



Greater Des Moines

AFFILIATE AND SUPPORT GROUP NEWSLETTER

October 2007
“Support, Education, and Advocacy”

The NAMI Walks For the Mind of America is on Saturday, October 6.

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.

Join a team, form your own team, or walk individually, raise money, and **WALK WITH US!**
 Ask family, friends, employers, and businesses you frequent to donate to the walk.

<http://www.nami.org/namiwalks/IA>
NAMIWALKSIAMGR@aol.com

The Walk Manager is Jay Brewer 515-321-8051.

Each walker who raises at least \$100 will receive a free T-shirt. We would love to have you join us on Saturday, Oct. 6.

The walk will be an anti-stigma event as well as a fundraising event. Please plan to join us. Together, we can accomplish so much.

DON'T ENTER THE WATERWORKS PARK FROM FLEUR DRIVE – FOLLOW FLEUR TO GEORGE FLAGG PARKWAY, TURN WEST AND FOLLOW THE SIGNS. The Walk will be in the west end of Water Works Park – A gate will be opened just for the Walk at the west end off George Flagg Parkway. Plenty of parking will be available.

<p><u>Education Meetings</u> 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. See the page 3 for support groups.</p>	<p><u>Business and Committee Meetings</u> are the 2nd Thursday of the month at 5 P.M. at the NAMI-Iowa Office.</p> <table style="width: 100%; border: none;"> <tr> <td style="border: none;">1. Business</td> <td style="border: none;">4. Education</td> <td style="border: none;">6. Fundraising</td> </tr> <tr> <td style="border: none;">2. Marketing and membership</td> <td style="border: none;">5. Advocacy</td> <td style="border: none;">7. Special Events</td> </tr> <tr> <td style="border: none;">3. Support</td> <td colspan="2" style="border: none;"></td> </tr> </table>	1. Business	4. Education	6. Fundraising	2. Marketing and membership	5. Advocacy	7. Special Events	3. Support		
1. Business	4. Education	6. Fundraising								
2. Marketing and membership	5. Advocacy	7. Special Events								
3. Support										
<p>Saturday October 6 * * * * *</p>	<p>NAMI WALKS FOR THE MIND OF AMERICA Des Moines Waterworks Park – 3 mile walk 8:30 AM check-in 10:00 AM Start time</p>	<p>Thursday, Oct. 11 5 PM</p>	<p>We will be discussing and planning around 7 topic areas.</p>							
<p>Mental Health Week – October 7-13, 2007 www.nami.org/miaw</p>										
Tuesday, Oct. 9	<p>National Day of Prayer for those with Mental Illness – for more information – go to - www.nami.org – go to “Take Action” on the tool bar and click on “Faithnet”.</p>									
Tues., Wed., - October 9-10	<p>“Recovery – Under Construction” – the State Mental Health Conference in Ames at the ISU Scheman Center – contact becky@trainingresources.org or call 309-3315</p>									
Thurs., Oct. 11	<p>National Depression Screening Day</p>									
Thurs., Oct. 11	<p>Bipolar Awareness Day</p>									
Nov. 1-4	<p>Training for Consumers to become a support group facilitator for NAMI Connections Support Recovery Groups. Contact the NAMI office for more information 515-254-0417.</p>									
Sunday, November 4 2 PM	<p>Part 2 - Understanding Social Security and the Appeal Process – our speaker will be Steve Moats. 2008 Elections for Officers & Board Members</p>	Thursday, Nov. 8 5 PM	<p>We will be discussing and planning around 7 topic areas</p>							
Nov. 16-18	<p>Visions for Tomorrow Teacher Training – contact the NAMI Iowa office for more information 515-254-0417.</p>									
Thursday, Friday Nov. 29-30	<p>NAMI Iowa Fall Conference at the Holiday Inn Hotel & Suites, 4800 Merle Hay Road, Des Moines - Mary Beth Pfeiffer, author of “Crazy in America” will be a featured guest speaker. Pfeiffer’s book details the criminalization and incarceration of some of our most vulnerable citizens-those who suffer from mental illness.</p>									
Sunday, December 2 2 PM	<p>The topic will be “Partial Hospitalization” – our speaker will be Becky James from Broadlawns.</p>	Thursday, Dec. 13 5 PM	<p>We will be discussing and planning around 7 topic areas</p>							
Sunday, January 6, 2008 – 2 PM	<p>The topic will be “Treatment for Psychosis” – Our speaker will be Darla Krom, from Golden Circle Behavioral Health.</p>	Thursday, January 10 5 PM	<p>We will be discussing and planning around 7 topic areas</p>							

