gracy, the police ran into the same kind of disconnects that have Govea sitting up late at night.

It sure is a funny way to start a social experiment, particularly when Seattle and King County are considering spending hundreds of million of dollars to build a new home for the Seattle SuperSonics.

Life After Hooverville

The last time America made such a sweeping social experiment was in the 1980s. President Reagan had been voted into office in 1980 to go after the Soviet Union, cut taxes, and disembowel the so-called welfare state.

Soon after, the Reagan administration oversaw the deinstitutionalization of hundreds of thousands of mentally ill from state hospitals and offered these same helpless people no housing. They cut tens of billions from public-housing programs, aimed at the working poor and the medically indigent. One homeless advocacy group estimates that the feds have cut public housing by \$52 billion over the last 25 years.

It was the imperfect storm and created a problem. America was the country that had learned from the Great Depression—when cities like Seattle had their own Hoovervilles—that it was unconscionable to kick your fellow countrymen to the curb.

By the late '80s, millions of Americans were living on the streets, camping in canyons, and sleeping in cars. No one seemed to have the answer for what to do about it. It became such a moral crisis that President George H.W. Bush proposed a system of "a thousand points of light"— in essence, trying to solve the problem through private charity and volunteerism. Hollywood celebrities organized fund- raisers. Politicians went to great lengths to show how much they cared about the homeless. San Diego's mayor costumed herself as a homeless woman and slept on the streets one night in a cardboard box.

In the early 1990s, homelessness lost its cause-célèbre status. Nothing worked, and good-natured people wearied of trying to engineer a fix. The Bush I and Clinton administrations did not come through with housing dollars. So, the condition of homelessness became normal, a regular feature of urban life in America that

doesn't exist in countries like Sweden and Japan. People got used to the idea of having to push past someone begging for money outside of a QFC or of men dropping dead in homeless shelters, as happened in Seattle three weeks ago.

The homeless were just another inconvenience in a busy day—one of those problems of modern life that are sad but insoluble.

But the Bush administration has insisted for the last few years that an end is at hand. The answer is to provide permanent housing with social services. You don't even need to get offended at the prospect of tax dollars going to support people many consider losers. This way will save money.

Mangano and others point to a series of studies that in recent years have tracked some of America's most hardened homeless—the ones who wind up in emergency rooms many times a year, who end up in jail several nights a year, who end up in psych hospitals and substance abuse programs. Studies in Boston and San Diego found that people like these can chew up \$50,000 a year in costs that the taxpayers pick up one way or another.

A Seattle version of the study confirmed that a sample of the so-called chronically homeless here racked up costs of about \$50,000 a year per person. The Seattle study also found that the same people could be taken from the streets, housed, and offered regular health care and other services for about \$13,000 a year per person.

Around the country, police officers, ER doctors, and social workers have pointed to this disconnect for years. That if someone doesn't have a home, then they end up costing a hell of a lot of money.

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/>

Impossibility – a word only to be found in the dictionary of fools.

Napoleon Bonaparte, Emperor of France

A book for all of us to read - **The Mad Among Us: A History of the Care of America's Mentally Ill** – written by Gerald N. Grob, a professor at Rutgers University. We're going backward in our country. We're locking up the mentally ill in jails and prisons, and that's exactly where they started out.



DVD's Related to the Theme of Mental Illness

A Beautiful Mind
The Aviator
The Caveman's Valentine
Monk
The Hours



DALLAS MORNING NEWS, September 3, 2006

1. SHE'S ILL AND ALONE, BUT SOMEONE'S DAUGHTER

By Steve Blow

She sits in the park across the street from the newspaper. Hour after hour, she sits there.

Her blond hair makes her stand out. It's cut above the shoulders, almost stylish. She doesn't look like she belongs on the streets.

But wherever she sits, three overstuffed bags and a filthy overcoat are always pulled close by, unmistakable evidence of a lost soul.

Periodically she gathers her things, drapes the old dress coat over an arm and strolls awhile. But soon she alights again on a park bench to sit and stare.

It's hard to guess her age. Late 30s, maybe? Still young enough to be somebody's baby. You look at her and know there's a heartsick mama somewhere.

