













NAMI GREATER DES MOINES

AFFILIATE AND SUPPORT GROUP NEWSLETTER

June 2006
“Support, Education, and Advocacy”

<p><u>Education and Support Group Meetings</u> are generally the 1st <u>Sunday</u> of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room. Dates on Sundays other than the 1st Sunday of the month are due to holidays or other special scheduled events. (Coffee and cookies are provided.)</p>		<p><u>Business and Committee Meetings</u> are the 2nd <u>Thursday</u> of the month at 4 P.M. at the NAMI-Iowa Office.</p>									
<p>Sunday, June 4</p> 	<p>The topic will be “depression and suicide prevention”.</p> <p>Joan Blundall, Executive Director of Higher Plain, Inc. will be disseminating depression toolkits, consulting on depression issues, talking about best-practice treatment of Major Depression and increasing understanding of how depression impacts parenting, work roles, and marriages.</p>	<p>Thursday, June 8</p> 	<p>We will be discussing and planning around the following topic areas:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Business</td> <td style="width: 50%;">5. Advocacy</td> </tr> <tr> <td>1. Marketing and membership</td> <td>6. Fundraising</td> </tr> <tr> <td>2. Support</td> <td>7. Special Events</td> </tr> <tr> <td>4. Education</td> <td></td> </tr> </table>	1. Business	5. Advocacy	1. Marketing and membership	6. Fundraising	2. Support	7. Special Events	4. Education	
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	<p>Weekend of June 10-11 Support Group Facilitators Needed!</p>	<p>NAMI Iowa’s Support Group Facilitator Training – 2 day event – This training is designed for the person co-leading a support group. Attendees are expected to use the training as a NAMI Iowa affiliate support group facilitator. Materials, meals, and hotel are paid for. Attendees must cover transportation and incidentals. Call 1-800-417-0417 or email porch@avalon.net. Location of training is in Des Moines.</p>									
	<p>June 28- July 2</p>	<p>NAMI National Annual Convention – “Changing Minds, Changing Lives, Keeping the Promise” at Washington (D.C.) Hilton Hotel. Check www.nami.org for more information and early bird rates.</p>									
<p>Sunday, July 9</p> 	<p>The topic will be dual diagnosis. 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>Thursday, July 13</p> 	<p>We will be discussing and planning around 7 topic areas.</p>								
	<p>Weekend of July 14-16 Family to Family Teachers Needed!</p>	<p>Family to Family Teacher 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 porch@avalon.net for further details.</p>									
	<p>Weekend of July 28-30 VFT Teachers Needed!</p>	<p>Visions for Tomorrow Teacher training – contact Jackie Elfmann at 254-0417 for more details or E-mail at nameducation@mchsi.com. Location of training is in Des Moines.</p>									
<p>Sunday, Aug. 6</p> 	<p>The topic will be mental health and the schools. The Visions for Tomorrow educational class will also be highlighted.</p>	<p>Thursday, Aug. 10</p> 	<p>We will be discussing and planning around 7 topic areas.</p>								
	<p>Wednesday, Aug. 16</p>	<p>Iowa Grants Symposium will be held at the Sheraton West Des Moines Hotel (formerly the Holiday Inn) at 50th & 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>Thursday, Aug. 31</p> 	<p>Family to Family class starts (12 weeks) Call NAMI-Iowa office to sign up – 254-0417. 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>									

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.



“Crazy: A Father’s Search Through America’s Mental Health Madness”

ENEWS - TREATMENT ADVOCACY CENTER
www.psychlaws.org

WASHINGTONIAN, April 2006

[Editor's Note: Many people have tried to help a son or daughter through the throes of mania, but not many of those have been former reporters for the Washington Post, authors of a string of investigative non-fiction books or, in the opinion of one main stream publication, one of the ten journalists or authors in the nation "who have the power to introduce new ideas and give them currency."

When restrictive treatment laws funneled his patently psychotic son from the mental health system into jail, Pete Earley did what comes naturally to him – he sought to find out why our society has designated the criminal justice system as the caretaker of hundreds of thousands incapacitated by severe mental illnesses.

His investigation led him to the Miami Jail and its 9th Floor, where the facility warehouses its inmates who are most ill.

The product of Mr. Earley's explorations is “**Crazy: A Father's Search Through America's Mental Health Madness**” (side note: the “crazy” in the title refers to our framework for treating people with severe psychiatric disorders and not the people themselves). Below is a feature article adapted from excerpts of the work.

Patty Duke calls the book “a godsend” while Bebe Moore Campbell christens it “a clarion call for change and justice.”

To Senator Pete and Nancy Domenici, Earley's work is “as riveting to read as it is important to be read.” We predict that this book will soon take a place on bookshelves alongside “I'm Not Sick, I Don't Need Help,” “Surviving Schizophrenia,” and “Madness in the Streets.”

“*Crazy: A Father's Search Through America's Mental Health Madness*” was released on April 20.

SAVING MY SON

By Earley, Pete.

In his twenties Mike started having breakdowns. When I tried to get him help, I found out that our mental-health system now is mostly jails and prisons.

"Dad, how would you feel if someone you loved killed himself?"

My son Mike sounded tired. We were speeding south on Interstate 95, near Baltimore, racing toward a Fairfax County hospital.

I had rushed to Manhattan that morning to get Mike after his older brother telephoned me in a panic. They both lived in New York City. Mike hadn't slept in five days, had been walking aimlessly throughout the city, and was about to lose his job as a waiter. He was convinced God was sending him encrypted messages.

In the car, Mike burst into laughter: "Dog God! God dog! Get it?"

Just as quickly, he began to sob. I hadn't seen him in such pain since he was five years old and got smacked in the head by a playmate. I had driven him to the hospital that day and held his hand while a doctor stitched him up. Now he was 23.

"Why are you crying?" I said.

"I can't tell you because you'll hate me forever."

I had been a journalist for more than 30 years, a Washington Post reporter, and the author of books about crime, punishment, and society. I'd interviewed murderers and spies, judges and prosecutors, attorneys and defendants. But I was always on the outside looking in.

I had no idea what it was like to be on the inside-until Mike was declared mentally ill.

Our trip from New York to Fairfax in August 2002 was the start of a harrowing journey. Because of what happened to Mike, I've spent four years examining America's mental-health system both as a father struggling to help his son and as a journalist.

