














# NAMI GREATER DES MOINES

## AFFILIATE AND SUPPORT GROUP NEWSLETTER

July 2006  
 “Support, Education, and Advocacy”

<p><b><u>Education and Support Group Meetings</u></b> are generally the 1<sup>st</sup> <u>Sunday</u> of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room. Dates on Sundays other than the 1<sup>st</sup> Sunday of the month are due to holidays or other special scheduled events. (Coffee and cookies are provided.)</p>		<p><b><u>Business and Committee Meetings</u></b> are the 2<sup>nd</sup> <u>Thursday</u> of the month at 4 P.M. at the NAMI-Iowa Office.</p>	
<p><b>Sunday, July 9</b>  </p>	<p>The topic will be <b>dual diagnosis</b>. Brian Bartemes and Julie Leffler from Broadlawn’s will be our speakers. “Double Trouble and Recovery” <i>The Family to Family educational class will also be highlighted.</i></p>	<p><b>Thursday, July 13</b>  </p>	<p>We will be discussing and planning around 7 topic areas.</p>
<p></p>	<p><b>Weekend of July 14-16</b>  <b>Family to Family Teachers Needed!</b></p>	<p>Family to Family <b>Teacher</b> training – Most expenses paid by NAMI-Iowa. Location of training is in Des Moines. Please contact Carol Porch at 319-351-3498 or leave a message at 1-800-417-0417 or e-mail <a href="mailto:porch@avalon.net">porch@avalon.net</a> for further details.</p>	
<p></p>	<p><b>Weekend of July 28-30</b>  <b>VFT Teachers Needed!</b></p>	<p>Visions for Tomorrow <b>Teacher</b> training – contact Jackie Elfmann at 254-0417 for more details or E-mail at <a href="mailto:nameducation@mchsi.com">nameducation@mchsi.com</a>. Location of training is in Des Moines.</p>	
<p><b>Sunday, Aug. 6</b>  </p>	<p>Curt Sytsma – <b>Attorney for the Legal Center for Special Education</b> will be our speaker. The topic will be mental illness, parents, and the schools. <i>The Visions for Tomorrow educational class will also be highlighted.</i></p>	<p><b>Thursday, Aug. 10</b>  </p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p><b>Wednesday, Aug. 16</b></p>	<p><b>Iowa Grants Symposium</b> will be held at the Sheraton West Des Moines Hotel (formerly the Holiday Inn) at 50<sup>th</sup> &amp; University, WDM. Cost is \$65. It is a chance for grant writers to meet grant giving organization representatives. More details will be given as they become available.</p>	
	<p><b>Thursday, Aug. 31</b>  </p>	<p><b>Family to Family class starts (12 weeks)</b> <i>Call NAMI-Iowa office to sign up – 254-0417.</i> 6:30 P.M. to 9:00 P.M. at the NAMI-Iowa office, 5911 Meredith Drive, Suite E, Des Moines. <u>Severe mental illness is traumatic to the entire family</u> - 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). <i>1000+ persons in Iowa have completed the course.</i></p>	
<p><b>Sunday, Sept. 10</b>  </p>	<p>Shannon Evers, of <b>Iowa Behavioral Resources</b> – will be our speaker. IBR is a recovery-based rehabilitation program for people who have a mental illness and would like to learn more about recovery and work toward long-term goal achievement. Their services are centrally located in Des Moines</p>	<p><b>Thursday, Sept. 14</b>  </p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p><b>Sept. 25-27</b></p>	<p><b>2<sup>nd</sup> Annual National CIT conference</b> – Orlando, Florida</p>	
<p><b>Oct. 1</b>  </p>	<p>The topic will be anxiety and panic disorders.</p>	<p><b>Oct. 12</b>  </p>	<p>We will be discussing and planning around 7 topic areas.</p>
	<p><b>Tues – Wed. Oct. 10-11</b></p>	<p><b>State Mental Health Conference</b> in Ames at the Iowa State Center - Scheman auditorium. The theme is “The Road to Recovery” – promoting early intervention, access to services and wellness across the lifespan. More details forthcoming.</p>	
<p><b>Nov. 5</b></p>	<p>“Ask the Doctor” session</p>	<p><b>Nov. 9</b></p>	<p>We will be discussing and planning around 7</p>

Please help to support us whether it is through payment of dues or attending meetings or both.

**THANKS** if you have paid dues to become a NAMI Greater Des Moines member. **WELCOME!**

## **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.

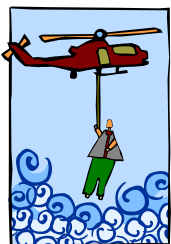
A heart attack is a symptom of serious heart disease, just as hearing voices, mood swings, withdrawal from social activities, or feeling out of control are common symptoms of a mental illness.

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.

*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.*



THE WICHITA EAGLE (KA), April 2, 2006

[Editor's Note: Vicky Collins is a messenger of hope – a symbol that having an illness as serious as schizoaffective disorder does not mean a person cannot have a meaningful life. At the same time, her ongoing symptoms are a reminder that there is not yet a cure for illnesses like hers. Her faithfulness to treatment, however, shows how such

conditions can be tamed.]

### **DEFYING HER MENTAL ILLNESS, A WICHITA WOMAN REBUILDS HER LIFE**

*By Deb Gruver*

When her schizophrenia was at its worst, Vicky Collins carried a stuffed rabbit everywhere.

The rabbit, Velvie, made her feel more secure, even if people stared.

When voices told her to kill herself, Collins would clutch the soft, brown rabbit with the red velvet dress.

Her longtime friend Kevin Bomhoff remembers the stuffed bunny.

"I noticed when she stopped carrying the (rabbit) and started carrying books," he said.

That's about the time Collins started getting better.

Academia replaced Velvie as Collins' security blanket. And the voices--while they still speak sometimes--became quieter.

Collins -- a daughter, a sister and a social worker -- wants you to know a few things about mental illness:

- You can get better.
- You can be successful.

- You can make up for the years you lost.

Collins, 47, lost about 20 of them.

### **A Brain Disease**

Around the age most people are engrossed in their first jobs or starting families, Collins was a patient at a mental hospital.

Now she works full time, teaches and has a master's degree in social work. Her diagnosis is schizoaffective disorder with a borderline personality disorder. She suffers from symptoms of schizophrenia and depression.

She agreed to spend time with an Eagle reporter and photographer to let others glimpse everyday struggles with mental illness.

Schizophrenia is a disease of the brain with symptoms such as delusions, hallucinations and withdrawal. Many people with the disease have trouble expressing thoughts. Their speech can be difficult to understand.

Comcare of Sedgwick County, which provides mental health services, says 14 percent of the nearly 5,200 adults undergoing treatment there have one of six types of schizophrenia.

"Never would I harm another person," she said. "If I was in the public and thought that about schizophrenics, I'd be scared, too."

### **'I Knew I Had Problems'**

Collins had symptoms of schizophrenia as a young woman.

But she didn't know she had a disease.

"I knew I had problems, but I didn't know to put a name to it," she said.

As a senior in high school, she went from being an honor student to flunking out. She had trouble concentrating and organizing her thoughts.

She attempted college but landed on academic probation.

She had migraines and began seeing a neurologist/ psychiatrist. At 20, she tried to kill herself.

She says the voices that spoke to her were ruthless and persistent. They told her, over and over, to kill herself.

On Jan. 2, 1984, she was taken in handcuffs to the Topeka State Hospital, a mental hospital that has since closed. She had tried to kill herself again.