Mental illness is obvious. It's in her calm, placid manner. It's in the fact that she is always alone. The other women on the streets, the dope addicts, they're twitchy and always with a man.

She is always, utterly alone.

I assumed she would soon disappear. They always do. Out my office window, I see a parade of homeless characters come and go through that park. Few hang around long enough to become recognizable. Or maybe I just don't try. "Homeless" is a convenient catchall. But that blond hair made me see a person, not a label.

Somebody's daughter.

I hesitated to approach her. I did not think it would go well. I knew the odds of steering her to help were almost nil. That's the nature of mental illness.

But as the brutal summer wore on, as her face looked more seared, I figured I had to try.

At the very least, maybe she could reassure me that she fares better than it appears.

Nervously, I approached her. "Hi. Could I talk to you a minute?" I said, trying to sound as non-threatening as possible.

"I'll move and let you sit here," she said apologetically, gathering her things from the bench.

"No, no, that's OK," I said. "I work over at the newspaper. I just wondered if we could talk."

"You mean like an interview? For a job?" she said, brightening.

"Are you looking for a job?"

"Yeah, yeah, I am," she said. "I'm thinking about going into room and board. That would be nice, wouldn't it? Room and board? Lois Lane never worked on that."

"Excuse me?" I said, not sure I could have possibly heard right.

"Lois Lane never worked on that," she repeated, words that only made sense to her. "Well, I need to get going," she said, edging away.

"Can we talk a minute?" I asked again.

"Let me think about it. I just talked to a young woman over there," she said, pointing across the park, "and it was nice." But she was leaving even as she said it.

Last week I approached her again. She stood beside a bench this time. "Good morning. Remember me?" I said. "Can we talk a minute?"

She looked confused. "Oh, I didn't get that," she said.

"I'm from the newspaper. You said you would think about talking to me."

"Oh, I hope I didn't assume anything," she said, bewildered.

"No, no, it's OK," I reassured. "I just wondered if we could talk a minute about your situation."

Her expression changed in an instant. Her eyes narrowed into a cold stare as she began reaching for her bags. I had said the wrong thing. I had intruded.

"It's not possible," she hissed. Or maybe, "It's not a problem." I didn't understand clearly because she was already fleeing.

I felt terrible about agitating her. I worried that I might have permanently scared her away from whatever safety she feels in the park.

But moments after I returned to my desk, there she was again outside my window, staring into space.

And I wonder: Who has lost sanity here? A lost soul in the park? Or the rest of us?

How did we reach this point as a society? Desperately ill people wander our streets and we allow it out of a twisted notion of "respect."

Real respect for that poor woman would mean clean clothes and a shower, a cool place to sit by day and a safe bed at night – the very things her illness now deny her.

How do we regain our sanity?

DALLAS MORNING NEWS, September 9, 2006

2. BECAUSE SABRINA'S NEUROSIS IS BENIGN, SHE'S LEFT, ALONE

By Steve Blow

Still she sits. And unfortunately, so do we.

In last Sunday's column, I asked who has lost their sanity: the homeless, mentally ill woman who sits hour after hour in the park across the street?

Or a society that has somehow decided that's OK?

I'm ready to proclaim that we're the crazy ones here.

And I hope we can agree that it's high time to get our thinking straight.

To briefly recap, for about the last two months, a blond, 30-something woman has taken up residence across the street from the newspaper in downtown's Ferris Plaza.

She doesn't sleep there. Police won't allow that. She must have a hiding spot nearby, probably behind some shrubbery.

But by day, hour after hour, she sits alone in the park with her three stuffed bags and filthy overcoat pulled close by, staring into space.

I have learned a little more about her since last week. She's too skittish to talk to anyone for long, but she has told others that her name is Sabrina.

She told one concerned woman who works nearby that she's from Houston and that "my mother is mad at me."

Beyond that, what little she says is the nonsense of profound mental illness.

Yet our mental health system is so out of kilter that doing absolutely nothing for Sabrina is considered showing her respect.

And by the way, as I write this, Sabrina has just ambled through the corner of the park outside my window, looking even more gaunt and bedraggled.

I learned that mental-health professionals are well aware of her.

