



NAMI

Greater Des Moines

AFFILIATE AND SUPPORT GROUP NEWSLETTER

March 2007

“Support, Education, and Advocacy”

<p><u>Education</u> Meetings are generally the 1st Sunday of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room. Dates on Sundays other than the 1st Sunday of the month are due to holidays or other special scheduled events. Caring and sharing will be held after the educational speaker has finished. See inside the newsletter for support groups.</p>		<p><u>Business and Committee</u> Meetings are the 2nd Thursday of the month at <u>4 P.M.</u> at the NAMI-Iowa Office.</p> <table border="0"> <tr> <td>1. Business</td> <td>5. Advocacy</td> </tr> <tr> <td>2. Marketing and membership</td> <td>6. Fundraising</td> </tr> <tr> <td>3. Support</td> <td>7. Special Events</td> </tr> <tr> <td>4. Education</td> <td></td> </tr> </table>		1. Business	5. Advocacy	2. Marketing and membership	6. Fundraising	3. Support	7. Special Events	4. Education	
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3. Support	7. Special Events										
4. Education											
	<p>Wednesday, Feb. 28</p>	<p>NAMI Iowa Legislative Breakfast at the Iowa State Capitol in Des Moines For information, call 515-254-0417 or 1-800-417-0417</p>									
	<p>Sat., March 3</p>	<p>“Comorbid Issues in Patients with Bipolar” presentation by Dr. Singh at the West Des Moines Marriott 11 A.M. – Lunch is provided. Please RSVP to Mark.Abbott@abbott.com or 963-8983 or 745-0395.</p>									
<p>Sunday, March 4</p>	<p>The topics will be an Overview of Mental Health Disorders and the Mobile Crisis Unit – Larry Hejtmanek, founder of the Mobile Crisis Unit, will be our speaker.</p>	<p>Thursday, March 8</p>	<p>We will be discussing and planning around 7 topic areas.</p>								
	<p>Thursday, March 8</p>	<p>NAMI Family to Family educational course begins. Call Teresa at 274-6876 or the NAMI Iowa office at 254-0417 to sign up. This course is for family members and friends of adults with severe mental illness.</p>									
	<p>Friday – Sunday March 9-11</p>	<p>Would you like to become a volunteer Family to Family teacher or Peer to Peer mentor? The training is free and we provide the hotel and meals. For either training, persons must be a NAMI member, be willing to teach the course at least once per year for 2 years, be comfortable with emotional issues and able to self-disclose. F2F trainees must have a family member who has a serious mental illness. Peer to Peer trainees must have a serious mental illness. All classes are team taught – that is, there are 2 teachers for each class of F2F, and 3 mentors for each class of Peer to Peer. If you are interested, please call Carol Porch at 319-351-3498 or email porch@avalon.net</p>									

***** NAMI Walks *****

For the Mind of America

Location	Waterworks Park Des Moines, Iowa
Date	Saturday, October 6, 2007
Distance	3 miles
Check-in	8:30 A.M.
Start Time	10 A.M.

The Walk Manager is Jay Brewer
515-321-8051

You can participate in the Walk in a variety of ways –

- Form a walk team
- Join a walk team – *check out Team Brainiacs!*
- Walk as an individual

And/Or You can help support the walk by –

- Sponsoring a walker
- Being an event sponsor
- Donations
- Volunteer to serve on a committee
- Volunteer to help the day of the event

One of the questions you will be asked is what affiliate you are participating on behalf of – we would be honored if you would indicate NAMI Greater Des Moines. If we aren't designated, we will not receive a portion of the funds for our efforts.

Visit the website for more details:
<http://www.nami.org/namiwalks/IA> NAMIWALKSIAMGR@aol.com

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.

Our website is: www.nami.org/sites/NAMIGreaterDesMoines

RESOURCES – RESOURCES - RESOURCES

SUPPORT GROUP MEETINGS

Family members, if you are interested in participating in a support group, please contact our Vice-President – Dr. Bobby Dickerson
Work phone: 288-1914 Cell phone: 979-8390
E-mail: bdickerson@paccdisciples.org – The next support group meeting is Sunday, Feb. 25, from 2-3:30 PM at Park Ave. Christian Church – 3219 SW 9th St., Des Moines.

⊙ **First Monday of each month -6:30 – 8 PM** - a support group for parents and caregivers of children with severe emotional disturbance (SED) or mental illness – meets at the Child Serve Center – 5406 Merle Hay Rd, Johnston. For more information – call Diane at 255-8157 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) – 48th & Franklin, Des Moines. This is a support group for both family members and consumers.

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

2nd & 4th Mondays of each month – 7 P.M. – For depression and anxiety disorders only – WestView Church, 1155 SE Boone, in Waukee. Call Julie at 710-1487 or E-mail at candlesinthedarkness@mchsi.com
Every Tuesday morning – 11 AM to Noon- A consumer support group – Wellness Recovery Action Planning – meets at the Res-Care Hope Center at 602 E. Grand. Call Deborah 283-1230 for more information.

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

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

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

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

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

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

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



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

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

911

If you have a mental health crisis in your family and need assistance – call 911. Be clear with the dispatcher what the situation is, that it is a mental health crisis, and you need the DM Mobile Mental Health Crisis Unit to assist. The goal is to keep everyone safe and to seek the appropriate level of assistance for the ill family member or friend.

The first people to arrive to the situation will be Des Moines police officers. When DM Mobile Mental Health Crisis Unit staff arrive, an assessment will be made whether transport to a medical facility is necessary, and medication can be administered if necessary. A psychiatrist is always on call to help make those determinations and authorizations.

DM suburbs also use the mobile crisis team services – their dispatchers make the decision whether or not the mobile crisis team is called.



Assistance with Prescription Cost

Polk County residents without full health insurance coverage can save on prescription drugs under a county sponsored drug discount program. For a complete list of card locations or a list of participating pharmacies, call 286-3895. and

The Partnership for Prescription Assistance - Call 1-888-477-2669 or visit www.pparx.org to see if you may qualify for a variety of programs available. and Patients who lack prescription drug insurance and are not eligible for Medicare - call 1-800-444-4106 or visit the [Together Rx Access Web site](#) for the **Together Rx Access™ Card**.