Nearly all Americans have a mentally ill relative. Three million Americans are so debilitated by mental illness that they're considered disabled.

Few of us worry we'll wake up mentally ill. But what if the phone rings and it's someone telling you about your sister, your daughter, your mother-your son?

My wife, Patti, had alerted the emergency room at Inova Fairfax Hospital. It's where we had taken Mike when he'd suffered his first breakdown a year earlier.

There had been no warning signs then, no known family history of mental illness.

SAVING MY SON (cont'd)

Mike had seemed ready for success. He had graduated from a Brooklyn art school and had started job-hunting when one of his friends showed up with him at my door.

Mike was babbling about a girl named Jen, telling me she was in danger, that people were going to hurt her and he needed to save her.

None of it made sense. I put him to bed, but he became paranoid. When I finally persuaded him to go to the hospital, security guards had to wrestle him down. That was when I first heard the term "bipolar disorder" applied to him.

With antipsychotic medication, time, and psychotherapy, Mike had become his old self again and returned to New York. I called every Sunday, but our recent conversations had been shorter than usual. Still, I hadn't suspected anything was wrong. The truth was that he and I both wanted to believe that the doctors had made a mistake—that he had been misdiagnosed and his first episode had been a fluke brought on by stress and too little sleep.

Then his brother called. Mike hadn't been taking his pills and was acting crazy.

"Please take your medicine," I said in the car. I'd been trying to get Mike to take Zyprexa, an antipsychotic drug, since I'd picked him up.

"Pills are poison."

Moments later, he said, "Okay, I'll take your damn pill."

He reached for a water bottle but paused before slipping the tablet into his mouth and then dropped his hand next to the car seat. Was that the pill?

I pressed harder on the gas pedal. I had to get him to the hospital. The doctors would know what to do.

Mike and I reached Fairfax Inova at 8 pm. The intake nurse rolled her eyes as Mike rambled on about God. She put us in an examination room to wait. For the next two hours, no one came. Another hour passed and then another. It was now midnight.

"I'm leaving," Mike said.

I flagged down a nurse. Moments later, an emergency-room doctor came in. As he stepped toward Mike, the doctor raised his arms as if surrendering to enemy troops. "There's not going to be much I can do for you," he said.

I thought: You haven't even examined him.

The doctor asked Mike: "Do you know who I am?"

"You're the witch doctor. Ow-ee-ow-ah-ah."

The doctor smiled.

This isn't funny, I thought. I said, "He's been hospitalized before for bipolar disorder. He hasn't been taking his medication."

The doctor cut me off: "What's happened before this moment really doesn't matter."

He asked Mike to name the President. He had him count backward from a hundred. He asked, "What does the phrase 'Don't cry over spilled milk' mean?"

Mike answered each question and then added that God had made him indestructible.

"Virginia law is very specific," the doctor told me. "Unless a patient is an 'imminent danger to himself or to others,' I cannot treat him unless he voluntarily agrees to be treated." Before I could reply, he asked Mike, "Will you take medication?"

"I don't believe in your poisons. Can I leave now?"

The doctor said yes.

Mike got off the exam table and hurried toward the exit.

"But he's not thinking clearly," I said.

The doctor told me if Mike tried to kill himself or hurt someone, I could bring him back.

Nothing can prepare a parent for watching his child being tormented by his thoughts. During the next 12 hours, Mike slipped deeper into a mental abyss.

In the morning, I spiked his cereal with an antipsychotic medication. But Mike spied flecks of the pill's pink shell in the milk and erupted: "Take me to Mom's house!"

His mother, my ex-wife, lives nearby. During the drive, he became so furious at my badgering about his pills that he jumped out before I could bring the car to a full stop. He ran the rest of the way there.

Forty-eight hours later, the Fairfax County police called. Mike had been arrested. He'd gotten up before sunrise and gone outside. Suddenly he felt so dirty that he had to take a bath immediately. He shattered a patio door at a stranger's house and went inside. The homeowners were away. After rummaging through the kitchen, Mike went upstairs to take a bath. Alarmed by the burglar alarm, the police sent a dog inside. It bit into Mike's arm and dragged him downstairs. It took six officers to subdue him.

The police drove Mike to the Woodburn Center for Community Mental Health, less than a mile from the Inova emergency room where I'd first taken him for help.

A police officer, Vern Albert, was standing at the Woodburn Center's entrance.

"Even though your son has broken into a house, unless you tell the medical personnel inside that he's threatened to kill you, they aren't going to treat him," Officer Albert said. "We'll end up taking him to jail, and you don't want that. Not in his mental condition."

"But he hasn't threatened to kill me."

Albert gave me an exasperated look.

So I went inside and lied. The police drove Mike to the psychiatric ward at Inova Mount Vernon Hospital in Alexandria.

When I got there, I asked a nurse, "How long does it take antipsychotic medicines to work?"

She seemed surprised: "Just because your son is being admitted doesn't mean he's going to be treated." It was against the law for doctors to force Mike to take antipsychotic medication, she told me, even though he was clearly psychotic.

A few hours later, an attorney called and explained she had been appointed to represent Mike. I was hopeful because I thought she was going to help him get treatment. But she said her job was to get him released as quickly as possible if that was what he wanted.

SAVING MY SON (cont'd)

"But he's not thinking clearly," I said. "He's sick."

"I'm just doing my job."

At a commitment hearing the next morning in the hospital, Mike agreed to sign himself into treatment.

"Why are you doing this?" the hearing officer asked.

"Because I'm having a relapse and my parents want me somewhere safe."

I felt relieved. Now he could get help.

That night, I brought Mike a box of fast-food chicken; I knew he wouldn't like hospital food. It happened to be my 51st birthday, and despite his confused state, Mike remembered and handed me a hand-drawn card.

From nowhere, he mentioned a fishing trip to South Dakota we'd once taken. He was five and wandered off from the lake. The ground gave way at the edge of a ravine, causing him to fall halfway down before he grabbed a shrub and stopped the fall. I climbed down and rescued him. Over time, the story grew. The gully became a hundred-foot cliff. That was when he was little and I was still his hero.

We laughed about the story in the hospital. Then I said, "Get well, son-that will be the best birthday gift ever."