And other outreach specialists stopped by the park to see her after reading my column.

But they all agree there is no way they can force her into treatment.

"We offered our services," an earnest mental health agency director explained, "but she declined."

Well, of course she did. She's mentally ill!

Keith Frazier of Adapt Community Solutions sighed patiently as I fumed over the absurdity of expecting a mentally ill person to think rationally and logically about her need for help. If Sabrina could think rationally and logically, she wouldn't need his help.

But as things stand, the mentally ill can't be forced into treatment unless a judge declares them "an imminent danger to themselves or others."

So if you care about Sabrina, pray she snaps out of her placid, passive state and starts waving a knife.

It's the only way she's going to get any help.

Common sense, of course, tells us that a woman living alone on downtown streets is in danger.

Maybe it will be the first cold snap that gets her. Maybe it will be a human predator. But as Tim Simmons of the local Mental Health Association grimly observed, "One day she will be gone."

If there is any good news, it's that Mr. Simmons and some others in the mental health community are waking up to this shameful situation. "There is a very strong internal debate," he said. "The division is around the notion of: 'Do you have the right to tell me to get treatment?'"

As we talked, a group of professionals happened to be meeting in the next room to discuss the homeless and what's called "mandatory treatment."

"Ten years ago, it would be one in favor and nine against in there," Mr. Simmons said. "Today it will be five and five."

But that five-and-five deadlock still leaves us stuck – sitting as idly as Sabrina.

For those closest to the problem, this is a no-brainer: Of course there should be mandatory treatment. I heard last week from heartbroken parents who told me of pleading for their adult children to be forced into mental treatment. Instead, their children ended up just like Sabrina – or worse.

"There really needs to be a major overhaul of the mental health system," said Dave Hogan, manager of Dallas' crisis intervention program.

"Right now, it's really not a 'system' at all," said assistant manager Ron Cowart. "It's in complete breakdown."

So Sabrina goes on sitting. And so do we.

DALLAS MORNING NEWS, September 23, 2006

3. A DOOR OPENED FOR HOMELESS WOMAN, BUT SHE COULDN'T GO IN

By Steve Blow

It was a heart-piercing sight on Friday morning – Sabrina back in the park, staring into space again.

After she came so close to the help she desperately needs, Sabrina's mental illness has put her right back where she started – alone and homeless, sitting on a park bench for hours at a time.

Tim Simmons, president of the Mental Health Association of Greater Dallas, was in despair Friday that all efforts to help Sabrina had come to naught. "I don't know what to do!" he moaned.

And that statement really says it all. Our current system leaves even professionals in the field frustrated and powerless to help those who won't help themselves.

While Sabrina's future may be uncertain, she has at least made it clearer than ever that we must change our laws to allow involuntary treatment for people like her.

"It's a debate whose time has come. We have to arrive at some common sense," said Julie Metzinger, public policy director for the Mental Health Association.

For those who missed previous columns, back during the hottest days of summer, I noticed that a blond woman had taken up residence in the small park across the street from the newspaper.

She appeared mentally impaired, and that was confirmed when I tried to talk to her. She veered off into irrational references to Lois Lane and looking for a job "in room and board."

I would later learn that her name is Sabrina, that she is 42 and is well-known to the city's homeless outreach team. She has lived off and on the streets for several years.

Her mental illness makes her highly resistant to getting help. But because she doesn't meet the legal threshold of being "an immediate danger to herself or others," no one can force Sabrina into treatment.

So there she sat in the park again on Friday – thanks to our society's misguided notion of respecting her rights.

After reading the previous columns, a suburban woman who has a grown daughter with mental illness went to see Sabrina in the park. She persuaded her to go home with her for a few days of rest and care.

The woman has requested anonymity, so let's just call her Ms. Samaritan. With some research, she found Sabrina's family in the area and contacted them.

The story she heard is a familiar one – mental illness that appeared in the teen years, repeated failed attempts to coax Sabrina into treatment, growing tension, estrangement and, finally, loss of all contact.

"It's the nightmare I feared when I first learned my daughter had mental illness," Ms. Samaritan said.