The voices were winning.

She waived her right to a hearing and declared herself incompetent. She did so, she said, to spare her parents.

Over the years, Collins also has spent time in the psychiatric unit of a Wichita hospital and at Comcare's "partial" hospital, a six-to-eight-hour structured daytime therapeutic program.

Comcare has since replaced that program with one in which clients go out into the community to receive services.

The medications Collins took initially numbed her brain and left her in a condition that was barely better than the symptoms they tried to control, she said.

People who didn't know her might have described her as "not quite there."

Collins now takes eight medications daily and says they -- particularly Clozaril--work far better.

### **Hard-Won Successes**

In 1996--with the help of the new atypical medications--Collins resumed her studies at Wichita State University. She eventually earned a bachelor's degree in psychology.

But she started preparing for college four years before enrolling. To help develop an attention span, she read children's books. To get used to sitting still, she took art classes.

She finished her undergraduate degree in 2001. She earned a master's degree in social work in 2003 and her license a year later.

"She's an academic animal," Bomhoff said.

Bomhoff, community support coordinator at Wichita State University's Self-Help Network Center for Community Support and Research, has known Collins since the '80s, first as a patient and now as a colleague.

Collins completed her practicum at the Self-Help Network, which works with nonprofit and community organizations across the state.

She now works there full time as a project facilitator. Her colleagues say one of her biggest strengths is helping people with mental illness learn coping tools.

Her downtown office, filled with plants, fish and Beanie Baby bears, overlooks a flowering Bradford pear tree.

Just recently, a fellow member of the Breakthrough Club, a place where people with mental illnesses can go to look for jobs and socialize, asked Collins about her job.

Does she answer phones?

Does she take out the trash?

Collins answered that she writes grants, does research and teaches classes for WSU's Leadership Empowerment Advocacy Project, which gives students with mental illnesses the opportunity to experience college life.

### **Trials of Daily Life**

Despite her successes, Collins is not cured.

She struggles daily. She keeps in check with a pill planner that monitors her medications.

Two Wednesdays ago, she was so depressed she wondered to herself who would take care of her cats, dog, fish and hermit crabs.

Luckily a friend called her at the worst of it and helped dig her out.

While she still plans her own death at times, she no longer acts on those plans. In the past, she overdosed on pills. At one time, she had a shotgun and shells. She's burned herself.

"My impulse control is a lot better now," she said. Her younger sister, Pamela Self, is proud of Collins. She said she remembers when Collins appeared dazed and confused much of the time.

"The changes in her are just outstanding," Self said. "I am so, so happy for her."

### **A Network of Support**

Collins lives alone in a two-bedroom apartment near 21st and Amidon.

About 86 percent of Comcare's patients with schizophrenia live independently.

Her interest in American Indian cultures is apparent at home. Indian art hangs on her walls. A curio cabinet holds more Beanie Babies. Fish tanks bubble.

She gardens in a shared plot at the apartment complex. Last year, she planted too many tomatoes, and they didn't fare so well. This year, she'll plant a smaller crop.

She reads all the time, especially books on leadership and mental illness. She especially recommends "The Day the Voices Stopped" by Kenneth Steele. She listens to the radio but rarely turns on the TV in her living room, she said.

Collins is proud that she takes care of herself. She has gone from depending on a disability check to earning her own money.

She's soft-spoken and modest but points out that her supervisors treat her like everyone else at the office.

Bomhoff and Greg Meissen, director of the Self-Help Network, say that's true.

Meissen was Collins' academic adviser at WSU. He said she put a lot of thought into how to accomplish day-to-day successes. If she felt overwhelmed, she'd figure out which class was the best to drop and would do the least amount of damage to her academic record.

"And she has woven the best support system around herself," he said.

### **Vision Of A New Day**

Collins wishes other people with mental illnesses would believe in themselves.

She says the stigma of mental illness keeps many from getting the help they need.

She sees a therapist once a week, a case manager once a week, a psychiatrist every six weeks and her primary care physician, Donna Sweet, every two months.

Collins worries that the community -- and the media -- talk about mental illness only when something such as the shooting at QuikTrip happens.

"They don't hear about those of us who work full time, who go to school full time," she said.

She hopes she is a role model for other people.

"I have a lot of pride in what I do," she said. "With the right medicine and the right support, you can do things you never thought you'd be able to do."

Collins hasn't tried to kill herself in years.

She partly credits her doctor for that. Sweet, Collins said, drilled it into her head, again and again, that self-harm is not acceptable.

"I don't think anyone wants to die," she said. "They just want the pain to go away."

Collins reminds herself -- and others who are mentally ill -- that the next day, you just might feel a lot better.



### **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](mailto: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.

### **SUPPORT GROUP MEETINGS**

🕒 **First Monday of each month – 6 – 8 PM** - a support group for parents of children with severe emotional disturbance (SED) – meets at the Child Serve Center – 5406 Merle Hay Rd, Johnston. For more information – call Diane at 255-8157 or Mary Ann at 883-8014.

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

**Every Monday evening – 7 PM** – Broadlawn’s-1801 Hickman – dual diagnosis support group “Double Trouble and Recovery” – call Brian or Julie at 282-6750

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

**Every Tuesday afternoon – 1:30 to 2:30 P.M.**- A consumer support group meets at Res-Care located at the Hammer Medical Pharmacy building at 602 E. Grand. Come early at Noon and have a hot lunch.

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

**Thursdays from 11:00 A.M. to Noon** - Anger Management class at Res-Care located at the Hammer Medical Pharmacy building at 602 E. Grand. A hot lunch is provided at noon.

**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 24<sup>th</sup> 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.

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



**NAMI Greater Des Moines is starting support groups for family members.**

Listed in the chart above are several support groups for consumers – one support group for parents of children with severe emotional

disturbance – and a support group at Mercy Franklin for both consumers **and** family members.

NAMI Greater Des Moines has been concerned about the lack of support groups for family members only. So – we are starting family member support groups.

If you are interested in participating, please contact our Vice-President – Dr. Bobby Dickerson  
Work phone: 288-1914  
Cell phone: 979-8390  
E-mail: [bdickerson@pccdisciples.org](mailto:bdickerson@pccdisciples.org)

Bobby will be organizing the support groups and will be able to give you details on day, time, place, etc.



### **Assistance with Prescription Cost**

Polk County residents without full health insurance coverage can save on prescription drugs under a county sponsored drug discount program. Discounts average 20% and can be used at more than 100 pharmacies throughout the county. There are no income or age restrictions. While anyone can use the cards for drugs not covered by an insurance plan, the program targets those without insurance. For a complete list of card locations or a list of participating pharmacies, call 286-3895. **Also**

**The Partnership for Prescription Assistance** can give you a helping hand. Call 1-888-477-2669 or visit [www.pparx.org](http://www.pparx.org) to see if you may qualify for a variety of programs available.

### **Also**

### **Free Rx Savings Card Available to Those Who Qualify**

Patients who lack prescription drug insurance and are not eligible for Medicare can determine in just minutes if they qualify for the Together Rx Access™ Card by calling 1-800/444-4106 or by visiting the [Together Rx Access Web site](http://TogetherRxAccess.com).

With the free-to-get and free-to-use Card, most cardholders save 25 percent to 40 percent on their prescription drugs and products, right at the pharmacy counter. The Together Rx Access program includes more than 275 brand-name medicines and products as well as a range of generic drugs.