The next morning, the hospital psychiatrist called. A pill had been found on the floor of Mike's room. He had pretended to take it and then spit it out. That night, I confronted him.

"I keep thinking this is all a dream," he said. "I'll just wake up and it didn't happen."

I touched his hand. "This is real. You've got to take your medication."

Dr. James Dee called the next morning. Mike was taking his pills, but there was a new problem. Our insurance company wanted Dr. Dee to discharge Mike later that day. Dee didn't believe Mike was ready, but because Mike hadn't tried to kill himself and was now taking his pills, the insurance company wanted him out.

I called the insurance company. The woman there said, "Your son can recover at home."

"But he's not stable!" I said.

Then I did something I had never done before as a journalist. I warned her I was a former Post reporter and was friends with Mike Wallace of 60 Minutes. If her company forced my son out, I'd notify the Post. I'd call Wallace.

I had lied to get Mike hospitalized and now I was violating my professional ethics to keep him there.

That afternoon, Dr. Dee telephoned and said the insurance company had backed off. Mike could stay in the hospital.

He slowly got better, and we arranged for him to enter a community day-treatment program in Reston. I began to feel optimistic. Then the phone rang.

"I'm Detective V.O. Armel," the caller said. "Two felony warrants have been issued for your son's arrest."

Mike had been charged with "intentionally destroying, defacing, and damaging property in excess of \$100" and "breaking and entering . . . with the intent to commit larceny." Both charges carried up to \$10,000 in fines and five-year prison terms.

"But my son's mentally ill," I said. "He didn't know what he was doing. I tried to get him help in a hospital before this happened."

"Just because your son is mentally ill doesn't mean he can't be charged with breaking the law."

A mental-health revolution has occurred in the United States. In 1955, some 560,000 Americans were patients in state mental hospitals. If you took the patient-per-capita ratio in 1955 and extrapolated it out to today, you'd expect to find 930,000 patients in mental hospitals. But there are fewer than 55,000. Where are the others?

More than 300,000 are in jails and prisons. Another half million are on court-ordered probation. The largest public facilities for the mentally ill are jails and prisons. They have become our new asylums.

To find out why, I went to Miami. I chose that city for two reasons. I didn't want to risk irritating local officials in Fairfax by writing about the jail system here, as they would be in charge of deciding Mike's fate. Also, I had been told that Miami has a higher percentage of mentally ill residents than any other big US city. Three percent of the population in most American cities is mentally ill; in Miami, the figure is 9 percent.

In addition to the usual 3 percent, 3 percent come to Miami for the warm weather, and another 3 percent arrived thanks to Fidel Castro. In 1980, Castro released patients from Cuba's mental hospitals into the stream of refugees fleeing to Florida from the port of Mariel.

Miami has been struggling to deal with its mentally ill. Its jail system is the nation's fourth largest. Sixteen percent of its inmates have severe mental disorders. The craziest are housed on the downtown jail's ninth floor in the "suicide watch" cells with plexiglass front walls so officers can watch them.

Dr. Joseph Poitier, the psychiatrist at the Miami jail, took me on his morning rounds. As we entered C wing, I gagged. The air smelled of urine, perspiration, excrement, blood, and discarded food. Prisoners hacked, coughed, groaned. Correctional officers yelled commands. Leg chains clanked as prisoners arrived.

A lot of it was typical jail noises. When I listened more closely, I heard asylum sounds: a prisoner sobbing, another moaning, a third screaming.

Thud, thud, thud. Then louder: THUD. THUD. THUD. An inmate was banging his forehead against a plexiglass cell front.

The inmates peering out in the first cells were naked. There was nothing in their cells except a combination sink and toilet. No chair, no place to sleep. The temperature in each cell hovered in the 60s.

Inmates trembled in the chilly air. A few rocked back and forth on their heels. Some had urinated and defecated on the floor. Most stood at their cell fronts looking out. They had blank expressions, hollow eyes.

"What I do here is triage," Dr. Poitier said.

There is no meaningful treatment, he said. As we moved from cell to cell, Poitier tried to persuade prisoners to take their medication. They had arrived on C wing with no medical records. Many were homeless. Most of their families

SAVING MY SON (cont'd)

had given up on them. Psychotic inmates could spend months there. Others would be released only to be arrested within hours on charges related to their illnesses, such as trespassing or being a public nuisance.

If they were charged with a felony, they would eventually be sent to one of Florida's three forensic hospitals. But there was a long waiting list, and even then they wouldn't be treated. Instead, they would be given medicine until they were judged "competent" for trial and returned to Miami. Sometimes it could take five or six trips between jail and hospital before they were stable enough to appear in court.

Dr. Poitier and I paused outside a cell designed for two men but holding six. A prisoner was lying on the floor next to a toilet that another was urinating in. Because the splash was hitting the inmate's face, Poitier asked a prisoner to rouse the man to make certain he was not dead. The inmate raised his head and rolled over.

As we were about to move on, I noticed movement under a steel bunk. Dropping to my knee, I peered through the plexiglass wall. A man was curled up—he had schizophrenia, which can cause hallucinations and confused thinking—and was chewing on orange peels. He smiled and waved.

I checked my watch after we finished the rounds. Dr. Poitier had spoken with or observed 92 inmates. His rounds had taken 19½ minutes.

"A lot of people think someone who is mentally ill is going to get help if they are put in jail," Dr. Poitier said. "But the truth is we don't help many people here. We can't."

A man with bipolar disorder, which causes rapid mood swings, had been put in jail. For 25 years, he'd taken his medication and lived an ordinary life. But then he'd lost his job and couldn't afford his pills. He had attacked his father and been arrested. In jail, he jumped from a top bunk headfirst into the floor, snapping his neck. Now he was a paraplegic.

"Jails are not hospitals," Dr. Poitier said. "Mentally ill people belong in hospitals."

That night I woke up sweating. I had dreamed I was making rounds with Dr. Poitier and spied an inmate under a bunk. When I bent down to see, the inmate eating the orange peel was Mike.

In a well-schooled Virginia drawl, Fairfax defense attorney Andrew Kersey assured me he'd be able to cut a plea bargain for Mike. Because my son had no previous criminal record, was clearly psychotic when he broke into the house, and was now in a treatment program, Kersey felt confident the Fairfax County prosecutor assigned to the case would reduce the two felony charges to misdemeanors. Mike would be given a year's probation.