After my columns and Ms. Samaritan's successful intervention, the local mental health community rallied to help Sabrina. A spot for her was secured at Safe Haven, a group home for those with mental illness. Such facilities are rare, and for Sabrina to be welcomed there was a real victory – especially since she has no disability income.

But when Ms. Samaritan drove Sabrina to Safe Haven on Thursday evening, insanity trumped reason. "She wouldn't budge. She wouldn't even get out of the car," Ms. Samaritan said.

"A resident came out. She was very nice and did her best to tell Sabrina it's a good place and so much better than living on the street. But she just shut down."

Ms. Samaritan sighed. "I don't know the answers. I just know legislation needs to change," she said. "She is obviously not able to make good decisions for herself."

Ms. Samaritan had made clear from the start that she could not take in Sabrina on a permanent basis. So Thursday evening, she did the only thing she could do. She returned her to the park.

"This isn't what I want," Sabrina said when they arrived there.

"But this is what you have chosen," Ms. Samaritan told her sadly.

"I have enjoyed my time with you," Sabrina replied.

With that, the two women hugged. And then they parted – one with a broken mind, one with a broken heart.

DALLAS MORNING NEWS, November 12, 2006

4. BY LAW, WE CAN AID MENTALLY ILL - AND WE MUST

By Steve Blow

She has no idea how many people care about her. But everywhere I go these days, I hear the same question: "How is the woman in the park?"

And I can only answer feebly, "OK – I hope."

It has turned into a crazy situation. When I first wrote about Sabrina, I was worried sick about constantly seeing the homeless, mentally ill woman in the park across from the newspaper. Now I worry that I don't see her there.

I know she still sticks close to this corner of downtown. But since I no longer have her in near-constant view out my office window, I'm always afraid the worst has befallen her.

Can you imagine what it must be like for the family of someone like Sabrina – who refuses all treatment and offers of a safe bed?

Sabrina, 43, has given me a taste of that helplessness and despair. We got another glimpse of it during the past week through the excellent, wrenching stories about Rosie Sims. Like so many others with mental illness, her journey ended with death in a jail cell.

In earlier columns, I expressed dismay that our mental health system basically leaves people like Sabrina and Rosie to fend for themselves. In a noble, misguided notion of respecting their rights, we allow people with serious brain impairments to refuse treatment.

It's as if we suddenly decided to respect the "right" of Alzheimer's patients to wander wherever they please. Sounds ridiculous, but that's basically the situation with so many of the people we call "homeless."

In truth, they are simply ill. They have a brain illness that impairs their judgment – tells them they have no illness, in fact. Yet our mental health system shies from forcing them into treatment.

I thought this absurdity was imposed on us by outdated laws. But I was appalled to learn last week that's not the case.

"Texas has a good law. It's just not used very much," said Mary Zdanowicz, executive director of the Treatment Advocacy Center in Arlington, Va.

That center pushes states to pass common-sense laws allowing for the caring, coerced treatment of people with serious mental illness.

In Texas, we just need to wake up and use our law. "There really ought to be a sense of public outrage that people can be helped and they're not," Ms. Zdanowicz said.

OK, count me as outraged – especially when I hear that San Antonio is already putting the law to work. There and in other places around the country, they are getting sick people off the streets, out of the jails and into proper, court-mandated treatment.

Dr. Jerome Byers, a longtime local advocate for the mentally ill, put it well when we visited last week. "It's high time to quit talking and start doing," he said.

The first, cautious steps are being taken here. But we need a sense of urgency.

So how is Sabrina? For my own peace of mind, I went in search of her last week.

I found her not far from the park, squatted atop one of her duffle bags. Though it was a hot afternoon, she wore a woolen overcoat. Another coat rested on the other bags clustered around her.

She sat with her knees drawn up close. Her face looked haggard. She stared blankly ahead.

I wrestled with whether to speak to her. Still unsure, I said casually, "Hi, Sabrina."

She gave me a silent, half-hearted wave. There was no look of recognition. Neither was there any hint of surprise that I knew her name.

"I'm the newspaper guy," I said. "Are you OK?"

And with that, a look of fierce defiance flashed across her face. Without a word, she jumped up and began reaching for her bags.