### **Speaker at our July 9 meeting**

The topic will be “dual diagnosis” – “Double Trouble and Recovery”  
Brian Bartemes and Julie Leffler from Broadlawn’s will be our speakers.



**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 in Des Moines will start on August 31.**

### **Looking for Family to Family Teachers**



Family to Family **Teacher** training will be held the weekend of July 14-16. Expenses paid by NAMI-Iowa. Location is Des Moines. Please contact Carol Porch at 319-351-3498 or leave a message at 800-417-0417 or e-mail [porch@avalon.net](mailto:porch@avalon.net) for further

details.



### Peer to Peer

Peer to Peer is a 9 week course for individuals with severe brain disorders. Each 2 hour session is taught by a NAMI Iowa team of three trained "mentors" who are personally experienced at living well with mental illness.

Participants come away from the course with a binder of hand-out materials, as well as other tangible resources such as: an advance directive, a "relapse prevention plan" to help identify feelings, thoughts, behaviors or events that may warn of impending relapse; information on how to organize for intervention; mindfulness exercises to help focus and calm thinking; and survival skills for working with providers and the general public.

Class topics include: stigma and discrimination, relapse prevention planning, story telling, language, emotions, addictions, spirituality, medication, coping strategies, decision making, relationships, empowerment, and advocacy.

Call the NAMI-Iowa office to sign up for Peer to Peer- 515-254-0417.



#### Looking for Peer to Peer Teachers

NAMI-Iowa is looking for persons who are living well with their mental illness who would like to become a Peer to Peer teacher. Please call Margaret Stout at 254-0417 for more information.



Sign up for the next "**Visions for Tomorrow**" class. It is an 8 week course (1 night a week for 2-2 1/2 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.



#### Visions for Tomorrow Teachers Needed

If you are interested in becoming a Visions for Tomorrow teacher, please contact Jackie Elfman at the NAMI-Iowa office - 254-0417 - The next class is July 28-30.

#### Letters to the Editor

You are welcome to send letters to the editor by mail or E-mail. Letters can be sent to:

Teresa Bomhoff  
200 S.W. 42<sup>nd</sup> St.  
Des Moines, Iowa 50312

Or E-mail: [tbomhoff@mchsi.com](mailto:tbomhoff@mchsi.com)



#### [www.polk.ia.networkofcare.org](http://www.polk.ia.networkofcare.org)

The web site contains information and resources regarding mental health in Polk Co. Some of the topics are community announcements, nationwide news, services (who are providers?), library, legislate (state and national legislation), E-mail service to contact your state and national legislators, links, insurance (plans available), support & advocacy, emergency services.

*Investing in effective community mental health services saves families, lives and dollars.*



#### Schizophrenia Digest magazine and BP (Bipolar) magazine are available at NAMI-GDM meetings

Both magazines are printed quarterly. We will have 50 copies of each magazine available for members and others attending the Sunday affiliate and support group meetings on a first come-first served basis.

What will be the cost to you? Please donate a \$1.00 per copy to our organization.

Each magazine offers information about the illness, latest research and legislative developments, and stories of hope. Many letters to the editor have said "**Now I know I am not alone.**"



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

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



#### Announcement:

Clinical Tools, Inc., a medical education company based in Chapel Hill, NC, is designing a website for older adults with depression (and their caregivers). They currently are recruiting participants for online focus groups that will provide feedback to help us build the best website possible.

If you are (a) an older adult (55+) diagnosed with depression, (b) a caregiver of an older adult with depression, or (c) a health professional who has worked with older adults with depression, please e-mail study coordinator Kevin O'Donovan at [odonovan@clinicaltools.com](mailto:odonovan@clinicaltools.com) (and put "Senior," "Caregiver," or "Health Professional" in the subject line). Compensation will be provided. This project is funded by the National Institutes of Health (Grant # 1 R43 AG022800-01A1).

Kevin O'Donovan, Study Coordinator  
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Tel: (919) 960-8118 Fax: (919) 960-7745  
E-mail: [odonovan@clinicaltools.com](mailto:odonovan@clinicaltools.com)  
Web: <http://www.clinicaltools.com>



#### FUNDRAISER

NAMI Greater Des Moines is selling NARSAD silver ribbon pins for \$3.00 each. They are available for purchase at Sunday affiliate educational meetings and at 2<sup>nd</sup> Thursday of the month business meetings.

NARSAD is the Mental Health Research Association (previously known as the National Alliance for Research on Schizophrenia and Depression). It is the largest donor supported association in the world devoted to scientific research on brain and behavior disorders.

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### NAMI WALKS

There are 70 sites around the country slated to have NAMIWALKS in 2006. NAMI-GDM would like to join the ranks in 2007. This event is subject to NAMI National's approval.

Funds raised would help to expand the number of educational course offerings, help with the distribution of newsletters, hire help to relieve administrative duties that are overwhelming volunteers, website development, and raise awareness and dispel myths that still surround mental illness.

If you are interested in helping us out with this event, either through donations or volunteering, please call Teresa at 274-6876 (voice mail available) or E-mail at [tbomhoff@mchsi.com](mailto:tbomhoff@mchsi.com)

***"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."* – Margaret Mead**



### America's Report Card: NAMI Grades the States

NAMI recently released the first comprehensive state-by-state report on the state of America's mental healthcare system for serious mental illness. The 2006 report, *Grading the States: A Report on America's Health Care System for Serious Mental Illness* covered widely in media outlets throughout the United States, confirmed what President Bush's New Freedom Commission called "a system in shambles."

Simply put, treatment works, if you can get it.

But in America today, it is clear that many people living with the most serious and persistent mental illnesses are not provided with the essential treatment they need. As a result, they are allowed to falter to the point of crisis.

This neglect and lack of will by policymakers often results in horrendous consequences. The number of people with serious mental illness incarcerated in jails and prisons is on the rise. Emergency room use is increasing. The availability of housing is being threatened. Increasingly, access to effective treatments is being limited by many state governments.

NAMI intends the report to be a consumers' guide to public services for adults with serious mental illness. We hope it will provide elected policymakers with a specific agenda for action. We also intend for this report to promote a dialogue among all stakeholders about what is and what is not working in the mental health system.

It is our strong sense that if we are to move forward, we must routinely engage in assessing the mental health care systems in

every state. We hope that our publication of these reports at regular intervals will over time drive the creation of service systems in all states that are not "patchwork relics," but ones of hope, opportunity, and recovery.

The 230-page report, including individual state narratives and scoring tables, is available online at [www.nami.org/grades](http://www.nami.org/grades).



### Grading the States

- No state received an A grade for services
- 17 states received an F grade for information

access

- New York and Colorado were the only states not to respond to NAMI's request for information
- Tennessee had the highest score on the Consumer and Family Test Drive but still only received 24.75 points out of a possible 40 points
- Illinois finances low-income housing from real estate transaction fees
- Kentucky set up a telephone triage system in jails financed through DWI fines
- District of Columbia ranks the highest in per capita mental health spending at \$414.08 and has the nation's lowest suicide rate.

**Iowa received an F.**



***Stigma is a real problem. It's a societal issue, but it is much more pronounced in the military.*** —

Col. Thomas Burke, Director of Mental Health Policy, U.S. Department of Defense, Stars and Stripes, July 22, 2005

Like their civilian counterparts, many active-duty and veteran United States military personnel are faced with the prospect of having a mental illness. However, unlike ordinary citizens, the situations under which these individuals work and live impact profoundly upon their ability to maintain mental health.