On the morning of his court appearance, I asked Mike if he understood what was happening. He didn't. He was still groggy from medication but was eager to go to court. When I asked why, he replied, "I get to wear my new suit!"

Before becoming manic, he had bought a suit for a job interview. His court appearance would be the first time he'd worn it.

"There's a problem," Kersey said moments before the hearing. "Our plea deal is off."

The assistant prosecutor had never cleared the deal with the homeowners. When they heard about it that morning, the wife got angry.

"She wants your son put in jail or an institution," Kersey said. "The victims are demanding he plead guilty to at least one felony charge."

"But a felony will ruin Mike's future," I said. His college degree was in a profession that required a Virginia state license. Felons were ineligible.

Kersey said, "What's odd is the judge will still give Mike the exact same sentence."

If Mike pleaded guilty to two misdemeanors, he'd get a year of probation. If he was forced to plead guilty to a felony, he would still get a year's probation.

Kersey wasn't certain whether the wife understood this, so he went back into the courtroom to talk to her, leaving us to wait in the hallway. I checked my watch. Six minutes to go before court started.

Kersey reappeared. The husband didn't care, but the wife wanted Mike punished. Before Mike had taken his bath in their house, he broke a family heirloom dish, turned photos of her children face down on the mantel, drank some liquor, and left the bath water running, causing extensive damage.

Most of all, Kersey said, the wife felt violated. Mike had taken a bath in her teenager daughter's bathroom. Why had he chosen their house? What if he came back? She was so unnerved that she was pressuring her husband to sell their house.

"What she really wants," Kersey said, "is for your son to be put in prison."

"But he's mentally ill," I said. "Bipolar disorder is a chemical brain disorder. It's like cancer. You don't do anything to get it. It just happens to you."

Kersey nodded at his watch. Four minutes to go. He explained our options. If Mike pleaded guilty to a felony, the case would be over. If he pleaded not guilty, the judge would set a trial date. But a jury would probably find Mike guilty because he'd been arrested inside the house. It might send him to prison.

There was a third choice. Mike could plead not guilty by reason of insanity, but if we won, he wouldn't be turned loose. He would be taken directly from the courtroom to jail to wait for a bed in a Virginia hospital. Mike could spend weeks waiting, and there would be no way to know when he might be released after he was sent to the hospital. He'd also be identified in court records as being innocent but insane.

"We'd win in court," Kersey said, "but your son would lose."

Three minutes and ticking. Three minutes to decide which was the lesser of three punishments that all seemed unfair.

"Offer them money," I said.

Kersey said no. The wife was legitimately afraid. She felt twice victimized. Mike had broken into her house. The prosecutor had not consulted her about the plea deal. She was the victim, not Mike.

Two minutes.

SAVING MY SON (cont'd)

"What do you want to do?" Kersey asked.

I didn't know. How could this be happening?

Kersey had another idea. He'd ask Detective Armel for help. The police often bond with victims. He went back into the courtroom while Mike and I waited. Mike didn't have any idea what was happening.

When Kersey rejoined us, he shook his head. Nothing had changed. Detective Armel had explained that Mike's punishment would be the same, but it hadn't mattered to the wife.

We were out of time. Mike and I followed Kersey into the courtroom. I noticed Detective Armel was still speaking to the victims. I didn't know what to tell Kersey. Which was better? Pleading guilty to a felony and having Mike marked for life? Risking a trial and having him found guilty? Or pleading that Mike was insane? I'd been given less than ten minutes to make a decision that was going to determine my son's future.

The judge entered. The clerk began reading the calendar of cases. Mike's name was third on the list. I was frozen with indecision. I looked at Mike. I looked at Kersey.

At that moment, I saw Detective Armel walk down the aisle to talk to the prosecutor. I glanced at the husband and wife. She was sobbing.

Kersey hurried up to Armel. The clerk called Mike's name. The prosecutor said, "Judge, we'd like to continue this case."

The judge agreed to put it aside for three months.

Kersey hustled us out into the hall. Detective Armel had won us more time by telling the wife that Kersey might be able to come up with an offer that would be better for them than one year of probation.

The homeowners and Armel exited the courtroom. None of them looked at us.

"Mike," I said, "do you see those people walking there?"

He had no idea who they were.

In 1843, activist Dorothea Dix visited a Boston jail to teach a Bible class and discovered that mentally ill prisoners had no heat despite freezing temperatures. The jailer said: "The insane don't need heat."

Dix spent the next two decades exposing how "lunatics" were abused in jails and prisons. She would be credited with persuading 30 states to build asylums for treating the mentally ill rather than punish them because they were sick.

By 1900, every state had a mental institution. Patients were often committed by relatives. The system was abused, and the hospitals became a catchall for society's disposables—the elderly, the deaf, the blind, the poor.

On May 6, 1946, Life magazine published the story "Bedlam: Most U.S. Mental Hospitals Are a Shame and a Disgrace." It began by describing a mental patient being tortured to death by the staff. Other articles compared conditions in state mental hospitals to Nazi concentration camps.

In 1963, President John F. Kennedy asked Congress to spend \$3 billion to replace the nation's state hospital system with a network of community mental-health centers. The discovery of promising new antipsychotic drugs made it possible for mentally ill patients to return to their hometowns and live outside locked wards.

It was a good plan, but then Kennedy was assassinated, the Vietnam War escalated, Congress got ensnared in Watergate, and the mentally ill were forgotten.

In the 1980s, civil-rights attorneys began filing class-action lawsuits to close state hospitals. They won a slew of precedent-setting cases.

The police could no longer arrest someone just because he was mentally ill; a psychotic person couldn't be locked up indefinitely in a hospital or be forced to take medication or undergo forced treatments such as electric shock or lobotomies. The US Supreme Court ruled that the mentally ill were entitled to the same due-process protections as suspects in criminal trials. Congress agreed to make the mentally ill eligible for Medicaid and Medicare, but only if they were not living in a state hospital.

Congress gave state legislators a way out. Afraid of class-action lawsuits and mounting public pressure to do something about the asylums, state legislators began closing mental hospitals and discharging patients. This exodus was called deinstitutionalization.

And what happened to the mentally ill?