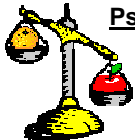
"No, no," I said. "You don't have to leave. I'll go." And I immediately walked away, sorry I had upset her. A block away, I allowed myself a peek back over my shoulder.

I was relieved to see that she had settled back to her spot, hunkered there on a busy downtown sidewalk, staring into space again.

In the solitary confinement of her mental illness, she has no idea how many people care about her.

I only hope she can hang on until we find the will to help her.

"As for me, you know I shouldn't precisely have chosen madness if there had been any choice. What consoles me is that I am beginning to consider madness as an illness like any other, and that I accept it as such. – Vincent Van Gogh



Psychiatric crisis beds in Des Moines

Broadlawn's 24-26 (lower level is used for storage)
Mercy Franklin – 24
Iowa Lutheran – 60 beds (34 for adults)
110 crisis beds? – Am I missing any?

Polk County's population is 401,066

1% of the population has schizophrenia – over 4000
1.2% of the population has bipolar - - close to 5000
5-10% have depression – over 30,000

39,000+ people with brain disorders

With an average of 3 relatives per person = 117,000
117,000 relatives + 39,000 persons with brain disorders =
156,000 lives affected

Of the 156,000 lives affected, how many businesses are affected?
How many school systems are affected?

Does anyone see a shortage of health services here?



Books Related to the Theme of Mental Illness

Divided Minds by Pamela Spiro Wagner and Carolyn Spiro, M.D.

72 Hour Hold by Bebe Moore Campbell

Sufficient Grace by Darnell Arnoult

Crazy by Pete Early

Shock by Kitty Dukakis

The Innocent Man by John Grisham

The Ghost in the House by Tracy Thompson

Lincoln's Melancholy by Joshua Wolf Shenk

Never Have Your Dog Stuffed by Alan Alda

What's Going on in another "F" State?

MAKING A CRIME OF MENTAL ILLNESS

Editorial Excerpts- BRADENTON HERALD (FL),
November 29, 2006



Out of sight, out of mind will no longer suffice as Florida's solution for its growing population of mentally ill persons - especially if the preferred hiding place is the county jail.

The Department of Children and Families faces a long-overdue challenge of its practice of stashing people with serious mental issues in county jails and then ignoring them. The challenge is being made by circuit judges in several state jurisdictions who consider DCF's non-response to the problem an act of contempt of the court. One judge, Crockett Farnell of Pinellas County, last week issued DCF Secretary Lucy Hadi seven counts of criminal contempt for ignoring his orders to clear the Pinellas County Jail of mentally ill inmates who have exceeded the 15-day maximum provided by state law for mental assessment.

Asked if he would have Hadi jailed, the judge responded, "Oh, I'd love to. I'll do whatever I have to do to get somebody's attention."

But the state is forcing counties to keep such inmates in jail for an average of around three months - six times what the law says it should. That's what has judges like Farnell in St. Petersburg fuming - and threatening to jail the DCF secretary and to court-order inmates into private facilities at a cost of \$800 per day.

DCF officials say they have no choice, given the state's shortage of secure psychiatric beds. Following the state's restructuring of mental health care in 2000, there are just 1,400 such beds in three state institutions statewide, while some 1,483 inmates were declared incompetent in 2005 alone. Obviously, the inflow of new patients overwhelms the existing facilities.

No wonder the National Alliance for the Mentally Ill rates Florida an F in its state-by-state report card on mental health services. Florida ranks 48th among the 50 states in mental health funding.

Patient Services Cut Back

DCF officials claim to be mystified by the sharp increase in the number of inmates ruled incompetent in the last few years. They shouldn't be. Policies by the governor and Legislature have had a direct impact on the spike in mentally ill people being arrested. A big contributor was the state's Medicaid reform effort of 2005. In changing the criteria for who is eligible to get mental health care and related services, the state simply lopped off nearly 5,900 mostly elderly patients who had been getting assistance. By definition among the poorest of the poor, these people were left with few treatment or medication resources.