Soldiers training for and participating in combat experience high levels of stress that heighten anxiety and increase the chances for depression.

Combat trauma, whether experienced in the form of bodily injury or fatigue from a constant exposure to threat, increases the likelihood of post-traumatic stress disorder (PTSD) and the possibility for poor performance or inappropriate conduct.

The impact of military reality on individual mental health is complicated further by the pronounced stigma associated with mental illness within military communities. Service members frequently cite fear of personal embarrassment, fear of disappointing comrades, fear of losing the opportunity for career advancement, and fear of dishonorable discharge as motivations to hide the symptoms of mental illness from colleagues, friends and family.

This silence and the attitudes and perceptions perpetuating it pose a significant challenge to those charged with making sure that the United States' fighting force is improving itself and taking care of its own members.

In response to this challenge, advocates from both within and outside the U.S. military and the U.S. Department of Veterans Affairs are working to counter stigma and reverse the fear that causes soldiers and veterans to associate mental illness with personal and professional failure.

Some programs, like the U.S. Air Force's suicide prevention initiative, provide a comprehensive approach to mental health education, training, and illness prevention that is made visible and acceptable inside military communities.

Other programs seek to explore less stigmatizing methods of identifying illnesses and delivering mental health services by taking advantage of communication tools such as the Internet.

Still other programs seek to promote the value of talking about illness by encouraging peer recognition and support for recovery from mental health problems.

-SAMHSA ADS center 3-23-06

### **Few Troops in Need of Mental Health Services Receive It, GAO Reports** ([Reuters](#), 5/12/06)

A Government Accountability Office (GAO) report [released](#) last week indicated that only 22 percent of American troops returning from Iraq and Afghanistan who were determined to be at-risk for developing PTSD were referred by military officials to mental health services. GAO investigators concluded that the Pentagon did not provide reasonable assurances that those troops in need of help actually got it.



### **Military Keeps Troops in Combat Despite Mental Health Problems, Records Show** (The Associated Press, 5/15/06)

Although the military has regulations requiring mental health screening and testing of troops, and evacuating "mentally unfit" troops from Iraq, the Pentagon either sent to Iraq or kept in the country several American troops who showed clear signs of mental distress and, some a few cases, later killed themselves, according to Pentagon records obtained by the Hartford Curran and interviews with family members. Col. Elspeth Ritchie, the Army's top mental health expert, acknowledged that practices such as sending troops with PTSD back into combat is partly driven by troop shortages. "The challenge for us ... is that the Army has a mission to fight. ... And so we have to weigh the needs of the Army, the needs of the mission, with the soldiers' personal needs," she said.

### **House Passes Veterans Spending Bill**

May 26, 2006 NAMI E-news excerpt



In a demonstration of the growing concern of mental illness treatment services for veterans and current service members, the House this past week passed a \$136 billion bill that includes record increases for both veterans with mental illness and soldiers returning from active duty that have experienced a growing range of mental health disorders.

The bill, known as the Military Quality of Life and Veterans Appropriations bill (HR 5385), includes FY 2007 funding for the Department of Veterans' Affairs (VA) and health care programs in the Department of Defense (DoD). The bill cleared the House on May 19 by a unanimous 395-0 vote.

The Senate is expected to take up the measure later this summer. As in the House, there is strong support in the Senate for additional investments to increase the capacity of both the VA and DoD to meet the mental illness treatment needs of veterans and active duty personnel.

### FY 2007 Funding for the VA

This is the second year in a row that the House Appropriations Committee has gone the extra step of requiring a minimum allocation for mental illness treatment services in the VA. It is a further reflection of the strong bipartisan support in Congress for addressing the treatment needs of veterans living with mental illness, both from the aging Vietnam era veteran population, and anticipated demand among veterans of recent conflicts including Iraq and Afghanistan.

A legislative report accompanying HR 5385, specifically notes--  
*The Committee is very concerned about the mental health and*

*wellness of troops returning from conflicts overseas. The full impact of the emotional toll that combat takes from our troops may not be fully realized for years into the future. The Committee believes that mental health and wellness need to be integrated into all aspects of military training, combat and support and that care cannot stop when the soldier returns home from the battlefield. The Department of Defense should be commended for the work it is doing and the improvements that have been made in the mental health area, but more needs to be done. The primary reason for soldiers failing to seek treatment for mental health issues is the stigma associated with seeking help. The Committee feels that the military needs to begin to integrate mandatory mental health services and counseling into the daily activities of soldiers and has included a \$25,000,000 increase in funds for this purpose. By making these programs a mandatory part of a soldier's tour of duty, the stigma associated with seeking care is eliminated. The Committee directs the Department of Defense to use the increased funds to initiate programs that make mental health screening and counseling a mandatory part of the operating procedures of soldiers in battle. The Department of Defense should report to the Committee on the use of these funds and an assessment of future funding requirements for this initiative by December 15, 2006. Further, the Committee directs the Department to continue to work with the Department of Veterans Affairs to study mental health issues, particularly Post Traumatic Stress Disorder (PTSD). The Committee has included Post Traumatic Stress Disorder as a disease available for study under the Peer-Reviewed Medical Research Fund in the Research, Development, Test, and Evaluation section of this appropriation and encourages increased research in this area. H.Rpt. 109-464, p. 40 - This language serves as a clear demonstration of the strong support in Congress for ensuring that the DoD undertakes screening and early intervention services for active duty and returning troops at risk of PTSD, depression and other disorders.*



### **DD-214's are now Online.**

The National Personnel Records Center (NPRC) has provided the following website for veterans to gain access to their DD-214s online:

<http://vetrecs.archives.gov/> This may be particularly helpful when a veteran needs a copy of his DD-214 for employment or other purposes.

NPRC is working to make it easier for veterans with computers and internet access to obtain copies of documents from their military files. Military veterans and the next of kin of deceased former military members may now use a new online military personnel records system to request documents.

Other individuals with a need for documents must still complete the Standard Form 180, which can be downloaded from the online web site. The requester will be asked to supply all information essential for NPRC to process the request.

The new web-based application was designed to provide better service on these requests by eliminating the records center's mailroom processing time.

The **VA Central Iowa Health Care System Medical Center** is located at 3600 30<sup>th</sup> St., Des Moines 50310, Phone 1-800-294-8387.

The **VA Regional Office** is located at 210 Walnut, Room 1063 of the Federal Building, Des Moines 50309 – Phone: 1-800-827-1000.

The **Des Moines Vet Center** is located at 2600 Martin Luther King Jr Pkwy, Des Moines 50310 Phone: 515-284-4929



" 330 kids [commit suicide], or a jumbo jetliner crash, every month. We need to get into the public's consciousness that this is a public health crisis, and that treatments do work," said Cynthia

Wainscott, NMHA's acting president and CEO at the first annual Children's Mental Health Awareness Day Capital Hill Luncheon briefing. "If we look forward 100 years, when people look back at us, will they say we were doing the best we could do? I don't think so, unless we change what we're doing."

**MonstersandCritics.com**, "[Community Model Best for Mentally Ill Kids](#)," 5/9/06



**Support S. 537 and H.R. 1106  
The Child Healthcare Crisis Relief Act**

*NAMI E-News*

NAMI families and grassroots leaders know all too well the crisis that our nation faces in the shortage of qualified mental health providers to treatment to children and adolescents with mental illnesses.