In most states, patients were released without much effort to link them to community services—if there were any. President Kennedy's call for \$3 billion went unanswered. There was no real network of community treatment centers, and those that had been built were never intended to help deeply disturbed patients.

Chronically mentally ill people began appearing on street corners. By the 1990s, so many were being locked up on minor charges that a word emerged: transinstitutionalization—bureaucratese for the "transfer" of the mentally ill from hospitals into jails.

Like most states, Florida made no preparations before it began dumping patients. Eventually, it found homes for many in "assisted-living facilities"—cheap hotels and boarding houses. Today 4,500 mentally ill patients live in 650 ALFs in Miami. Almost 400 of these ALFs fail the state's minimum standards for boarding homes. They're unsanitary, unsafe, and in most cases wretched.

"I wouldn't put my dog in this house," a Miami police officer told me when we toured an ALF. But Florida allows these homes to operate because there is nowhere else to house the mentally ill.

Florida's state mental hospitals had been closed by deinstitutionalization, but the lives of the mentally ill hadn't gotten better. The state had scattered them and hidden them.

I checked the Washington area. Since 1955, the District has lost 92 percent of its public mental-hospital beds; Maryland has lost 86 percent, Virginia 84 percent. Although private hospitals have opened some wards, there are only 98 beds for every 100,000 mentally ill people in the metropolitan area.

As in Florida, the number of mentally ill in Washington-area jails has mushroomed. Today 2,551 inmates in Virginia state jails and prisons are considered severely mentally ill. Another 3,330 prisoners in Maryland—14 percent of the state's inmate population—are mentally ill. Thirty-three percent of the District's inmate population require mental-health services.

SAVING MY SON (cont'd)

In a letter to the couple whose house Mike had broken into, our attorney said Mike would meet a much tougher set of restrictions if the homeowners would allow him to plead guilty to misdemeanors.

Instead of serving a year of probation, he'd serve two. He'd stay in the day-treatment program, continue seeing a psychiatrist after he was discharged, and submit to blood tests to prove he was taking his bipolar medicine. Kersey would obtain a restraining order that would forbid Mike from coming near their home. He reminded them that Mike had a clean record, was truly remorseful, and had chosen their house at random.

"This should do it," he told me.

A few weeks later, he received the couple's response. They wanted Mike in jail. They insisted he plead guilty to a felony. If anyone deserved sympathy, they said, they did.

"You need to prepare Mike," Kersey warned me. "He's going to become a felon."

Mike was wearing his new suit again when we returned to court. Just before it was about to start, Kersey came rushing up. The victims had telephoned the prosecutor's office the night before and asked for a continuance. The husband was out of town on business, and the wife didn't want to come to court alone. But the prosecutor had turned them down.

"If the wife isn't here, there's a chance the prosecutor will let your son plead to the two misdemeanors," Kersey said. He'd shown the prosecutor the list of additional restrictions that Mike was willing to accept.

We stepped inside. Every time I heard the courtroom doors open, I turned to see if it was the wife. The judge entered. The clerk began to call the docket. When he reached Mike's case, I heard the door swing open. When I glanced around, it was a stranger who had come in.

Still, none of us knew whether the prosecutor would accept our offer.

"Your honor," Kersey said, "we have reached an agreement in this matter."

In less than three minutes, it was over.

As we left the courtroom, I thought about the wife. I had come to despise her. But now I wondered how I would have felt if I had come home and discovered that a madman had broken through my patio door. How would I have reacted if he'd taken a bath in my teenage daughter's tub? What if I had become so distraught that I had put my house on the market? Would I have acted as she had? Or would I have showed compassion?

Because it was Mike, the answer had seemed obvious. But when I stripped away his face and replaced it with a deranged stranger's, I realized I might have reacted much as she had.

She and her husband hadn't had the knowledge that I now had about mental illness. But I wouldn't have had it either had it not been for Mike's plight.

I began to see the wife as the reader I most wanted to reach, the audience I needed to persuade. I was also forced to realize that she was a victim. Mike had victimized her.

I hoped that someday she would come to see that he had been a victim, too.

Mike kept the plea deal. He completed the day-treatment program, stayed on his medication, and began looking for a job.

He'd been told that being mentally ill was nothing to be ashamed about because it was a chemical imbalance. But when he mentioned that he had bipolar disorder, his job applications were rejected. Mike had a college degree, but our neighborhood supermarket turned him down for a job bagging groceries.

A sympathetic human-resources director told him not to be so forthcoming: "If I knowingly hire someone who is mentally ill and you end up hurting someone on the job, that person can sue me and the company. No one is going to hire you if you tell them the truth."

Mental illness, we discovered, carried its own life sentence.

A temporary service found Mike menial work, and he eventually became a full-time employee. Proud of his new independence, he invited me to lunch. We met at a steakhouse and sat outside.

He had come a long way. He recalled how I'd brought him fried chicken in the hospital. We talked again about the fishing story-about his falling down a South Dakota cliff and my rescuing him.

I watched him eat his steak. He was a handsome man. Tests showed his IQ was higher than mine. I realized how lucky we both were. He had recovered. He hadn't spent time in jail or been marked as a felon. He was doing well on his medication. His bipolar disorder was in check.

I thought about people I'd met in Miami. Judy Robinson's mentally ill son had been in and out of jail 40 times. Another mother's son had lived on the streets for nine years, despite her attempts to get him help. She had seen him rooting through garbage cans every morning on her way to work and had been helpless under the law to intervene. Civil-rights laws that had been passed to prevent the mentally ill from being abused in state hospitals were being cited to keep them from getting help until they hurt themselves or someone else.

I'd met a woman in Miami the same age as Mike. Her mother had gone to court several times to force her into a hospital, but doctors had repeatedly discharged her because her life wasn't in imminent danger. She had been twice gang-raped while psychotic on Miami's streets.

Another woman, Alice Ann Collyer, had shoved an elderly bystander at a bus stop during a delusional moment. Because she was considered dangerous, prosecutors had transferred her between the Miami jail and a state hospital for three years to keep her off the streets-three years in jail without being convicted of a crime.

Miami's treatment centers were overwhelmed and inadequate, its mental-health system broken. We now treat the mentally ill in America just as we did in the 1830s, when they sat in freezing jail cells because there was nowhere else for them to go.