The Medicare Part D prescription drug plan that went into effect this year also hit the mentally ill population. By requiring those eligible for Medicaid to choose Part D, it exposed them to the "doughnut hole" of no drug coverage when they hit the coverage ceiling. With a single prescription costing as much as \$600, and some mental patients needing more than one drug to overcome their illness, many were simply forced off the medications that gave them a chance at a normal life.

Florida isn't alone in ignoring the needs of the mentally ill; advocates say it's a national crisis, with the number of beds in psychiatric hospitals down 40 percent in the last decade. But that's no excuse for Florida to continue this neglect of the mentally ill whose untreated illness may be the reason they're in jail in the first place. It's often been said that a society is judged by the way it treats its weakest members. Florida does not earn a high mark for its treatment of the mentally ill.



VA: One-Quarter of Recent Vets File Disability Claims

Federal Daily 10-23-06

1 in 4 veterans of the Iraq and Afghanistan wars – or 150,000 veterans – are filing disability claims, suggesting that official estimates dramatically understate the future cost of the twin foreign conflicts. The VA report offers no

reason for the claims' numbers, but experts say the Iraq War may have the highest rate of combat stress victims.

Mental health problems are real, common, and treatable. Seeking help is not a sign of weakness – taking care of yourself is an act of strength.



Suicide Prevention

Information provided by Larry Hejtmanek, Director of Professional Services Behavioral Health Resources

- 33,000 Americans commit suicide each year
- 1,000,000 uncompleted suicides each year
- 438,000 ER visits yearly for self-inflicted injuries

This is a public health problem requiring a prevention strategy. Teenagers and preteens have a high risk factor. Suicide is the second cause of death for this population.

- 90% of individuals who complete suicide have either a diagnosable mental illness or substance abuse disorder
- Firearms are used in 58% of successful suicides
- Men are 4 X more likely to complete suicide than women.
- Women attempt suicide more frequently.

What is the profile of 70% of the suicides each year?

- White
- Male
- Divorced
- Depressed
- Substance abuser
- Owns firearms

In Polk County during July of 2006, there were 10 suicides – persons between the ages of 18 and 65. During the same time period in 2005, there were 3 suicides.

Suicide in Jails and Prisons

- Suicide is the 3rd leading cause of death in prison
- Suicide is the leading cause of death in jails.
- 30% of deaths are in holding facilities
- 70% occur in detention facilities

Who completes in jail?

- 72% white
- 94% male
- Average age 30
- 60% intoxicated at time of incarceration
- 75% of victims being held on non-violent charges
- 27% detained on alcohol/drug related charges

Holding facilities

- 46% faced alcohol/drug related charges
- 82% intoxicated on admission

Causes of prison suicides

- Isolation from family
- Highly controlled
- Dehumanizing environment
- 28% additional legal problem
- 23% marital/relationship issues
- 28% inmate conflict

Why do suicides happen in jail?

- Young, highly traumatized, alcohol compromised often first offenders detained with little screening, limited supervision.
- A National study found that 89% were not screened for suicidal behavior at booking
- 51% occurred in the first 24 hours of incarceration
- 48% intoxicated died within the **first 3 hours**

Suicide myths

- Those that talk about it won't do it.
Not every victim openly or verbally expresses their intentions, many do, and should be heeded.
- Suicide victims want to die.
Not true – suicidal individuals are typically ambivalent about dying and most only seek to die because they feel that there are no other options.
- Suicidal individuals don't want to be helped.
Not true – suicidal individuals have often sought help from physicians, counselors, ER's and other sources.
- Asking about suicide may only give people ideas.
Not true – Talking about suicide is the most effective way of determining if an individual is thinking about suicide.
- Only those who are chronic substance abusers or long-term mentally ill attempt suicide.
Not true – while these groups are at a very high risk, inmate suicide involve many individuals who are intoxicated but not alcoholics or addicts as well as those with short term transient or situational depressions.
- Calling their bluff can snap them out of it.
Not true – this is the single worst thing that could be done.