U.S. Surgeon General Satcher highlighted this crisis in the seminal 1999 report -- Mental Health: A Report of the Surgeon General. According to that report, 13.7 million or 20% of our nation's children and adolescents have a diagnosable mental illness -- with 6 to 9 million or 9 to 13% having a mental illness that causes serious impairment.

Tragically, in any given year, only 1 in 5 of these youth receive mental health treatment and services.

The lack of qualified mental health providers is part of the reason for the unacceptably high number of youth with mental illnesses that fail to receive treatment and why families are often told that they must wait on long waiting lists for services for a seriously ill child.

The Surgeon General put it best in stating that there is a "shortage" of child psychiatrists, appropriately trained clinical child psychologists, and social workers in this country. Here are the facts:

The federal government has designated 3,543 urban, suburban, and rural localities as Mental Health Professional Shortage Areas due to their severe lack of psychiatrists, psychologists, social workers and other professionals to serve children with mental illnesses (all of Iowa except for metropolitan counties are Mental Health Professional Shortage areas);

According to the U.S. Bureau of Health Professions, the demand for the services of child and adolescent psychiatrists is projected to increase by 100% by 2020, while the number of these professionals is expected to increase by only 30% resulting in a severe shortage of child and adolescent psychiatrists;

According to the American Academy of Child & Adolescent Psychiatry, there are currently approximately 6300 child and adolescent psychiatrists in this country with a need at 32,000;

The National Center for Education Statistics within the U.S. Department of Education reports that the national average student-to-school counselor ratio in U.S. schools is 513:1, more than double the recommended ratio of 250:1.

The consequences of untreated mental illnesses in children are devastating. These youth are at higher risk for school failure and drop out, alcohol and drug use, suicide (the 3rd leading cause of death for 10-24 year old young people), and engaging in high risk and unlawful activity.

As a result of the crisis in the shortage of qualified mental health providers to treat children and adolescents with mental illnesses

– House co-sponsors introduced H.R. 1106 – the Child Healthcare Crisis Relief Act and Senate co-sponsors introduced a senate version of the Child Healthcare Crisis Relief Act S. 537. The following is a summary of the provisions included in S. 537 and H.R. 1106:

**Loan Repayments, Scholarships, and Grants.** The bill creates incentives to help recruit and retain child mental health professionals providing direct clinical care, and to improve, expand, or help create programs to train child mental health professionals through the following mechanisms:

- 1. Loan Repayment and Scholarships** for child mental health and school-based service professionals to help pay back educational loans.
- 2. Grants** to graduate schools for internships and field placements in child mental health services.
- 3. Grants** for the pre-service and in-service training of paraprofessionals who work with children in mental health clinic settings.
- 4. Grants** to graduate schools to help develop and expand child and adolescent mental health programs.

**Graduate Medical Education Program Extension.** The bill also allows for an increase in the number of Child and Adolescent Psychiatrists permitted under the Medicare Graduate Medical Education Program and extends the Board Eligibility period for residents and fellows from four to six years.

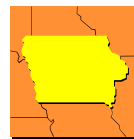
**Child Mental Health Professionals Report.** The bill instructs the Secretary to prepare a report on the distribution and need for child mental health and school-based professionals with respect to specialty certifications, practice characteristics, professional licensure, practice types, locations, education, and training, broken down by state.

**Action Requested:**

NAMI members are asked to contact their Senate and House representatives to ask them to co-sponsor and support S. 537 and H.R. 1106. The hope is to get as many co-sponsors in the Senate and the House as possible.

All members of Congress can be reached by calling the Capitol Switchboard toll free at 1-800-839-5276 or at 202-224-3121 or by going to the policy page of the NAMI web site at [www.nami.org/policy.htm](http://www.nami.org/policy.htm) and click on "Write to Congress."

District and Washington office numbers can be found in your local phone book or through [www.congress.org](http://www.congress.org)



**The Iowa Dept. of Public Health Center for Health Workforce Planning** has posted two new reports that describe the mental health workforce in Iowa. Both documents are designed to be used and shared by any constituent working to improve mental health services in Iowa.

Iowa's Mental Health Workforce is an in-depth analysis of seven categories of licensed mental health workers. It documents factors that signal potential shortages in several health professions:

[http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mental\\_health\\_0306.pdf](http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mental_health_0306.pdf)

A Summary of Four Mental Health Surveys enumerates and describes workers employed in mental health settings, their salaries, numbers of vacancies, and their use of telehealth technology in the workplace:

[http://www.idph.state.ia.us/hpcdp/common/pdf/health\\_care\\_acc\\_ess/mental\\_health\\_workforce\\_summary.pdf](http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_acc_ess/mental_health_workforce_summary.pdf)

Iowa is 46<sup>th</sup> in the nation in psychologists and 47<sup>th</sup> in the nation for number of psychiatrists.

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

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

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 will become increasingly acute.

- ✓ **Addressing mental health workforce shortages should be a legislative priority in the state legislature.**
- ✓ A great start was in this year's Health & Human Services Budget (HF 2734) - \$160,000 was appropriated to the University of Iowa for an initiative to address the shortage of mental health professionals throughout the state.

Here are three places on the web to access E-mail to contact your legislators:

- <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://polk.ia.networkofcare.org/mh/legislate/state_index.cfm)
- <http://www.legis.state.ia.us/>



**More Money for MH/MR/DD/BI Services in Iowa in 2007**

May 12, 2006 [www.infonetiowa.com](http://www.infonetiowa.com)

As you may remember, ten years ago legislators decided that the state would become equal partners with counties in funding MH/MR/DD/BI services. They passed a law that required the State and counties to evenly split the cost of services, and the state would pick up the growth in the system (what we call "Allowed Growth").

Back in 2002, the State hit some bad budget years and the economy was bad. The State made all kinds of cuts then, including taking \$18 million out of the MH/MR/DD/BI Allowed Growth funds. They did that because several counties were sitting on very large fund balances (meaning they were taking money and not spending it on services to people).

Legislators created a formula to force these counties to spend down these balances before they are allowed to get state Allowed Growth funding. This formula directed the money to where it was most needed – counties with low fund balances and counties that were already getting as much money as they could from local sources (taxes).

This year, legislators realized their formula worked. Counties spent down their money, so more and more counties were becoming eligible for the Allowed Growth funds. However, as more and more counties became eligible, that meant more money needed to be added back into the pot.

Counties and consumers came to the Capitol this year after word came out that counties would be forced to cut services unless more money was added to Allowed Growth.

Counties were set to get about \$5.3 million in new money this year – but that wasn't enough. It would have led to massive cuts

in services in most of the large urban counties and in several smaller counties.

That's where the good news comes in – legislators found another \$5.1 million to add to Allowed Growth this year. That means counties will get \$10.4 million more than last year for MH/MR/DD/BI services. **Send your legislators a big thank you!**



**MH/MR/DD/BI Redesign – HF 2780**

*(Mental Health/Mental Retardation/ Developmental Disabilities/Brain Injury Redesign)*

**What it Means to You** [www.infonetiowa.com](http://www.infonetiowa.com) 5-12-06

- ✓ **Establishes a new Division of Mental Health & Developmental Disabilities in DHS to give some leadership in the area of mental health and disability policy.** DHS Director Kevin Concannon told legislators that the state has missed out on a lot of opportunities at the federal level, and that re-establishing this Division which was eliminated several years ago would help to make sure we do not miss any other opportunities. This should help elevate disability issues for legislators, and make them more comfortable in giving additional resources.
- ✓ **Begins the transfer of state cases to the counties and begins to remove the barriers to eliminating legal settlement.** People without legal settlement served under the State Payment Program ("state cases") have their services paid for by the state. The state reimburses providers at a lower rate than many counties, and offers fewer services than many counties. In addition, counties and the state spend a lot of time tracking down a person's legal settlement. Getting rid of legal settlement is one of the first goals of redesign – and this bill starts that process three years earlier than recommended by the MH/MR/DD/BI Commission. The bill does not eliminate legal settlement – it simply eliminates some of the barriers to getting rid of legal settlement.  
  