Positive Alternatives to Hospitalization (PATH)

Positive Alternatives to Hospitalization (PATH) is a community based support program at Broadlawns.

PATH works with individuals and their families to help them manage their psychiatric disabilities and improve the quality of their lives. A multi-disciplinary team helps individuals make self-determined choices, establish and achieve their personal goals, increase skills, and develop a better understanding of community resources.

For further information or to make a referral, call 515-282-6770 or 282-6750.



Program for Assertive Community Treatment (PACT)

PACT provides the care level of an inpatient psychiatric facility within the consumer's home.

PACT is a multi-disciplinary team of mental health professionals, including a psychiatrist, nurses, social workers, mental health professionals, vocational and addiction specialists that provides care to people where they live. PACT services are intended to be long term. PACT is available to its consumers 24 hours a day, seven days a week for crisis intervention. Office hours are Monday through Friday 8 a.m. to 8 p.m. and 8 p.m. to 4:30 p.m. weekends and holidays. To make a referral or to learn more about the local PACT team please contact the Team Leader, Darla R. Krom, LMSW at 235-8846.

RESOURCES – RESOURCES - RESOURCES



The website for Polk County Health Services is www.polk.ia.networkofcare.org.

Intensive Psychiatric Rehabilitation (IPR)

IPR is a 2 year recovery based rehabilitation program. This is a voluntary program for persons with mental illness who want to focus on building skills and working on long term goals in their recovery. Clients and staff meet for 4 to 10 hours per week in group settings as well as individually with a practitioner.

Recovery is characterized by growth beyond the effects of the mental illness. Recovery is a complex and time consuming process.

People who are in a recovery process are recovering from more than just the symptoms of mental illness. The examination of loss plays a major role in recovery as clients try to rebuild social networks and role identities.

The experience of recovery is an individual's experience of living successfully with a mental illness. IPR believes in each person's inherent capacity to grow. For more information, call Shannon Evers at 515-241-0982 or her direct line 515-235-8830.



Iowa Federation of Families for Children's Mental Health Website at: www.iffcmh.org
Check out their newsletters and library for a multitude of information.

For assistance in determining your child's rights, your parental rights, and next steps to be taken to improve your child's ability to learn – consult the following resources:

The Legal Center for Special Education

ASK Family Resource Center
317 East 6th St., Des Moines, IA 50309-1903
Telephone: 515-309-0033
Toll free: 866-250-4545
Fax: 515-309-0035
E-mail: advocates@tlciowa.org

Parent & Training Information Center of Iowa
<http://www.askresource.org/pti/index.html>



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.



Family to Family Education - Take the 12 week course (1 night/week for 2-2 ½ hours) NAMI Family to Family educational course to obtain coping skills and information about mental illness. Severe mental illness is traumatic to the entire family - you might consider asking other family members to attend with you – a friend, a parent, spouse, a sibling, or one of your children (must be at least 14 years old). Topics include brain biology, schizophrenia, major depression, mania and schizoaffective disorder, anxiety disorders, dual diagnosis, basics about the brain, problem solving skills, medication review, empathy and understanding, communication skills, self-care, recovery, and advocacy. Call the NAMI office to sign up – 254-0417. **The next Family to Family class will start March 8.**

Peer to Peer Education



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.



Provider Education – The 10 week course (1 day/week) NAMI Provider educational course is for personnel at agencies or organizations who encounter or work with persons with mental illness. The course can be CEU accredited.

The course is taught by a team of 2 Family to Family teachers, two consumers and a family member or consumer professional.

Course components:

- Orientation
- Clinical Bases
- 3 Major Mental Illnesses
- Types/Subtypes of Mood Disorders/Diagnosis of panic Disorder, Obsessive Compulsive Disorder and Co-Occurring Brain and Addictive Disorders, interventions which are effective for Family in Stage 1 Crisis
- Research into the Biological Basis of Mental Illness
- Medication review
- Inside Mental Illness
- Responding Effectively to Families in Stage 2
- Meeting the whole family/problem solving
- Why advocacy?/Helping Families in Stage 3

Call the NAMI office to sign up – 515-254-0417. There are 3 programs underway at the Independence Mental Health Institute, Magellan Health, and the University of Iowa.

Iowa Coalition on Mental Health & Aging

www.icmha.org



Warning: Regular or heavy alcohol use can worsen most psychological states, such as anxiety, depression, bipolar, schizophrenia, or eating problems. Alcohol can change the way a person feels in the short run; however, the overall effect only worsens a disorder. Marijuana and other drugs can have similar or more serious effects on the brain.

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

HOW YOU CAN MAKE A DIFFERENCE

Federal Legislative Issues www.nami.org/advocacy

Contact information for members of Congress
Capitol Switchboard 1-202-224-3121

Contact via E-mail can be made directly through their web sites.

<http://grassley.senate.gov/> <http://harkin.senate.gov/>
<http://www.house.gov/boswell/> <http://www.tomlatham.house.gov/>
<http://www.house.gov/steveking/> <http://www.braleigh.house.gov/>
<http://www.loebsock.house.gov/>

State Legislation

Here are 4 places on the web to access E-mail to figure out who your legislators are, to contact your legislators, get mailing addresses, and phone numbers.

<http://www.infonetiaowa.com/> - Also has the latest on legislation and the progress of the Mental Health Redesign.

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

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

Senator Charles Grassley

Senator Tom Harkin

House District 3 – Leonard Boswell (D)

Governor of Iowa – Chet Culver (D)

Lieutenant Governor – Patty Judge (D)

Polk County State Senators Polk County House Representatives

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

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

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

We have been warned how this will affect Polk County. Mental health services are poised to be cut. In October, a waiting list of approximately 50 people couldn't receive services due to lack of money. The list continues to grow. The funding of mental health services is in crisis.