Suicide assessment

Physical assessment

- Signs and symptoms of a physical illness
- Somatic complaints
- Difficulty concentrating
- Changes in appetite
- Decrease in energy
- Decrease in libido
- Change in sleep pattern

Emotional Assessment

- Any expressions of suicidal thoughts and/or feelings
- Level of lethality: explicit thoughts of suicide a weapon or plan chosen and available, history of a previous suicidal attempt, perceives no support system, has written a suicidal note and is unable to control the impulse.
- Depressed mood; expressing no hope for the future
- Has the individual told anyone about his/her suicidal thoughts or plans?
- How does the person identify his/her self esteem and sense of accomplishment?

Cognitive assessment

- Does the person have a plan to suicide that is developed?
- Is there a preoccupation with self?
- Is the judgment clouded with suicide as the only option.
- Does the individual have insight into his/her problems or behavior?
- Does the individual have commanding hallucinations that are suicidal and/or homicidal?

Social Assessment

- Is there interaction with family, friends, boss and co-workers?
- Is there participation in the therapeutic environment on an inpatient unit or in a day program?
- Is the individual functional in the home, work or in the community?

Spiritual Assessment

- Has the individual begun to question the role of his/her spiritual beliefs?
- Is the person angry with God?
- Is the individual able to identify a purpose and meaning in his/her life?

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 _____ \$3.00 Consumers/Limited Income
 _____ \$50.00 Professional
 _____ Gift \$ _____

Be part of a movement to create awareness of the facts of mental illness – it is a human issue, a health issue, a community issue.
 At our meetings, you can meet, share, and care with others who are living with mental illness, as well as obtain information about mental health resources, meet speakers knowledgeable about mental illness, have access to informational resources and legislative issues.

Suicide Assessment (cont'd)

Stages of Suicide

Stage 1

- No thought pattern of suicide or self harm.

Stage 2 - Mild

- No verbal expression of intent for suicide unless asked
- Passing thoughts of death with assurance to others that no attempt will be made.
- Feeling overwhelmed, depressed, "the blues", rejection and disappointment
- Express options
- Support system available
- Will contract for safety

Stage 3 – Moderate

- Hesitates when asked if suicidal ideation is present
- Admits to thoughts of suicide with no plan
- Thoughts of wanting to go to sleep and never waking up
- May abuse alcohol or drugs
- Support system not utilized
- Spiritual thoughts a deterrent to self-harm
- Agrees to contract for safety which includes going to ER or calling someone.

Stage 4 – Advanced

- Plans a suicide attempt and selects method/weapon
- May attempt suicide or self harm
- "It will never get better", "pain of living is just too much to bear"
- Gives things away, makes will, checks insurance policy
- Writes letters of goodbye
- No support system, sees self as a burden
- Can think of no other option
- Hesitant to contract for safety

Stage 5 – Severe

- May or may not admit to thoughts of death.
- Plans a suicide attempt and selects highly lethal method/weapon
- # of unsuccessful attempts
- Can think of no other option
- Will not disclose plan to prevent someone intervening
- Refuses or hesitant to contract for safety
- Increase in outward "energy"
- Writes a note
- Ignores or does not recognize support system

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

In an emergency situation, **call 911** – advise the dispatcher what the situation is, and ask for assistance from the Mobile Crisis Team.



Iowa Coalition on Mental Health & Aging

www.icmha.org

In 2005, the Iowa Coalition on Mental Health and Aging (ICMHA) initiated a process to expand and improve the delivery of specialty mental health services to older Iowans.

Older adults are the least likely of any age group to receive mental health care. More than 50% of persons in nursing homes and other residential care have a mental illness but few receive treatment. Even though there are effective ways to treat mental illnesses, less than 20% of older adults with mental illnesses receive any special care. These are mental illness estimates for Iowans 65+:

Any mental health disorder	20.0%
Depression	4.7%
Dementia	5.5%
Schizophrenia	.5%
Anxiety	7.0%
Substance Abuse	2.6%

Contact ICMHA if you would like to help in improving mental health care for older Iowans or e-mail lstarr@dhs.state.ia.us at the Iowa Dept of Human Services or e-mail Julie-Bobbitt@uiowa.edu.

In 2010, there will be an estimated 500,000 Iowans, age 65+.

State Legislation

Here are 4 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/> - click on advocate at the bottom of the home page
http://polk.ia.networkofcare.org/mh/legislate/state_index.cfm
<http://www.legis.state.ia.us/>
www.nami.org/advocacy

Go to www.infonetiowa.com site to find out the latest on legislation and the progress of the Mental Health Redesign.