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

RESOURCES – RESOURCES - RESOURCES

SUPPORT GROUP MEETINGS

Third Sunday of the month - Family members, if you are interested in participating in a family support group, please contact Glenn Hobin IowaGH@aol.com or call 965-9799 - or contact Grace Sivadge 961-6671. Meetings are at Park Avenue Christian Church, 3219 SW 9th St., Des Moines – 2:30 – 4:00 P.M.

First Monday of each month -6:30 – 8 PM - a support group for parents and caregivers of children with severe emotional disturbance (SED) or mental illness – meets at the Child Serve Center – 5406 Merle Hay Rd, Johnston. For more information – call Diane at 255-8157 or Mary Ann at 883-8014.

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

2nd Tuesday of the month – New Light Support Group – for persons experiencing depression or other mental health issues – at Westkirk Presbyterian Church, 2700 Colby Woods Drive, Urbandale, Iowa – 515-253-0330 – Pastor Michael Mudlaff

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

Every 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)

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



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

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 officers make the decision whether or not the mobile crisis team is called.

We hope you are enjoying the newsletter we are sending you.

If you've come to our once a month affiliate meetings, we hope you've obtained useful information.

Please help to support our organization by becoming a member of NAMI Greater Des Moines.

Dues are:

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

Send to: Don Jayne, Treasurer
1291 16th St.

West Des Moines, IA 50265

*Please make the check payable to
NAMI GDM*

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

Thanks for your generosity!

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

NAMI GREATER DES MOINES

President and Editor of Newsletter Teresa Bomhoff E-mail: tbomhoff@mchsi.com	274-6876
Vice-President – Diane Johnson E-mail: itsdianej@aol.com	255-8157
Treasurer – Don Jayne E-mail: dojayne@hotmail.com	225-8912
Secretary – Sharon Browne E-mail: mrvliving@hotmail.com	988-5151
Board members Kevin Lind E-mail: Kevin.lind@performancefinishinc.com	208-6250
Glenn Hobin E-mail: IowaGH@aol.com	965-9799
Diane Banasiak E-mail: diban@aol.com	334-5159

Thanks to Jack Holveck for this article – please see the new website the Iowa Office of Consumer Affairs has just completed – <http://www.iowaofficeofconsumeraffairs.com/>.



Famous People and Mental Illnesses

Isaac Newton, most famous mathematician of the 17th Century was responsible for many scientific discoveries we take for granted today such as the "corrected" Gregorian calendar date. Newton's greatest mathematical discovery was the gravitational relationship between the earth and the moon, and of centrifugal force. Newton was well educated, had access to the best knowledge of his day and was wealthy in later life. He suffered from several "nervous breakdowns" in his life and was known for great fits of rage towards anyone who disagreed with him which some have labeled Bipolar Disorder which was unknown at the time. In 1705 Newton was the first Scientist to be knighted by Queen Anne for his great scientific contributions.

Ludwig Van Beethoven, composer, had bipolar disorder which some have said gave him such creative power that his compositions broke the mold for classical music forever. He was a child prodigy which his father tried to exploit. His "manic" episodes seemed to fuel his creativity. He wrote his most famous works during times of torment, loneliness, and suffering psychotic delusions. It took him 12 years to finish his last and 8th Symphony in total deafness. He then medicated himself with the only drugs available in that day to bring some relief –opium and alcohol- and died several years later of liver disease.

Abraham Lincoln, 16th President of U.S. suffered from severe and debilitating and on occasion suicidal depressions, as recorded by Carl Sandburg in his comprehensive six-volume biographical analysis of his life. "A tendency to melancholy" Lincoln once wrote in a letter to a friend, "...let it be observed, is a misfortune, not a fault." The most amazing part of his story was the sheer determination with which he willed himself to overcome his serious affliction and still achieve all he was able to achieve for our young and troubled nation at war with itself.