- ✓ **Expanding mental health parity.**

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

Expanding mental health parity is a priority of NAMI GDM, NAMI Iowa, and the Mental Health Advocacy Coalition

- ✓ **Address mental health workforce shortages.**

What's more basic than having enough mental health professionals when assistance and treatment is needed? 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/mentalhealth_0306.pdf. Iowa is 46th in the nation in psychologists and 47th in the nation for number of psychiatrists.

Addressing mental health workforce shortages is a priority of NAMI GDM, NAMI Iowa, and the Mental Health Advocacy Coalition

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

Psychiatric crisis beds in Des Moines

Broadlawn's 24-26 (lower level is used for storage)

Mercy Franklin – 24

Iowa Lutheran – 60 beds (34 for adults)

110 crisis beds? – Am I missing any?

Polk County's population is 401,066

1% of the population has schizophrenia – over 4000

1.2% of the population has bipolar - - close to 5000

5-10% have depression – over 30,000

Does anyone see a shortage of health services here?

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

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

Mental health jail diversion is a priority of NAMI GDM, NAMI Iowa, and the Mental Health Advocacy Coalition

The Justice Reform Consortium recommendations are:

1. *Mandate treatment* rather than prison for those people who commit crimes attributable to being addicted to drugs/alcohol, to being severely mentally ill or both.
2. *Legislate and appropriate drug courts and mental health courts* or alternative programs for diverting offenders from prison.
3. *Appropriate adequate community substance abuse and mental health treatment funding* for people to be treated in the community rather than sent to prison.
4. *Provide funds for re-entry programs* that connect mentally ill people with treatment and resources for continuing their medications which begin before they ever leave prison.
5. *Provide funding for in-patient beds for the mentally ill* rather than more funding for more prison beds.

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

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

- ✓ **Retain "open access" for mental health drugs.**

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

CATIE III notes that second generation drugs "have primarily changed side effects, rather than clinical efficacy." But it is important to understand that in terms of side effects, the choice of first generation drugs runs the risk of permanent, untreatable, debilitating and stigmatizing movement disorders.

.Call – visit in person – write a letter – write an e-mail – please talk to your legislators to make systemic changes to Iowa's mental health system. See Iowa's "F" grade at http://www.nami.org/gtstemplate.cfm?section=grading_the_states&stid=682

HOW YOU CAN MAKE A DIFFERENCE



Ads target stigma of mental illness among youth

By Donna Leinwand, USA TODAY 12/4/06

The federal government is launching a \$1 million public service campaign beginning today aimed at reducing the stigma surrounding mental illnesses such as depression and bipolar disorder.

Health agencies say millions of U.S. adults go untreated for mental illnesses because they are too ashamed to tell friends and family. The government's campaign will use public service radio and TV ads to encourage young adults to stand by their peers. Later phases of the campaign will address older people and rural areas.

"If you have early and consistent support from your peers and you get appropriate treatment, then you have a much better chance of managing the illness over time," says Kathryn Power, director of the Center for Mental Health Services of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

"It's important as a friend in a relationship with someone recovering from mental illness that you exhibit social acceptance."

When Cara Anthieny, 18, spent a week in the hospital dealing with depression, her school friends, bearing books, flowers and candy, traveled more than 100 miles to visit with her. She says their support speeded her recovery.

"They really understood. I wasn't embarrassed," says Anthieny, a student in Chico, Calif. "It was important to me not to feel like an outcast."

But SAMHSA and the Center for Mental Health Services say millions of other adults go untreated because they are too ashamed to tell friends and family.

In 2005, nearly 25 million people 18 or older had some type of serious psychological distress - about 11.3% of the population overall and 18.6% of young adults ages 18 to 24, according to the National Survey on Drug Use and Health. Of the 13.5 million people who did not seek treatment, 26% cited as one of their primary reasons the stigma associated with mental illness.

"We're trying to change the social norm," says Peggy Conlon, president and CEO of Ad Council.

The council decided to target friends instead of the patients themselves after focus groups and surveys showed that young adults were not educated about treatment for mental illness, she said.

"We felt that engaging friends would not only encourage people to get help, but it would also destigmatize the issue," she said.

"We wanted to help them understand that people can recover and there's a role for them as friends to play."



An Excerpt From My Memoir

by Robin Cunningham for the HealthCentral Network at www.schizophreniaconnection.com

The perspectives I can provide on schizophrenia are not those of a psychiatrist, psychologist or licensed clinical social worker, but rather those of a consumer and a family member. I have walked the walk on both sides of the street. As such, I can speak with experiential authority.

It is my objective to share with you, as best I can, what my experience with schizophrenia has been like on a day to day basis, i.e., to compare notes with you. I will also make observations about being a family member and advocate based on my own experience. Any observations or comments you choose to make in return will be of great value.

In this blog, I'm going to present an abridged excerpt from my upcoming memoir "One Mind Two Worlds" along with commentary. The narrative prior to the excerpt is to set the scene. In my closing observations, I will indicate what I believe to be the significance of the events described.

* * *

The first symptoms of schizophrenia I experienced were thought insertions.

Raised in a fundamentalist religious sect, I had been taught all my life that Satan was after me, was clever and ruthless, and I had to be forever vigilant. It was, therefore, no great surprise when he first inserted blasphemous thoughts into my mind using my own voice.

I was stunned, however, when my family tried to convince me I was mentally ill and needed treatment. I was greatly offended. Their suggestions terrified me. Severe bouts of anxiety soon followed.

From the outset I also experienced anosognosia (lack of insight) and soon became delusional. I did not believe I was ill, but rather under siege by Satan because God had given me a sacred mission that would save the universe.

Within a week I found myself in a private psychiatric hospital. I vowed to refuse all treatment.

The following abridged excerpt recreates my first encounter while in the hospital with my psychiatrist and shortly after an agonizing bout of anxiety.

"Your nurse, Beth, told me that things got a little rough this morning." Dr. Levy said.

I did not respond.

"Is Satan still putting thoughts directly into your mind?"

"Yes."

"Beth says you left us for about an hour, that you turned completely inward. She was worried about you."