Under the bill, counties will assume responsibility for providing and paying for services to persons with state case status not being served by Medicaid (such as MR Waiver state cases), starting October 1, 2006. Legislators will have to come back next year to move the Medicaid state cases (like MR Waiver state cases) to counties at a later date. The Legislature also added \$1.4 million to state cases funding to help address the increased costs to counties.  
  
As a consumer, this is all good news. This means persons without legal settlement will be treated to the same services, paid at the same rates, as others living in their county. There are still a lot of details that need to be worked out this summer related to how to distribute the state case money to counties, but everyone has a seat at the table for those discussions.
- ✓ **Establishes a review committee to look at how we fund MH/MR/DD/BI services in the state and the formula for distributing it** (recommendations are due by January 1, 2007). Only a handful of people understand the MH/MR/DD/BI formula, and with the Redesign effort moving forward, it's time to take a look at the formula. It's a great time to remind legislators that funding should follow the person – and that the money distributed to counties isn't money for counties – it is money for people. They will not likely have a meeting until September at the earliest.

- ✓ **Requires all counties to have the same eligibility guidelines.** This starts to equalize services across the state by requiring everyone to have the same rules to get services. Persons earning up to 150% of the federal poverty level will be eligible for county-funded MH/MR/DD/BI services. Counties may continue to charge co-pays for some services, but few do and all do it on a voluntary basis.
- ✓ **Requires counties of residence to assume responsibility for managing a person's care (but the county of legal settlement will continue to foot the bill).** Beginning July 1, 2007, counties of residence will manage the services provided to people served in their county but with legal settlement elsewhere. The county of legal settlement will be billed for services, and will have to pay for any services authorized in the county of residence's management plan. That means if you live in Polk County but have legal settlement in Woodbury County, and Polk County authorizes a service not paid for if you lived in Woodbury County, Woodbury County would have to pay for it. This is an important move in getting rid of the disparities in services offered to people, gives counties time to see how eliminating legal settlement will affect their financial bottom line, and makes sure people living in a county are treated the same way, whether state case, resident, or legally settled elsewhere.
- ✓ **Requires Magellan (managed care) to pay community mental health centers at 100% of their actual costs, and reimburse psychiatrists and inpatient psychiatric providers at the same rate Medicaid pays.** Providers serving people with mental illnesses under the Magellan managed care contract have not received the same increases in provider rates that those who serve persons covered under regular Medicaid. These providers are hurting and in some cases the counties make up for the difference, putting further strains on county budgets. This move could free up county resources, eliminate disparities in the system, and help people get the services they need because funding will no longer be a barrier.

#### **Threat to State Mental Health Parity Laws Averted – For Now**

*May 12, 2006 NAMI E-news*



By a vote 55-43, the Senate rejected the effort to limit debate on S 1955, legislation to

authorize new small business health insurance plans that would have significantly undermined laws at the state level requiring health plans to cover treatment for mental illness on the same terms and conditions as all other illnesses (insurance parity).

The vote was on a critical parliamentary motion to impose "cloture" -- to cut off debate and move S 1955 to final passage with very limited opportunities for amendments. In the Senate, 60 votes are required to impose cloture, thus the motion fell five votes short.

With the prospect of unlimited Senate debate on S 1955, the legislation was pulled from consideration. This means that S 1955 has been derailed in the Senate. However, Senator Frist and bill sponsor Senator Mike Enzi (R-WY) have the option of bringing the bill back to the full Senate at any time.

NAMI would like to thank advocates for their efforts in reaching out to Senators to urge opposition to S 1955. Yesterday's Senate vote is a victory for preserving mental illness insurance parity laws at the state level.



#### **True or False? The Top 10 Myths About Bipolar Disorder**

by: John McManamy

HealthCentral's Bipolar Connection  
at [www.bipolar-connection.com](http://www.bipolar-connection.com)

Like many mental illnesses, the commentary surrounding bipolar disorder is saturated with myths--it's hard to tell what's true and what's not. Below you'll find the real story.

**1. Everyone has their ups and downs, so mine aren't that serious.** Yes, everyone has good days and bad days, but when these ups and downs seriously interfere with your ability to work, relate to others and function effectively, it is advisable to seek out a psychiatrist.

**2. Bipolar disorder is a mood disorder.** Half true. Bipolar disorder certainly affects mood, but it also affects cognition and the ability to perform mental tasks. Some days we can out-think Stephen Hawking. Other days we make Forrest Gump look like an intellectual.

**3. Yes, but bipolar disorder is still a mood disorder.**

Granted, but for most of us it is also part of a package deal that may include anxiety, substance and alcohol abuse and sleep disorders. Also, researchers are finding smoking guns linking the illness to heart disease, migraines and other physical ailments.

**4. Bipolar disorder is characterized by mood swings ranging from severely depressed to wildly manic.**

Not necessarily. Most people with bipolar disorder are depressed far more often than they are manic. Often, the manias are so subtle that they are overlooked by both patient and psychiatrist, resulting in misdiagnosis. People with bipolar disorder can also enter long periods of remission.

**5. Mania is like being on top of the world—if you could only put it in a bottle and sell it.** You wouldn't want to with most manias. True, some forms of mild mania are characterized by feelings of elation, but other types have road rage features built in. More severe mania turns up the heat, resulting in different kinds of out-of-control behavior that can ruin your career, relationships and reputation.

**6. Bipolar disorder is caused by a chemical imbalance of the brain.** This is the simpler explanation—what you tell your family and friends. What you need to know is our genes, biology and life experience make us extremely sensitive to stress. Various stressors, such as personal relationships and financial worries, have the potential to trigger a mood episode if not effectively nipped in the bud.

**7. Medications are all you need to combat bipolar disorder.**

False. While medications are the foundation of treatment for bipolar disorder, recovery is problematic without a good lifestyle regimen (diet, exercise and sleep), effective coping skills and a support network. People with bipolar disorder also benefit from various forms of talking therapy and religious/spiritual practice.

**8. Medications don't work for me.** For some people this may be true, but we all need to give our meds a chance. Treatment guidelines anticipate initial failures, and while no two guidelines are in agreement they are all based on the premise that eventually you will find a medication or combination of medications that will help you.

**9. Lower quality of life and sluggish cognition are fair trade-offs for reducing mood symptoms.** False, big time. In the initial phase of treatment, meds overkill may be justified to bring your illness under control. But full recovery is based on improving your overall health and ability to function, not just eliminating mood symptoms. Over time, the side effects of medication tend to go away, so patience is advised. You may

choose to live with minor side effects such as mild hand tremors. But if major side effects persist, you should work with your psychiatrist in adjusting doses or switching to different meds. The onus is on you to alert your psychiatrist to major side effects and to insist he or she take appropriate action.