I had begun my research because I wanted to save my son. I now realized that I had been searching for a way to save both of us. I had been trying to learn how a parent comes to accept his child's mental illness. So what had I learned-not

SAVING MY SON (cont'd)

as a reporter but as a father? Several quiet truths.

Life is often unfair, and nothing in life is guaranteed. There was a slim chance Mike would never have a relapse. But there was a better chance he would stop taking his medicine because he would become convinced he no longer needed it. His illness wasn't over.

"You know what your problem is, Dad?" Mike said as if reading my thoughts. "You worry too much. Just eat your steak and enjoy this lovely day. Everything is going to work out fine for me-you'll see."

It was the optimism of youth talking. At that moment, everything was fine. My son was thinking clearly. He had a job, was making plans for his future, and seemed happy.

No one knows whom mental illness might strike or why. There's no known cure. It can last forever. Because Mike is sick, he'll always be dancing on the edge of a cliff. I can't keep him from falling. All I can do is stand next to him, ready to extend my hand. All I can do is to promise that I'll never abandon him.

The sun was warm on my face. I was a proud father. Mike was laughing. He was safe. At least for now.



Iowa's Prisons and the Count of Inmates with Mental Illness

Excerpts from Dm Register 4-8-06

More than one-third of the 8800 inmates in Iowa's prison system have been diagnosed as mentally ill. Previous estimates were 16-18%. This means there are almost 3,000 inmates who fit that category. About 31% of Iowa's male inmates are considered mentally ill, while 60% of the state's female inmates have mental illness. Depression, substance abuse disorders and anxiety/panic disorders are the leading psychiatric diagnoses for both men and women in Iowa's prisons.

My Story

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.

Old vs. New Medication: Stories Wanted

NAMI wants to hear from consumers or family members describing the difference that newer antipsychotic medications for schizophrenia have made in their lives. Please send your short, personal story to storybank@nami.org, including your name, age, city and state, telephone number, diagnosis, treatment history, and relevant details.

NAMI will consider stories for use in testimony, media interviews, or other advocacy efforts. All submissions remain confidential. No story will be used without further contact and direct authorization.

SUPPORT GROUP MEETINGS

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.

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 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. 24th 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 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.

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

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 to see if you may qualify for a variety of programs available.



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 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 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.

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. 42nd St.
Des Moines, Iowa 50312

Or E-mail: tbomhoff@mchsi.com



Speaker at our June 4 meeting

The topic will be “**depression and suicide prevention**”.

Joan Blundall, Executive Director of Higher Plain, Inc. will be disseminating depression toolkits, consulting on depression issues, talking about best-practice treatment of Major Depression and increasing understanding of how depression impacts parenting, work roles, and marriages



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, nation-wide 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>

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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



Meds Alone Couldn't Bring Robert Back

by Jay Neugeboren, *Newsweek*, 2-6-06

"Experts like to debate the effectiveness of new drugs, but they overlook a key element of recovery."

When my brother Robert arrived at Bronx Psychiatric Center in 1998, Dr. Alvin Pam, chief of psychology, told me it was the consensus of the staff that Robert would never be able to live without supervision, and if discharged, was destined to be repeatedly re-hospitalized. By this point in time, my brother had been a patient in the New York state mental health system for nearly 40 years, and had been given nearly every antipsychotic medication known to humankind.

But he had not yet been given any of the new medications – the so-called atypical anti-psychotics a National Institute of Mental Health study recently found were not significantly better than the old ones, a discovery that has caused intense debate in the mental health community. (*The study was CATIE I – which has since been further explained in CATIE II – see May 2006 NAMI GDM newsletter*).

Robert's reaction to the drug was seemingly dramatic. Several months after Robert started taking it, Dr. Pam called to say his recovery was nothing short of miraculous – he was clear thinking, free of delusions, and the hospital was planning his discharge.

A few weeks after that, Robert telephoned. "Alan's leaving – Alan's leaving!" he kept screaming. Alan was my brother's social worker – a man to whom he was very attached and whom he had known for many years, from his long-term stay at another hospital. I called and discovered that, without warning, Alan had transferred to another state hospital.

Robert began having tantrums, hallucinations, bodily tremors, irrational fears, panic attacks, and he became both dangerously manic and depressed. It would be more than a year before the hospital would again prepare him for discharge. The question, then: why did the medication that worked so well – so miraculously – on Monday stop working on Tuesday? The answer: because Robert was deprived of a relationship that had been a crucial element in his recovery.

At about this time I was interviewing hundreds of former mental patients for a book I was writing. They were people who had been institutionalized, often for periods of 10 or more years, and who had recovered into full lives: doctors, lawyers, teachers, custodians, social workers. **What had made the difference?**

Some pointed to new medications, some to old; some said they had found God; some attributed their transformation to a particular program, but no matter what else they named, they all—every last one—said that a key element was a relationship with a human being. Most of the time, the human being was a professional – a social worker, a nurse, a doctor. Sometimes it was a clergyman or family member. In every instance, though, it was the presence in their lives of an individual who said, in effect, "I believe in your ability to recover, and I am going to stay with you until you do" that brought them back. So it was with my brother, who, through his daily collaboration with Alan and the dedication of Dr. Pam (who refused to go along with the staff consensus that Robert would never live on his own) has not had a single recurrence for more than six years, the longest stretch in his adult life.

At Robert's new home at Project Renewal in Hell's Kitchen, the staff is equally dedicated to the 60 or so residents. Re-hospitalization rates are below 3% each year, and director Jim Mutton says, "Most individuals remain compliant with their medications for years at a time."

Like Jim, I too have witnessed hundreds of formerly homeless, mentally ill adults renew their lives not only through access to a wide range of medications, but through access to individuals like Jim and Dr. Pam, who believe that pills, while useful, are only a small part of the story, and that the more we emphasize medications as key to recovery, the more we overlook what is at least as important: people working with people, on a sustained long term basis.

In New York State, there are more than 60,000 individuals living with psychiatric disabilities. What does it matter if one medication is superior to another if 34,500 of these people have no safe place to live, and therefore no opportunity to work, no choice of treatments and no access to dedicated individuals who are being paid decent wages to work with them?