"She doesn't understand."

"No. I suppose not. But then, she didn't do anything to make matters worse, did she?"

"No."

"Well, that's good. And you're right. She doesn't understand what you were going through. Perhaps she never will. But that's not surprising. Not many people do, you know."

"But you understand, don't you?"

"Perhaps I do, at least more than some."

Dr. Levy was being modest. I knew intuitively that he somehow fully appreciated the nature of my terror.

"How is it that you understand when no one else does?"

"Well, I've been at this for a long time."

Neither of us spoke for several minutes.

"Well, if there's anything you need, just let Beth know, and we'll take care of it."

Dr. Levy got up to leave.

"Dr. Levy?"

"Yes."

"Does everyone think I'm sick?"

"Does it matter?" He asked, sitting down again.

"No."

"Then why do you ask?"

"You told my mother when we were in your office that you had treated my Uncle Walt and Aunt Mildred for a while. Were they sick?"

"Why do you ask about them?"

"I'm not sick. It would be a mistake for anyone to think that I am."

"Why does that concern you?"

"I don't want to end up in the state hospital like they did. I've visited my aunt there. It's a horrible place."

"Why did it seem so horrible?"
 "It was full of really strange people. They scared me. They didn't know what they were doing."
 "I can see where that must have been frightening. But you don't have to worry. You're not going to end up at Eastern State. I promise. You and I'll make sure of it."
 "Good. It wouldn't be right."
 We sat in silence for several minutes.
 "Well, I have to get back to my office," Dr. Levy finally said.
 Again, he got up to go.
 "Dr. Levy?"
 "Yes?"
 "Do you think I'm sick?"
 "You've told me that you're not. That's good enough for now."

The significance of this pivotal conversation with Dr. Levy was his unconditional acceptance of me and what I perceived to be my circumstances. Dr. Levy was the only one that didn't insist I was mentally ill, didn't immediately challenge my delusions, didn't try to tell me he knew more than I about what was happening to me, didn't make demands upon me I could not fulfill, and didn't lay a guilt trip on me. In other words, he treated me with respect. This cemented our relationship from the outset and initiated a foundation of trust which enabled me to take the medicines he prescribed and embrace his many suggestions, including effective coping mechanisms.



Mental Health Court A SECOND CHANCE THAT COUNTS

Editorial – Baltimore Sun – Dec 9, 2006

You've seen them around Baltimore, talking to themselves on the street, weaving in a drunken haze, flailing at an invisible enemy. They may be homeless and living in a shelter of found objects near a downtown church. They may be working at a dry cleaner, but off their medication because it made them drowsy.

They may be selling their bodies for drugs and have neither the will nor the means to face their demons. When they're acting out, they have a way of running afoul of the law. Loitering, disorderly conduct, prostitution, lewd behavior and drug possession are among their common crimes. They cycle in and out of the courts, and can disappear into jail for months at a time. You don't hear much about them until their demons overtake them.

Their schizophrenia, bipolar disorder or depression are much to blame, their addictions complicit in their downward spiral. The more times they cycle through the system, the more hopeless they seem. But they're not all lost or lost causes.

Consider the seriously mentally ill who are arrested for non-violent offenses and appear before a group of judges at the John R. Hargrove Sr. Courthouse in south Baltimore. They have a real chance at saving themselves through a district court program that diverts them from jail, gets them help and treatment through supervised probation.

District Judge Charlotte M. Cooksey is presiding on the day that Madeline Leslie and six other defendants are graduating, a year or more after they first came under the mental health court's supervision.

An addict who sold drugs and her body to support her habit, Ms. Leslie has been drug free for eight months. She lives in a recovery house and has reconnected with the two daughters she lost to foster care.

"I look forward to waking up in the morning. I take a bath every day. I comb my hair every day," says Ms. Leslie, who has been

diagnosed with bipolar disorder. "I put on deodorant every day. I don't have teeth to brush - yet."

This lucid assessment shows how far she has come; she was a woman with a 17-year addiction to crack cocaine who would spend days or months in jail on a criminal charge, return to the street and pick up where she left off.

On this recent Thursday, Ms. Leslie is an example of how a voluntary jail diversion program with state workers committed to its goals can help restore these defendants to a healthy life and keep them from reoffending. It is a joint effort of the district court, prosecutors, public defenders, mental health professionals, and pretrial release and probation agents that has overseen 910 defendants in three years.

Judge Cooksey and Sue Diehl of the Baltimore Mental Health Systems got this program off the ground, but the support staff keeps it running. Some probation agents assigned here take their work home with them - the better to help their clients who are readjusting to the real world.

The court operates two half-days a week, and it's not enough. Another half-day (and the funding to cover the additional therapists and social workers needed to assess and evaluate potential clients) would help meet the need - state officials say 15 percent of men at the city detention center and 43 percent of women inmates need mental health services. A new data system would enable the court to track and assess outcomes. Finding suitable housing for these defendants is a constant struggle; more public housing certificates should be set aside for them.

Mentally ill defendants charged with non-violent crimes can be rerouted from the system. They can mind their demons and treat their illnesses. They may falter more than once. But they can succeed, in part because Judge Cooksey and her colleagues are able to see beyond their disheveled appearance, their blank stares and angry expressions. They don't write them off.

As a recent graduate of the court, Dennis Williams, explained: "I wouldn't have been able to get my mind back together without all of you."

If only more mentally ill offenders had the chance to say the same.



Experts Advise Emotional Recovery for Heart Attack Patients

January 16, 2007 - Komfie Manalo - All Headline News Correspondent-Los Angeles, CA

A new study published in the January issue of the Mayo Clinic Women's Health Source said that emotional recovery from heart attacks is crucial to a patient's health and advised them to join a support group to relieve themselves of depression.

The report said patients who develop depression after surviving a heart attack are more likely to return to the hospital within a year for a heart-related problem than heart attack survivors who are not depressed.

The study adds that heart attack patients with depression are three times more likely to die of a heart attack or other heart problems.