In the October NAMI Greater Des Moines newsletter, we outlined the legislative issues we are concerned about.

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

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To learn more about mental illness, call NAMI Iowa (515-254-0417) or visit their office library at 5911 Meredith Drive, Suite E, Des Moines, IA 50322-1903. Check out the online resource NAMI website, www.nami.org, for information on research, disorders, treatments, medications and other topics. NAMI Iowa's website is at www.namiiowa.org. Polk Co. Health Services' website is www.polk.ia.networkofcare.org.

The 2007 Iowa Legislative session will start January 8.

We ask that you join us in talking to legislators about the following issues – again and again and again:

✓ **Appropriate more state dollars for MH/MR/DD/BI or change how the limitation in property taxes is applied.**

We have been warned how this will affect Polk County. Mental health services are poised to be cut. At our October meeting, we were informed that there was already a waiting list of approximately 50 people who couldn't receive services due to lack of money. The list continues to grow. Now, we have been informed the Mobile Crisis Unit will lose its entire funding from Polk County as of July 1.

✓ **Expanding mental health parity.**

Eating disorders, panic and anxiety disorders including post traumatic stress disorder, diagnoses for children and adolescents and substance abuse should be covered.

✓ **Address mental health workforce shortages.**

What's more basic than having enough mental health professionals when assistance and treatment is needed? Iowa is at the bottom of the rankings for this basic need.

✓ **Address the critical lack of inpatient psychiatric beds and recovery centers**

Another basic need – we hear heartbreaking stories every day related to this issue. After a break, how is it possible to have achieved a level of stability and understanding about their illness or know that the medication prescribed is effective after a stay of 3 days in the hospital – that is if you can get into the hospital in the first place.

✓ **Develop state-wide diversion programs to reduce the number of individuals put in jails and prisons instead of treatment programs.**

Taxpayers ought to be outraged that we are squandering taxes to support jails and prisons as our mental hospitals instead of funding effective treatment and support systems. Are we really that inhumane to keep throwing medically ill people in the closet?

✓ **Make ACT a Medicaid reimbursable service in Iowa.**

This is an evidence based practice that is cost neutral with high consumer and family satisfaction. There should be a reliable stream of funding and expansion of these services.

✓ **Retain “open access” for mental health drugs.**

Recent studies (the CATIE studies) are not yet complete. Yes, they've shown that older first generation anti-psychotics are less costly than the newer 2nd generation atypical anti-psychotics with seemingly equal effectiveness in relieving the clinical symptoms of mental illness. What has been loudly absent in all this rhetoric is that the side effects (which can be just as devastating) are horrible for the ill person with first generation anti-psychotics. They forgot to ask the ill person (the real victim in all of this). Isn't it a cardinal principle “to first, do no harm”?

Here are the legislators and officials to contact for Polk Co.

Senator Charles Grassley
Senator Tom Harkin
House District 3 – Leonard Boswell (D)
Governor of Iowa – Chet Culver (D)
Lieutenant Governor – Patty Judge (D)

Polk County State Senators Polk County House Representatives

District 30 – Pat Ward (R)	District 42 – Geri Huser (D)
District 31 – Matt McCoy (D)	District 59 – Dan Clute (R)
District 32 - Brad Zaun (R)	District 60 - Libby Jacobs (R)
District 33 – Jack Hatch (D)	District 61 – Jo Oldson (D)
District 34 – Dick Dearden (D)	District 62 – Bruce Hunter (D)
District 35 – Larry Noble (R)	District 63 – Scott Raecker (R)
	District 64 – Janet Petersen (D)
	District 65 – Wayne Ford (D)
	District 66 – Ako Abdul Samad (D)
	District 67 – Kevin McCarthy (D)
	District 68 – Rick Olson (D)
	District 69 – Walt Tomenga (R)
	District 70 – Carmine Boal (R)

Feb. 1 is Legislative Advocacy Day at the State Capitol. Join us! Then keep in contact by phone, letter, and/or E-mail & visit again.