Let's provide a range of medications, and let's study their effectiveness, but let's remember that the pill is the ultimate downsizing. Let's find resources to give people afflicted with mental illness what all of us need: fellow human beings upon whom we can depend to help us through our dark times and, once through, to emerge into gloriously imperfect lives.

"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



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 (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).

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Tel: (919) 960-8118
Fax: (919) 960-7745
E-mail: 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 2nd 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.

An example of the research funded is the development of a treatment approach using electrical stimulation – similar to a heart pacemaker – to overcome acute melancholia or deep depression. NARSAD gave multiple grants to Dr. Helen Mayberg at the U. of Toronto which supported the research and clinical trials with patients.

Wearing a silver ribbon pin shows your support for brain and behavior research.



No Extra Cost for Mental Health Insurance

Federal Employees News Digest 4-10-06

Health insurance that covers mental health as well as it covers physical health doesn't necessarily cost extra, and can actually result in significant cost savings, according to a new study.

The study, published in the New England Journal of Medicine, shows that, contrary to long held fears by policymakers, several Federal Employees Health Benefits (FEHB) plans that offer parity of coverage do not cost extra. And they spare subscribers significant out-of-pocket of costs, too.

The study authors looked at nine FEHB plans, including two "control" plans that did not pay equally for mental health care – a factor that was thought might save the insurer money.

But offering parity in insurance benefits for behavioral health care resulted in a jump in use only in one plan – in the others, mental health care usage stayed the same or even went down.

The idea of equal insurance coverage for mental health problems, particularly for federal employees, has been tossed around Washington since John F. Kennedy's presidency.

But concerns about expense won out until 1999, when President Bill Clinton directed the Office of Personnel Management to begin offering health insurance that provided parity in mental health benefits. This new study is the first to compare the new plans' costs in detail.

The authors admitted it was difficult to ensure that, in a parity plan, quality will be maintained over the long haul. But data showed that follow-up care for depression – a good indicator of quality – stayed the same after plans converted to parity coverage.

For an abstract of this study, go to:

<http://content.nejm.org/cgi/content/short/354/13/1378>



National Children's Mental Health Awareness Day

*Capitol Hill Luncheon
May 8, 2006*

*Excerpts from Statement of Michael J. Fitzpatrick,
Executive Director, NAMI*

Introduction

NAMI is delighted to be joining our national partners today in honor of the inaugural national children's mental health awareness day.

Reports by the U.S. Surgeon General and President Bush's New Freedom Commission on Mental Health offer great hope to the millions of children and adolescents in this nation living with mental illnesses and their families.

We know that through appropriate and early identification, evaluation and treatment – children and adolescents with these illnesses can lead productive lives. They can achieve success in school, in work and in family life. They have the chance to thrive in their communities – something that all children want and deserve.

Unfortunately, the overwhelming majority of children with mental illnesses are not identified. They simply fall through the cracks and fail to receive much needed services and supports.

Research released in June of 2005 by NIMH found that half of all lifetime cases of mental illness begin by age 14 and that despite effective treatments, there are long delays - sometimes decades - between the first signs of symptoms and when people get treatment. That study also revealed that untreated mental illnesses can lead to more severe and difficult to treat illnesses.

A Focus on Schools

You have all heard the data about how few children are identified and get treatment for their mental illnesses. I am going to focus on how these children do in school.

You all remember what it was like to go to elementary, junior and high school. Now add to that experience mental illness and stigma.

Children with mental illnesses in schools are labeled as "bad" and "poor academic performers." Their families are often blamed by the schools for their child's illness. It's hard to imagine a teacher blaming a family for their child's asthma or cancer. Yet families continue to be blamed for mental illnesses.

As a family organization, we hear every day about the toll that mental illnesses take on the lives of our young people. Just this month, we heard from two families from as far away as Wisconsin and Washington State. In both cases, the child suffered from a mental illness and in both cases they were relentlessly teased and bullied by students in school. The parents expressed grave concerns about the bullying and the lack of understanding about their child's illness, but the schools took no action. Tragically, this 7th grade boy and 10th grade girl committed suicide. Two promising lives taken because schools and families could not work together.

A quick look at the data confirms that these stories are part of a larger, bleak picture. In a 2001 report to Congress, the Department of Education revealed that almost half of students with a mental disorder dropped out of school. Students with mental disorders continue to have the highest drop out and failure rates of any disability group. Those numbers need to change.

There is hope. We greatly appreciate our nation's teachers and school professionals and we know that the overwhelming majority of them want to see students reach their full academic and social potential.

Many educators have told us that they feel ill equipped to meet the needs of students with mental illnesses.

In response to the experiences of both teachers and families, NAMI recently launched a new program: **Parents and Teachers as Allies**. This program is designed to help teachers recognize the early warning signs of mental illness before a child is labeled as "bad" or "dumb." It helps them communicate with and build alliances with families.

Parents and caregivers share information about the joys and challenges of raising a child with a mental illness. The program also includes adults with mental illnesses who had their first symptoms as children. They talk about their days in school and how they were treated.

This program is being piloted in Florida, California, Illinois and Utah. The response has been very positive. Educators really want information and this program has taught us a great deal about the challenges facing schools. Our approach right along has been for families to work side-by-side with school professionals – joining together for positive change. It puts families in the driver's seat, consistent with the values and principles that have helped make SAMHSA's systems of care program work so well for youth and families. But Parents and Teachers as Allies is just a small program and when 50% of our children are dropping out, we need much much more.

First, we need a place for children and families to go when a child clearly needs an evaluation and treatment. Too many of our communities do not have an appropriate infrastructure of effective home and community-based services. The SAMHSA systems of care program has shown us how this can work to benefit children and families but we need more of

our communities to develop effective systems of care. This will take increased funding.

Second, we need more trained mental health professionals, especially in our nation's schools. Data from the Department of Education shows that there are approximately 513 students for each school counselor in our schools. This ratio is more than double the recommended ratio of 250 students for each school counselor. It is difficult to imagine how a counselor could even know the names of 513 students, let alone how to effectively address their social and academic needs.

We also have a critical national shortage of child psychiatrists. **The Healthcare Crisis Relief Act, currently pending before Congress** is designed to help end the workforce shortage of school and community-based child mental health providers.