The researchers said this could be linked to a lack of follow-up care, as they found that depressed patients are more prone to forgetting their medications and following the advice of their doctors.

Depression, fear and anger are the most common reactions from a person who survived a heart attack. But these could be prevented by doctor's follow-up care.

The article offers the following tips from heart doctors for patients to help them in their depression.

1. Discuss your feelings openly and honestly with your doctor, family members and friends;
2. If you think you may be depressed, seek treatment;
3. Talk to your doctor about joining cardiac rehabilitation programs – many of which offer counseling and support groups;
4. Get regular exercise as directed by your doctor as exercise not only boosts heart health, it may also help relieve anxiety and depression; and
5. Try to resume the activities and hobbies you enjoyed before the heart attack so as to keep you in a positive mood.



Kids with ADHD Need to Be On the Move

(The following comes from the CDC-funded National Center on Physical Activity and Disability - NCPAD)

One of the most common conditions in children is attention deficit hyperactivity disorder (ADHD). Characteristics of ADHD include hyperactivity, fidgetiness, and/or squirming, which can make it difficult to stay on task, remain still, and focus on schoolwork.

That can be a major challenge for some children with ADHD, who need to move more, and perhaps even learn more, while moving. Think about how difficult it would be if you were told to keep moving for 8 straight hours and not allowed to stop until you were completely exhausted!

Similarly, ask a child with ADHD to sit for a few hours at a time: you'll see how difficult that can be for someone who inherently wants to move. You may as well have asked the child to stop blinking.

There are inborn needs that require many children with ADHD to be constantly on the move, and while it's not possible to accommodate every child who has to move often, it would be good for teachers to understand how to build in more physical activity throughout the day to accommodate the need to be kinetic rather than sedentary.

Physical activity specialists have a great opportunity to assist frustrated teachers who have difficulty redirecting their children's behavior. From the perspective of "less is more," a little more physical activity during the school day may result in a little less fidgeting and higher levels of concentration for a period of time after the activity.

Physical activity transports greater amounts of blood to the brain and increases core body temperature, both of which may elicit a soothing or relaxing effect on a child with ADHD. In particular, vigorous physical activity (exercise performed at a high heart rate/intensity level) in the right amount and at the right time of day may dissipate some of the excess energy that seems to build up in children with ADHD.

While there is still a need for more research on how physical activity affects behavior in children with ADHD, the general consensus is that it seems to work with a certain portion of children with this condition. We need more research to determine the actual "dosing" effect that comes with various amounts, types, and intensities of different physical activities in order to provide more specific recommendations to teachers and parents.

Until that time, using physical activity as a remedy for helping children with ADHD manage their behavior better could be a win-win for the child and the teacher or parent.

DID YOU KNOW?

According to the American Heritage Dictionary – "Brainiac" – is defined as "a highly intelligent person". Want to join our walk team?



Unseen Trauma - Veterans Try to Heal from War's Emotional Wounds

Monday, January 22, 2007

Dean Baker – The Columbian Staff Writer

When Army Spc. Joel Steinmann first returned to Vancouver from the Iraq war two years ago, he slept with a .45-caliber pistol next to his head, hoping the gun would go off and end his nightmares.

Later he developed another suicide plan: "I'd just keep on volunteering to go back to Iraq until I didn't come back," he said.

But the gun didn't fire and the 2002 Prairie High School graduate didn't go back to war. Instead, his doctor steered him to the outpatient program for post-traumatic stress disorder at the Vancouver Veterans Affairs Medical Center.

He went. Now he keeps his firearms in a closet, and he spends his nights in a Beaverton, Ore., condo with his fiancée, hair stylist Lindsey Mobley, 23.

He isn't cured. But he said he's better. He has post-traumatic stress disorder, meaning he suffers from nightmares, anger, fear, hypervigilance and depression. He still can't keep a civilian job or go to college, he said, because his anger flashes unexpectedly. He's never hurt anyone, but he doesn't have complete control of his emotions.

His problem is increasingly common to America's troops, experts say, although many soldiers shy away from seeking treatment for fear of being branded as too soft.

At least one in six U.S. soldiers today is troubled by severe anxiety or PTSD, according to the New England Journal of Medicine. It reported two years ago that more than 6,000 soldiers were surveyed before and after service in Iraq or Afghanistan. Almost 17 percent of those who fought in Iraq reported those symptoms, compared with about 11 percent of the troops who served in Afghanistan.

"Those are figures from troops with one deployment," said psychologist James Sardo, who heads a 10-member staff dealing with PTSD for the Portland and Vancouver Veterans Affairs Medical Center. "I'm waiting to see what they find out for those after two or three deployments."

Not all troops are getting that kind of help. Marine Sgt. William C. Wold of Camas, for example, died for lack of adequate help with PTSD, according to his parents, John and Sandra Wold. The 23-year-old Iraq vet and 2002 graduate of Mountain View High School was found dead Nov. 10 at Balboa Naval Hospital in San Diego.

His death remains under investigation, Sandra Wold said this month, and "we are angrier than ever." She believes her son died by accident due to improper medication and counseling. His personality changed after he returned from Iraq, she said. Fellow Marines hazed him, and no one helped him overcome his nightmares and resulting drug addiction. "They made him worse," she said.

But a helping hand is being extended in Vancouver. Those treated include not only Steinmann and his Iraq war buddies but also vets from World War II, Korea, Vietnam, the Gulf war and eastern European conflicts.

Iraq war vets seem different from those of earlier wars, said Sardo, himself a U.S. Air Force major who served two tours providing mental health services in Iraq, in 2003 and 2006. Iraq vets nationally seem to like one-on-one counseling and don't want group interaction, such as the class Steinmann took with counselor Amy Wagner, learning how to handle PTSD symptoms.

"For me, there is a lot of stuff you don't want to talk to with your buddies," Steinmann said. "These are the guys you were with when you were trying to have this macho, tough-guy thing, and so you push them away. You don't want your peers to think you are a coward. It is hard for me and my friends to open up to groups." Sardo said the self-conscious troops are those, especially, who plan to stay in the military and don't want a mark on their record saying they sought mental health counseling. Some would rather lose an arm than concede they needed mental health counseling, he said.