Vincent Van Gogh, famous painter and artist was labeled peculiar with unstable moods most of his short life. He suffered from epileptic seizures some believe from excesses of absinthe, very strong liquor popular among talented people for inspiring greater creativity. Many have tried to give a

definitive diagnosis of his illness through reading his personal letters. From them it seems clear that his depressive states were also accompanied by manic episodes of enormous energy and great passion. Van Gogh committed suicide at age 37.

Winston Churchill, Prime Minister of Great Britain who, as one of the "Big Three" (Churchill, Roosevelt and Stalin) to lead the world to the defeat of Hitler in WWII, told in his own writings of suffering from "black dog" Churchill's term for severe and serious depression. Less often talked about are his writings of how he often self-medicated with alcohol to deal with these times. Like so many other famous people with a mental illness, he was able to make the great contribution he did through sheer personal determination. There was a nation, he said, and a world depending on his efforts to lead Britain and the world in the defeat of their common and formidable enemy of Nazism.

Virginia Woolf, the British novelist, born of privilege, experienced the mood swings of bipolar disorder her entire life. She wrote to make sense out of her mental chaos and gain control of

madness; and was greatly admired for her creative insight into human nature. She was tolerated by friends and family, receiving great care and understanding during her entire life and because of this, never had to face institutionalization, the only medical "treatment" in those days. She died at her own hand by filling her pockets with stones and walking into a nearby river. The cause of death was determined as "Suicide, while the balance of her mind was disturbed."

Jane Pauley, NBC newsbroadcaster, since the age of 25, talks candidly about her depression and bipolar illnesses. In her new book, "Skywriting: A Life Out of the Blue." she tells about her childhood and family problems, and how she discovered her need for medication to control mood swings.

Linda Hamilton, actress, has gone public with her diagnosis of bipolar disorder diagnosed at a young age. Hamilton, well known for her part with Arnold Schwarzenegger in "The Terminator" movies explains how helpful medication has been for her and that she understands she will have to be on medication for the rest of her life.

Shawn Colvin, Winner of two Grammys in music, talked about her struggle with depression. Colvin has suffered from major depressive disorder for more than 20 years. "During the worst times, I shut the world out, refusing to get out of bed. Even the smallest tasks were overwhelming," she said.

Judy Collins, singer and songwriter, has written a book titled "Sanity and Grace: A Journey of Suicide, Survival and Strength," (2003). The book chronicles her journey as a survivor of depression after the suicide of her 33-year-old son in 1992. She states that her own spiritual life and practice have been a strength for her as she battles with her illness.

Dr. Kay Redfield Jamison, prof. of psychiatry at Johns Hopkins University, Baltimore, MD, author of many books on mental illness. Dr. Jamison has bipolar illness herself and has attempted suicide. Her book "Touched With Fire," lists and describes many famous persons whose lives have been changed by bipolar illness.

Maurice Bernard, portraying Sonny Corinthos on "General Hospital" weekdays on ABC, tells the National Mental Health Association that he suffered from bi-polar disorder for many years before he was diagnosed and given medication to bring his illness under control.

William Styron, author, writes about his own depression in his book, "Darkness Visible: A Memoir of Madness," (1990) and his decision to seek help. His earlier works which he wrote prior to his diagnosis and admission of his illness described with uncanny accuracy, the symptoms and the problems he would experience later in his life. He was one of the first to write about other famous persons who struggled with mental illness and for explaining the almost unexplainable experience of a brain disorder to those who had never experienced it in a way which gained their sympathy and admiration.

John Nash, Nobel Prize Winner in mathematics, has faced a lifelong battle with schizophrenia. He was known as the "Phantom of Fine Hall" at Princeton where his reclusive, ghost like figure could be seen roaming around, leaving messages of his mathematical genius on the boards of empty classrooms. His struggle was well documented in the book "A Beautiful Mind," by Sylvia Nasar which was later made into a movie by the same name.