There are also efforts in a handful of states to transform their state mental health care systems, including child-serving systems. We greatly appreciate SAMHSA's commitment to transforming mental health systems across the country consistent with the recommendations included in President Bush's New Freedom Commission report.

But when only 1 in 5 children with mental illnesses are identified and getting treatment, all states need to be involved in the transformation work. This will also take increased funding.

Too many kids are being robbed of their potential when they go undiagnosed and untreated. We simply must implement effective early identification programs and link these children and families to services. No longer should kids lose critical developmental and school years that simply cannot be recaptured.

As the data from the SAMHSA systems of care communities shows, investing in effective mental health services can make a world of difference for children and families. We need to build on this success so that we do not continue to spend money in all of the wrong places.

We appreciate this opportunity to share the first annual Children's Mental Health Awareness Day with all of you and look forward to working with our national partners, members of Congress and other colleague organizations to improve the lives of children, youth and families.

Depression in the Brain

The Infinite Mind - Broadcast Week of April 23

Dr. Peter Kramer examined new research on the biology of depression including new findings showing depression is not only a disease that affects the balance of chemicals in the brain, but the anatomy of the brain, as well.

This is the latest scientific evidence confirming that clinical depression is a physical, medical illness which causes changes in the brain. These studies should quiet any remaining claims that depression is not a real illness or exists "only in the mind".

Dr. Yvette Sheline (Washington University) described how in her research, she used structural MRI to look at the hippocampi of women suffering from recurrent depression and found the hippocampal volume in the brain was smaller in these women than in match controls. In addition, the decrease in volume appeared to be proportional to the number of days depressed. She also found subtle memory problems in these women.

Please detach, complete, attach check, and mail to NAMI-GDM Treasurer – Don Jayne, 1291 16th 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	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 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.



Moodswings and Creativity

Aristotle associated creativity with melancholia and depression. He stated “All who are eminent in philosophy, politics, poetry and arts had tendencies towards depression”. Between 1770 and 1900 a mad

genius myth was wide spread in Europe in which “suffering was associated with art”. At that time the writers and people involved in the various forms of art felt that depression, madness were often associated with genius in the art fields.

Clinical evidence exists that during depressions or manic episodes, work is usually mildly to severely impaired.

When an artist is **between** the extremes, increased creativity can result. Dr. Fieve, in the book Moodswings, contends that swings of creativity and unproductiveness are very similar to the swings of depression and elation. He cites further examples of men in history who have suffered from some form of mood swings.

Handel wrote his most famous work, the Messiah, an orchestrated work of approximately 200 pages, in only 6 weeks. Most composers would probably take nearly 1 year to compose such an extensive work. It is Fieve’s contention that Handel was in a hypomanic mood swing at the time he produced this incredible work.

Rossini wrote the Barber of Seville, a well regarded opera with full orchestration, in 13 days. Later it was found that it takes 13 days to recopy the opera.

Other major creative historic figures were Honore de Balzac and Van Gogh. They both suffered from psychiatric illnesses and were hospitalized in the equivalent of our psychiatric facilities several times in their lives. Both suffered from some sort of mood swings in which they returned to a fairly normal state after several months of being institutionalized.

Others cited in the book were Robert Schumann, Ernest Hemingway, Virginia Woolf, Hart Crane, Dylan Thomas, Thomas Wolfe, F. Scott Fitzgerald, Ralph Nader, Abraham Lincoln, Winston Churchill, and Theodore Roosevelt.

People with manic depressive illness can be very productive. They can achieve great things. But only while they are controlled and either not too high or not too low.

Lithium

In 1817 a young Swedish chemistry student, Johan Arfvedson, discovered lithium. He named it lithium because it was found in stone (lithos in Greek).

Lithium salts occur in mineral rocks, natural brines, mineral waters and in some plant, animal, and human tissues. The presence of lithium in mineral waters of European and American spas, used for drinking and bathing, was thought to prompt physical and mental health.

In 1949, the Australian psychiatrist, John Cade, discovered that lithium was effective in the treatment of mania, but it wasn’t until 1970 that it was available as a standard prescription drug in this country.

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.



Many thanks to Dr. Steven Hagemoser and Linda Kramer from the Veteran's Administration. Both spoke at our May 7 meeting on PTSD (post traumatic stress disorder) and other veteran's issues.

Dr. Hagemoser said a diagnosis of PTSD is given if symptoms last longer than a month.

Symptoms can involve "re-experiencing" which range from nightmares and night terrors to flashbacks – where they literally relive the experience and can lose touch with reality. Something triggers the memory such as sudden loud noises or the smell of burning rubber or diesel fuel.

Other symptoms are grouped as avoidance symptoms (which are also common with depression) – such as avoiding family events or work, memory gaps, sleeplessness, socially detached and withdrawn, isolation of oneself, no sense of joy, loss of interest in social activities and surroundings (absence of positive arousal), a sense of a foreshortened future, and lack of goal setting.

There can be a heightened negative arousal – tension, anxiety, jumpy, jittery, poor concentration, can't study, significant decline in self care, and often there is substance abuse to reduce the unpleasant feelings they are experiencing.

There may be hyper-vigilance (not to be confused with paranoia). Paranoia implies there is a special relationship between the person and the threat. Hyper-vigilance is when the person is extremely "on guard" – the world is not a safe place. They may be constantly checking their perimeters, usually armed, and suspicious.

This can lead to exaggerated arousal where they have a hard time getting back to basic breathing and normal blood pressure.

It is not unusual for the person to have a problem with authority and problems holding down a job.

If medication is prescribed, it is usually an antidepressant or anti-anxiety prescription.

Linda Kramer indicated that there will be training in June called Vet to Vet (similar to NAMI's Peer to Peer program) by Moe Armstrong.

Ms. Kramer also said it is essential for all vets to enroll at the VA within 2 years after returning from military service.

NAMI Greater Des Moines will be working with Linda to put together a chart of the different levels of services the VA offers in central Iowa.

The **VA Central Iowa Health Care System Medical Center** is located at 3600 30th 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

A young veteran, just back from Iraq, killed himself in front of his screaming mother last year. His parents, Ellen and Randy Omvig, have created a Website to his memory. This has become a place where other soldiers confess their silent suffering.

This family didn't know that Josh's problems were classic PTSD.

This is their website: <http://joshua-omvig.memory-of.com>

They are getting messages from all over the world.