Still, he said, his staff has worked hard to help any vet who asks for it. They don't know yet how effective they are from any objective measure. But it appears their work is helping. And they want more troops to visit them.

"It affects everyone around me, but it's getting better," said Steinmann, 23, the son of Ron and Kathy Steinmann of Vancouver. A member of the Oregon National Guard since he was 17, he served under fire in Iraq in 2004-2005, seeing more than any young man's usual share of death and destruction. He serves with the Oregon Guard's B Company, 2nd Battalion, 162nd Infantry. After Iraq, he did tours in Mongolia and helping victims of Hurricane Katrina before training in Japan last year.

"I recognized that I needed help, and I wanted help, and I got help," said Steinmann, who works as a member of Willamette National Cemetery's honor guard detail handling soldiers' burials -- flag-folding, pall bearing, 21-gun salutes. He's deciding whether to quit the Guard when his enlistment is up March 23, or to re-enlist and possibly face another tour in the war zone.

Pursuing recovery, he spent a month in 2005 at the VA's special inpatient PTSD unit at Roseburg, Ore., and a week in the Portland VA hospital. The purpose of his hospitalization was to quell his suicidal thoughts.

"My nightmares are down quite a bit. I don't really have flashbacks. I'm starting to get my focus back, and untangle a rat's nest of feelings that I never got to express in combat. I go from zero to floored in like nothing," he said. "Something small just gets to me and I go full anger mode."

He also has black moods. He feels guilty about firing his weapon blindly in a fire fight out of Camp Taji in Iraq. It plays on his conscience that some of those who died in the fire fight were children. "When they draw down on you, it doesn't make much difference," he said.

He recalls being fired upon by enemies with AK-47s: some of them children, some of them men. He remembers working on squads that came upon scenes after battles and cleaned up the bloody bodies. He remembers losing a half-dozen buddies. Now he is trying to get past it. He's trying to recover and line up his emotions for civilian life, and isn't sure he can do that. He might have to re-enlist in the military to feel he belongs, he said.

"It's the only life I've known," he said. "Maybe I'll just stay there."

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

Did You Know?

According to WordNet – "Brainiac" is a noun meaning someone who has exceptional intellectual ability and originality. Want to join our Walk team now?

HOW YOU CAN HELP

Needed – Your Stories



to

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 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.

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



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

Several Schizophrenia Studies are also at the U. of Iowa

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

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

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

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

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

BECOME A VOLUNTEER for NAMI Greater Des Moines

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

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

- For Family to Family educational classes
- For Visions for Tomorrow educational classes
- For Peer to Peer educational classes
- For Provider educational classes
- In Our Own Voice presenters for grassroots civic educ.
- Parents and Teachers as Allies team presenters
- Support Group facilitator (involves once a month 2-1/2 hr commitment of time)

Committee assignments:

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

NAMI Walks – October 6, 2007

- <http://www.nami.org/namiwalks/IA>

Your help will be most appreciated. Thanks.



2007 NAMI National Convention

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

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

Apply for a Scholarship to attend the NAMI National Conference in San Diego June 20-24

The Center for Mental Health Services (CMHS), within the Substance Abuse and Mental Health Services Administration (SAMHSA), through a contract with AFYA, Inc. (AFYA), is providing financial support to **consumers of mental health services** who would like to participate in the annual conference sponsored by the National Alliance on Mental Illness. The purpose of the scholarships is to foster transformation of mental health care to focus on recovery. Please note:

To be eligible for this scholarship, a completed application and letter of recommendation **must be received by March 1, 2007**.

Phone: (301) 957-3049 (direct) (301) 957-3040, ext. 249
Fax: (301) 457-9902 E-mail: lkelly@afyainc.com

NAMI GREATER DES MOINES

By paying for a membership to NAMI Greater Des Moines – you help to support all 3 levels of the NAMI organization.

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

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
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
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

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Top 10 Myths About Post Partum Depression

<http://www.mededppd.org/mothers/myths.asp>

Myth 1: PPD is normal -- all new mothers feel tired and depressed.

Fact: New mothers often feel tired and overwhelmed. They may be experiencing "baby blues." Women with baby blues may feel tired, weepy, and have no

energy. However, the feelings that go with PPD are stronger and longer lasting. A mother with PPD may not want to play with her baby. She may have trouble paying attention to things and may not be able to meet her baby's needs for warmth and affection. She may feel guilty or worthless.

Myth 2: If you don't get PPD right after you give birth, you won't get it at all.

Fact: PPD can happen any time in the first year after a woman gives birth.

Myth 3: PPD will go away on its own without treatment.

Fact: The "baby blues" may last up to 4 weeks but usually goes away on its own. Like many illnesses, PPD almost never goes away without treatment. The good news is that there are available treatments that work.

Myth 4: All women with PPD have thoughts about hurting their children.

Fact: Women with postpartum psychosis, which is a life-threatening disorder separate from PPD, are at risk for hurting their babies or themselves. If you have thoughts about harming yourself or your child you should ask for help right away from your family and your doctor.

Myth 5: Women with PPD look depressed or stop taking care of themselves.

Fact: You can't tell someone has PPD by looking at her. A woman with PPD may look perfectly "normal" to everyone else. She may even try especially hard to look polished or put together – keeping her makeup done, and her hair styled – to turn attention away from the pain she is feeling on the inside.

Myth 6: Women with PPD are bad mothers.

Fact: Having PPD does not make someone a bad mother.

Myth 7: If you have PPD, you must have done something wrong.

Fact: PPD is nobody's fault. There is nothing that a woman with PPD could have done to avoid having this disorder.

Myth 8: You'll get over your PPD if you just get more sleep.

Fact: Although it's important for women with PPD to get enough sleep, sleep by itself will not cure PPD.

Myth 9: Women with PPD can't take antidepressants if they are breastfeeding.