**10. Once you've been diagnosed with bipolar disorder, you can forget about leading a normal life.**

False. Living with bipolar disorder is a challenge, and you may have to change your expectations, but you should never give up on living a rewarding and productive life.



**FDA Approves EMSAM**

*EMSAM is the first transdermal patch for the treatment of Major Depressive Disorder in adults.* EMSAM belongs to the MAOI class of antidepressants. Recommended starting

dose is 6 mg/24 hr patch. It will require dietary modifications to reduce the risk of hypertensive crisis when using the EMSAM 9 mg/24 hr patch and the 12 mg/24 hr patch.

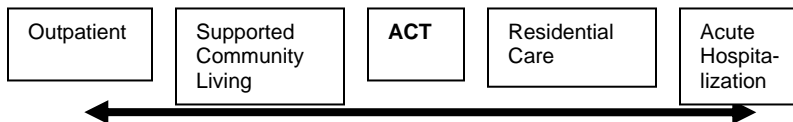
In clinical studies, patients continually receiving EMSAM experienced a significantly longer time to relapse. Patients are instructed to inform all of their health care professionals that they are using EMSAM and should not stop or change treatment without consulting their health care professional.

EMSAM is not approved for the treatment of bipolar depression.

**Assertive Community Treatment (ACT)**

*Betsy Hradek, ARNP*

The levels of care for persons with severe mental illness are:



**Who is Assertive Community Treatment for?**

- Persons with severe mental illness – primarily persons with schizophrenia, schizoaffective, bipolar and severe depressive disorders
- Persons with significant functional impairment
- Persons who are the highest users of health care resources either through institutionalization, acute hospitalization, homelessness, or jail.

**ACT is needed.** Persons with severe mental illness have multiple bad outcomes compared to the general population:

- the suicide rate is 10 X higher.
- the HIV rate is 10 X higher.
- substance abuse is 3 X higher
- When combined with substance abuse, the violence rate is 8 X higher
- 28% of the homeless have severe mental illness.
- A shorter life expectancy of 6-25 years– being more prone to accidents, infection, and cardiovascular problems.

**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.
- Skills learned while institutionalized don't generalize well to community living.
- 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
- Time unlimited services

The Program for Assertive Community Treatment (PACT) was started in Madison, Wisconsin in 1967 – spread statewide in Wisconsin in the 1970's, was implemented in Michigan statewide in 1978, and was utilized in large cities such as Chicago, Philadelphia, St. Louis, Baltimore, and Indianapolis – by the early 1990's – several states had established PACT teams.

In 1998, NAMI began "the PACT Across America Initiative" and national standards were developed. Iowa began PACT teams in 1996 (there are 5):

- ✓ 1996 - Iowa City (UIHC IMPACT)
- ✓ 1998 – Des Moines (Golden Circle)
- ✓ 1998 – Cedar Rapids (Abbe Center)
- ✓ 2004 - Fort Dodge (North Central Iowa Mental Health Ctr)
- ✓ 2006 – Council Bluffs (Heartland Family Services)

Nationally, ACT is proliferating rapidly because of:

- Recent emphasis on evidence based practices. ACT has been identified as one of 6 evidence based treatments by experts convened by the Robert Wood Johnson Foundation PORT study – it recommended ACT for treatment of schizophrenia.
- The Health Care Financing Administration has authorized ACT as a Medicaid reimbursable treatment.
- The 1999 Surgeon General's report on Mental Health endorsed ACT as an essential treatment for severe mental illness.
- NAMI's commitment to ACT.
- The Olmstead Decision by the Supreme Court which affirmed the right of individuals with disabilities to live in their community rather than be forcibly institutionalized.
- The President's New Freedom Commission Report on Mental Health.

**How well does ACT work?** Here are some outcomes:

- ✓ Fewer hospitalization 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)
- ✓ Positive findings have been replicated in multiple studies.

### **ACT in Iowa**

Primary diagnoses of patients are:

- 65% - schizophrenia
- 15% - schizoaffective disorder
- 15% - bipolar disorder
- 5% - major chronic depression

60% have a co-occurring substance abuse disorder

### **Barriers to ACT in Iowa**

- Cost issues – each team has fragmented funding streams and there is the lack of a strong state mental health agency to coordinate funding and accreditation standards.
- Rurality - PACT teams have been difficult to establish in rural areas of the state. 67% of Iowa counties have no psychiatrist.
- Workforce issues – recruitment, training, continuing education and support and credentialing bodies.
- Requires strong leadership and advocacy at both the state and local levels.

### **Overcoming Barriers**

- A Statewide Advisory Board is needed to develop Iowa's vision for ACT.
- **Workforce issues need to be addressed** (see articles earlier in this newsletter on this topic)
- Address special needs of rural teams
- Address standards adoption and accreditation issues
- Ongoing examination of fidelity to the PACT model
- Use of standardized outcome measures across teams
- **MH/MR/DD/BI redesign** may result in a meaningful mental health agency (see articles earlier in this newsletter on this topic)

- ✓ **Work to make ACT a Medicaid reimbursable service in Iowa.**
- ✓ **Making ACT a Medicaid reimbursable service in Iowa should be a legislative priority in the state legislature.**
- ✓ *ACT could be one of the most effective tools counties across the state could use in delivering services to their citizens with mental illness.*

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



Many thanks to Joan Blundall for speaking to our affiliate meeting on June 4. We all left with copies of the toolkits on depression. Here's more information:

### **Beyond Depression: Tools for Collaboration**

**Beyond Depression** provides three separate, yet related, toolkits for medical providers, patients and their families, and community members. Treatment is most effective when all three groups are actively involved. The management of health and disease is too difficult to be handled in isolation. Healthy communities work cooperatively to make up for resource scarcity.

### **Excerpt - the Toolkit for Those Who Live with Depression:**

Major depression is a common medical condition much like diabetes, heart disease and other chronic disorders. 1 in 4 women and 1 in 7 men are likely to experience an episode of Major Depression at some point in their lives. Many of these people will have repeated episodes. Medical treatment is necessary to control the symptoms of this disease.

Major Depression develops due to a variety of factors. Genetic factors may be a cause since people with a family member with Major Depression are more likely to have the disorder. Personal losses and other stressors, combined with limited assistance from family and community, may lay the foundation for depression to occur and reoccur. Environmental stressors and toxins may trigger an episode. The bottom line is that Major Depression is a biological condition that calls for medical treatment, personal management, and sometimes psychotherapy.

The good news is that **80-90%** of people diagnosed with Major Depression can be successfully treated and recurrent episodes can be avoided or managed.

### **Excerpt from the Toolkit for Community Members**

*Why Communities should be concerned-* Major Depression causes more disability than any other disorder in the United States, and is becoming recognized as a major public health problem.

Major Depression can have serious effects on family members as family relationships are disrupted. Marital relationships can become strained and conflicted. Children of depressed parents are at greater risk for depression, because of family stress and impaired parenting skills.

### **Benefits of Treating Major Depression**

1. Improves abilities in managing life and caring for oneself and others.
2. Helps maintain family and social relationships.
3. Reduces workplace disruptions and revenue losses.
4. Reduces long-term health care costs
5. Reduces attempted or completed suicides.
6. Improves lives and relationships throughout the community.