Fact: Studies have shown that there is a very small risk to the baby with the antidepressants most likely to be prescribed for PPD. If it is necessary for a woman with PPD to take an antidepressant, her doctor will carefully choose one that is most likely to help her and least likely to hurt her baby.

Myth 10: Pregnant and postpartum women don't get depressed.

Fact: Being pregnant, or having just given birth, is not a guarantee against getting depression. In other words, pregnancy does not protect a woman from depression, and in fact, studies show that the childbearing years are when a woman is most likely to experience depression in her lifetime.

Schizophrenia Digest – Winter 2007 issue

Look for the 2 page article where Nancy and Courtney Hale are quoted. Nancy and Courtney will be our speakers at the April meeting. The topic will be Schizophrenia and Recovery and Research at the University of Iowa.



STATE OF THE UNION

Challenges: Out of the Hospitals, Into the Streets

By Randy Barrett, NATIONAL JOURNAL,
January 19, 2007

After 40 years of blue-ribbon panels, myriad reports, and poorly aligned public policies, severe mental illness remains an intractable and deepening problem in America. For proof, look no further than the homeless lady muttering on the corner outside your office building.

"Mental illness is the No. 1 public health crisis in the U.S. today," declared Ron Honberg, legal director for the National Alliance for the Mentally Ill, an advocacy group based in Arlington, Va.

The numbers back his claim. According to the World Health Organization, mental illness and suicide account for more than 15 percent of the mortality and disability in countries with established market economies. That's more than all forms of cancer combined.

In 2001, the most recent year for which official figures are available, the U.S. spent \$85 billion on mental health treatment. Experts estimate that figure is closer to \$130 billion today, with federal prescription coverage included. The costliest subset by far is the severely and persistently mentally ill -- about 12 million adults with schizophrenia, bipolar disorder, and major depression -- who account for 58 percent of the spending, according to researcher and activist E. Fuller Torrey.

This group includes about one-third of the homeless population and up to 25 percent of inmates in state and local jails, according to NAMI and the Justice Department. "County jails and prisons have become the new mental hospitals," said NAMI Executive Director Mike Fitzpatrick.

The problem, nearly everyone involved agrees, is an incoherent patchwork of federal and state laws and policies that effectively deny the seriously mentally ill the most-basic services and treatment. Last year, Fitzpatrick's group gave the nation's mental health system a D after surveying each state's service offerings. Only five states earned a B: Connecticut, Maine, Ohio, South Carolina, and Wisconsin. (*Iowa received a grade of F*)

"Many states do nothing but drive people to emergency rooms, shelters, and jails," Fitzpatrick said. "It reflects a lack of a federal plan."

A key problem is a fractured funding stream. About 55 percent of treatment dollars for serious mental illness comes from state Medicaid budgets, which have their own rules and criteria for coverage. "The whole system has grown by [local] accretion," said Ron Manderscheid, a former federal mental health official who is a consultant with the Constella Group, a health research contractor. "It's an elephant designed by committee."

It doesn't help that the federal government continues a long-standing ban on the use of Medicaid money to fund state mental hospitals, said Mary Zdanowicz, executive director of the Treatment Advocacy Center. The policy led to a wholesale emptying of state psychiatric hospitals in the mid-1960s and another wave of discharges in the early 1990s. "In Virginia, we've closed 50 percent of state hospital beds in the last 20 years," Zdanowicz said. "That's a critical -- and often overlooked -- loss for people who need intensive treatment for a severe mental illness."

Critics say that the federal government has also done a poor job leading the way to best practices in treatment. "In mental health at the national level, we're doing an excellent job doing demos." Manderscheid said. "It's entirely another thing to bring them up to scale."

There has been no lack of expert advice on how to fix the system. Every few years, a blue-ribbon panel examines the familiar problems and recommends the same solutions, said Chris Koyanagi, policy director for the Bazelon Center, a legal advocacy group.

In 2003, the president's New Freedom Commission on Mental Health concluded that the system is "fragmented and in disarray," and counseled the government to "address mental health with the same urgency as physical health." Like its predecessors, the report was barely acknowledged by the White House or congressional policy makers before staggering to the blue-ribbon morgue and expiring.

"It had no traction because it had no enabling legislation with it," Fitzpatrick said.

And no extra money. Consumers, psychiatrists, insurers, and the business lobby continue to clash over the costs of adequately treating severe mental illness -- and to what extent lesser mental ailments should be included in coverage.

Advocates for the mentally ill are hopeful that a substantive private insurance parity bill -- which would require equal reimbursement of mental and physical illness claims -- can pass Congress soon. But they say much more remains to be done to build a cohesive federal response on best practices, research, mental health funding accountability, and assertive treatment programs.

"We know what the policies ought to be," Koyanagi said. "We need the political will."



Many thanks to Carolyn Hejtmanek, from Orchard Place -- our speaker at the February 4 affiliate educational meeting.

Carolyn gave us an overview of children and adolescent mental health disorders -- we had lots of good discussion.

Orchard Place started out as an orphanage and now has a residential program, a day program, outpatient programs, and works closely with the Child Guidance Center and PACE -- the juvenile justice center.

Here's a snippet from Carolyn's presentation:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real painful and can be severe.
- Mental health problems can be recognized and successfully treated.**
- Children make up 28% of the population but account for 14% of the health expenditures and only 7% of mental health expenditures.
- Six (6) million children have difficulties diagnosed as serious mental disorders, tripled since the early 1990's.
- Suicide is the second leading cause of death among college students, the third leading cause of death among adolescents 15 to 19 and the sixth leading cause of death among children 5 to 14.
- Adolescent males complete suicide at a 4 to 1 ratio over females.
- 90% of adolescent suicide victims have at least one diagnosable active psychiatric illness at the time of death. Most often depression, substance abuse and conduct disorders. 50% have had a diagnosis for 2 years or more.
- Only 20% of emotionally disturbed children and adolescents receive some kind of mental health service.

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

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

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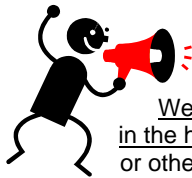
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GDM dues include local, state, and national membership

(please check one)

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.



Crisis in Mental Health Funding is Here

Lynn Ferrell, Executive Director,
Polk County Health Services

We are facing the greatest crisis in disability funding in the history of the state. This crisis is real. It is not Polk or other counties' crying wolf. It is affecting consumers all over the state, but we're really feeling the pinch in Polk County.

In the past 12 months, county after county has reduced the level of services available to persons with disabilities. Over one-third of the state population lives in a county which today is providing less service than a year ago. By July, over half of the state will live in a county which has had to cut services.

In Polk County we made some service reductions last July, and we started a waiting list for new consumers. While we have been able to take 50 consumers off the waiting list, we still have 130 on the list, waiting for someone else to leave the system so they can get services for the first time.

Unfortunately, the picture for FY08 is a nightmare. We will soon be sending notices to 240 people informing them that they will not be eligible for any county-funded services come July 1. Another 700 people will get a notice that they will lose part of their services. That's 940 people who'll be losing all or part of their services because we do not have the money to pay for them. To put that in perspective, there are 88 counties which don't even have 940 consumers.

Why are we in this financial situation? It is because the state did not keep its promise to fund growth in the system after adoption of SF 69 ten years ago, and that legislation tied our hands to do anything about the problem locally. The state has appropriated 2 to 3 percent per year in additional funding for mental health services to counties, but we've been seeing our expenses grow by 5 and 6 percent per year because of inflation, new consumers, and Medicaid changes. Our hands are tied because the state froze county MH/MR/DD property taxes at the 1998 dollar level rather than freezing the levy rate, as the state does with any other property tax limitation. Because of that hard dollar freeze, we have seen mental health property taxes here in Polk go from \$1.44 per 1,000 to 96 cents. The counties have done everything they could to maintain services, but they're now broke.

69% of the population lives in a county which is at its maximum mental health levy

42% live in a county with a mental health fund balance below 10%

The legislature must do 2 things this session to fix this problem, and they have to do it in 2007:

First, the state must restore the county allowed growth cut made in FY02. That was supposed to be a temporary cut but it has yet to be restored. Adjusted for inflation, that is about \$20 million which must be added to the system for FY08.

Second, it is time to acknowledge that, over the long haul, the state probably will not be able to live up to its commitment to fund all system growth by giving counties the flexibility to raise their local mental health levies.

One sometimes tempting solution is just to have the state take the system over. That would be a huge mistake for three reasons:

1. Virtually all innovation in the system during the past generation has come at the county level in spite of the state. Local inpatient services instead of MHIs, targeted case management, and the Adult Rehab Option are just three examples of programs which benefit consumers which were initially opposed by the state.
2. Any claims of administrative savings are dubious at best. The total MH/MR/DD administrative cost for all 99 counties is just \$9 million per year. Counties spend a little over \$300 million per year for MH/MR/DD services, and their funds generate about another \$300 million in federal Medicaid match. That makes a total administrative expense of about 1.5%.
3. A state takeover doesn't print any additional money for the system. In fact, we're in the mess we're in because of state, not county decisions. Unfortunately counties are delivering the bad news about inadequate funding when they make tough decisions necessary to balance their budgets, so they're getting the blame for what's going awry. The finger should be pointed at the state level where decision makers have been ignoring for many years warnings that this crisis was coming.

It is time for the legislature to realize that the budget line item "county allowed growth" is not just money going to counties. It is the money which serves persons with disabilities.

Polk County just conducted a series of educational forums for consumers and family members to explain how the funding works, why we're having to cut services, and what some possible legislative solutions are. I encourage NAMI Greater Des Moines members to call or write their legislators and tell them to fix this problem.

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

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

A MUST READ IN THE WINTER 2007 NAMI ADVOCATE

“INVESTIGATING THE EVIDENCE-BASE FOR NAMI’S FAMILY-TO-FAMILY AND PEER-TO-PEER PROGRAMS”

If you are a NAMI member, the winter 2007 NAMI Advocate is in the mail and you will not want to put it aside when it arrives. Lisa Dixon, M.D., at the University of Maryland, Division of Services Research, has written a most informative article about the research project on the effectiveness of the Family-to-Family and Peer-to-Peer programs. She has broken down the technical research terms making it very easy to understand what is happening to families and consumers in our education programs plus there's a wonderful chart to further clarify the process of change for Family-to-Family program graduates.

The Advocate will be posted on the NAMI Web site and there will be a link to go directly to the article. From there you can print the article or e-mail it to others.



Seasonal Affective Disorder

If you notice periods of depression that seem to accompany seasonal changes during the year, you may suffer from seasonal affective disorder (SAD).

SAD is characterized by recurrent episodes of depression – usually in late fall and winter – alternating with periods of normal or high mood the rest of the year.

Most people with SAD are women whose illness typically begins in their twenties, although men also report SAD of similar severity and have increasingly sought treatment.

SAD can also occur in children and adolescents, in which case the syndrome is first suspected by parents and teachers.

Symptoms of winter SAD usually begin in October or November and subside in March or April.

Some patients begin to slump as early as August, while others remain well until January. Regardless of the time of onset, most patients don't feel fully back to normal until early May.

The usual characteristics of recurrent winter depression include oversleeping, daytime fatigue, carbohydrate craving and weight gain, although a patient does not necessarily show these symptoms.

Additionally, there are the usual features of depression, especially decreased sexual interest, lethargy, hopelessness, suicidal thoughts, lack of interest in normal activities, and social withdrawal.

SAD is often misdiagnosed as hypothyroidism, hypoglycemia, infectious mononucleosis, and other viral infections.

If you suspect that you or someone you know may have SAD, learn more about it and how it is treated by reading NAMI's [Seasonal Affective Disorder Fact Sheet](#).



By the time you receive this newsletter, our website will be operational. The website address is at the bottom of each page in the newsletter.

If you see information that is in error, needs to be added, or deleted, if you like it, don't like it, have suggestions for improvement, do not hesitate to contact tbomhoff@mchsi.com.

We also have a new NAMI Greater Des Moines design for the newsletter. This same design appears on our website.