### **Excerpt from the Toolkit for Medical Providers**

The scientific literature indicates that Major Depression is one of the most costly chronic conditions facing our citizenry. When depression occurs with other disorders (e.g. congestive heart failure, diabetes, cancer, stroke, rheumatoid arthritis), patients may find it more difficult to adhere to depression treatment and engage in self-care. The literature shows that depression is under-diagnosed by primary care providers and they may not follow the recommended treatment regimens.

Primary care providers in Iowa are often in difficult situations because they frequently provide service in Medically Underserved Areas as well as Mental Health Shortage areas. Staff support may be limited. Limited access to specialty services can result in long waiting lists which hinders successful referral processes. Stigma and belief systems place barriers to patients' adherence to treatment recommendations. Beyond Depression is designed to help health care providers deal with these barriers. We also have a desk reference for physicians.

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The next project Joan will be working on is geriatric depression.  
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These publications are part of a project supported by the Wellmark Foundation. These toolkits can be obtained by contacting: The Higher Plain, Inc.

680 Garfield Road  
West Branch, IA 52358  
319-643-5628

Or contact Joan Blundall, Project Director:

[Joan-blundall@higherplain.org](mailto:Joan-blundall@higherplain.org) or downloading the toolkits from their website at: <http://beyonddepression.info>

Please detach, complete, attach check, and mail to NAMI-GDM Treasurer – Don Jayne, 1291 16<sup>th</sup> St., West Des Moines, Iowa 50265

- For Renewal of NAMI – GDM dues for 2006  
 To become a NAMI-GDM member in 2006



Please make checks payable to NAMI-Greater Des Moines

**IT'S TIME**

We look forward to seeing you in 2006!!

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip code \_\_\_\_\_  
 Phone \_\_\_\_\_ E-mail \_\_\_\_\_

**Dues are as follows:**  
 (please check one)  
 \_\_\_\_\_ \$35.00 Individual/Family  
 (\$10 national, \$10 state, and \$15 local)  
 \_\_\_\_\_ \$3.00 Consumers/Limited Income  
 \_\_\_\_\_ \$40.00 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.



**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	<b>No membership</b>	<b>No membership</b>
When dues are paid to NAMI Iowa – you have a state membership and a national membership		
NAMI-National	NAMI-Iowa	NAMI-GDM
Yes	Yes	<b>No membership</b>
<b>When dues are paid to NAMI Greater Des Moines – you have NAMI GDM membership, a state membership, and a national membership (3).</b>		
NAMI-National	NAMI-Iowa	NAMI-GDM
<b>Yes</b>	<b>Yes</b>	<b>Yes</b>

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

NAMI GDM dues also cover all 3 levels of membership for a consumer membership of \$3.00 and a professional membership of \$40.

NAMI GDM dues paid in 2006 cover the calendar year.



"Disclosure is not a black and white choice. Mental illness is a complex experience." — Patrick Corrigan and Robert Lundin, Don't Call Me Nuts: Coping with the Stigma of Mental Illness, Recovery Press, 2001.

According to the [National Institute of Mental Health \(NIMH\)](#), about one in four American adults, or approximately 57.7 million people, will experience a diagnosable mental illness in the coming year.

Millions of these people will be faced with a choice: Do I tell other people— my friends, my family, my co-workers— about my illness, or do I keep it a secret?

Though many will choose to disclose their mental health problems in some way, the stigma and discrimination that still surrounds people labeled with a mental illness will force many others to keep all or part of that information to themselves.

As the quote above illustrates, the decision to disclose mental health problems is not straightforward. In fact, for many people the act of coming out of the closet about having a mental health problem is a complex process of weighing the benefits and risks of speaking up.

Yet, research indicates that, despite its difficulties, self-disclosure has a positive effect on peoples' lives overall— freeing disclosers from secrecy, opening new opportunities for support and recovery, and offering hope to others with similar concerns.

The same is true of the effect self-disclosure has on stigmatizing perceptions. Since public attitudes toward mental illness have been shown to improve when a member of the general public interacts with a person with a mental health problem, the shared act of self-disclosure has an important role to play in future efforts aimed at reducing stigma and discrimination. —SAMHSA Ads Center 4-20-06



70% of all anti-depressants are prescribed by primary care providers, not psychiatrists.

The average primary care doctor visit lasts 8 minutes.

The subject of depression does not usually get brought up unless the patient or family member brings it up.

An assessment for depression is usually not done prior to giving a prescription for antidepressants.

There is usually no follow-up by the primary care physician after the prescription for anti-depressants is given.

70% of persons who committed suicide had visited their primary care physician within the last 3 months.

7% of persons who committed suicide had visited their primary care physician within the last week.

75% of people with depression don't get treatment.

80-90% of those who do seek treatment have successful relief of symptoms.

Depression commonly co-occurs with other chronic diseases such as diabetes, high blood pressure, cancer, etc.

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](http://www.nami.org), for information on research, disorders, treatments, medications and other topics.

*From In Our Own Voice: Living with Mental Illness*

### **Dark Days: A Commonplace Experience**

A severe episode of any serious mental illness often leaves people feeling different and alone, believing that no one understands what they are experiencing.

Their ability to think, focus, and concentrate seems to disappear. They have disturbing changes in their sleep patterns, appetite, and level of energy. They may feel hopeless or worthless and have thoughts that do not make sense.

All of this is usually much worse when first diagnosed and at the beginning of the illness.

Severe brain disorders can turn life upside down, put important plans on hold, and rob people of precious years of opportunities. The stigma/discrimination experienced with a diagnosis of serious mental illness also prompts the reevaluation of one's self-concept and self-esteem.

First you must accept your illness and the fact that it is a serious brain disorder in need of treatment. Dealing with your illness requires changes in your life, and can be a difficult struggle and adjustment. It is important to remember that recovery is possible and this is not your fault.

Recovery from a serious mental illness can be a long difficult journey. For those who have been successful, accepting the reality of having a serious brain disorder was the first step toward being well again. Recovery always leads to a better quality of life and concept of self.

### **Acceptance**

Learning to accept the reality of having a serious mental illness is quite a challenge. It can be hard for anyone to come to terms with having a serious illness, no matter what it is, but acceptance is essential to beginning recovery.

While there is nothing you can do to change the fact that you have a mental illness, you decide how to respond to it. You can make choices that will help you lead the life you want. Please

remember – you are not your illness, you are living with an illness.

With acceptance, you can again begin to take control of your own life. Being a victim is not acceptable. Many people have shared their thoughts about accepting their brain disorders, and they made it clear that the “right” attitude helped them improve their lives. Their experiences may help you understand how important acceptance is to recovery.

### **No One is to Blame**

Having a mental illness does not mean that there's anything inherently wrong with you. Having a brain disorder does not affect your worth as a human being or encapsulate who you are any more than being diabetic would.

In spite of their illnesses, all people are valuable and have much to offer others. Some of the most courageous people in the world are those who are living daily with the realities of having a brain disorder. They and their families should be looked upon for wisdom and guidance.

### **Successes – Hopes – Dreams**

Certain aspects of recovery are common to all people who have brain disorders. Accepting the illness, taking daily medication as prescribed, and using coping strategies for managing stress are basic steps that provide the foundation for moving forward and accomplishing personal goals.

Start small, and build on early successes. Set realistic, attainable goals. Break larger goals into smaller more manageable ones. Accomplishing one goal will give you confidence to go on to the next.

Recovery doesn't happen overnight. Even if there are setbacks, and discouragement sets in, determination to stay as healthy as possible will help you progress toward accomplishing the things in life that are the most personally meaningful.