Carrie Fisher, the child of two Hollywood stars (Debbie Reynolds and Eddie Fisher) and actress, in her own right, played Princess Leia in "Star Wars" movies. Early in the 70's she says she started using cocaine. Her experiences with drug addiction led to her first

best selling book, *Postcards From the Edge*. The book was made into a film in 1990 starring Meryl Streep. Her illness comes from her mother's side of the family.



Lionel Aldridge, a football player for the Green Bay Packers during the 1960's, developed paranoid schizophrenia and was homeless for 2 1/2 years. "Once I accepted and cooperated with the treatment, I started to beat the illness," he said. He now speaks to groups to help them better understand mental illness. He states that he is completely symptom free and that helping others understand mental illness is "therapy" for him.

Eugene O'Neill, famous playwright, author of "Long Day's Journey into Night," and "Ah, Wilderness!" came from a deeply troubled family background, suffering from clinical depression the greater portion of his life. His most famous plays were written between 1935 and 1943 despite persistent mental illness. He is the only American playwright to have won the Nobel Prize for literature.

Vivien Leigh, actress made famous by her leading role in "Gone With the Wind" and her creative genius for stage and screen, suffered from serious bouts of manic depression, tuberculosis, and poor health her entire life. It was, in fact, because of her illness, that she was frequently cast into roles that required a personal experience of the torment that comes from the experience of this disease. Vivien was once able to make a full recovery after shock treatments, only to succumb some years later. A nervous breakdown associated with a miscarriage proved to be the unraveling of her marriage with actor Lawrence Olivier who continued to be a devoted friend. She was finally diagnosed with cyclical manic-depression with hallucinations and had to be confined to a nursing home only to recover and return to the screen for her last movie. Leigh finally succumbed to the tuberculosis at the young age of 53 of while filming "The Ship of Fools". She became known and admired for her ability to fulfill her passionate dream for stardom despite her TB and debilitating manic-depression.

Ruth Graham (daughter of Ruth and Billy Graham) writes about her many years of suffering with depression, drugs, eating disorders and thoughts of suicide in her 2004 book "In Every Pew Sits A Broken Heart," Church was never the comfort for her that it seemed to be for others. An adult with a tragic life behind her, she was finally able to talk about it. Being the daughter of a famous preacher she felt she should not have problems. Through the steady love of her family she was able to feel God's forgiveness. Her message today is that being a Christian doesn't guarantee us a perfect life. She hopes her story will give those who want to serve others a place to start in knowing what to do and say.

Brooke Shields talked about her disabling Post Partum Depression in her newly published book "Down Came the Rain: My Journey Through Postpartum Depression." Shields reported she first had difficulty bonding with her baby and later thought of hurting it and even killing herself. She was able to gain a significant improvement in her mood through medication and the help of a skilled nurse-helper who recognized her problem and encouraged her to get help.

Additional Famous People Known to have Coped with Symptoms of Mental Illness

Leo Tolstoy, author	Connie Francis, singer
Charles Dickens, English author,	Kristy McNichols, actress
John Keats, poet,	Axl Rose, musician
Michelangelo, artist	Ted Turner, entrepreneur
Bette Midler, entertainer	Robin Williams, actor
Charles Schultz, cartoonist	Tony Dow, actor

Dick Clark, entertainer	Kitty Dukakis, former
Irving Berlin, composer	Massachusetts first lady
Rosemary Clooney, singer	James Taylor, musician
Jimmy Piersall, baseball player, Boston Red Sox	
Burgess Meredith, actor,	
Peter Illyich Tchaikovsky, composer	
Charlie Pride, singer	
Sylvia Plath, poet and novelist.	
Janet Jackson, singer	
Patty Duke, actress,	
Roseanne Barr, comedian	
Marlon Brando, actor	
Maurice Bernard, actor	
Buzz Aldrin, astronaut	
Margot Kidder, Actress	
Jonathon Winters, comedian	
Pat Conroy, author	
Ernest Hemingway, Pulitzer Prize-winning novelist,	
Tennessee Williams, American playwright	

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,



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**.

Letters to the Editor

You are welcome to send letters to the editor by mail or E-mail. Letters can be sent to: Teresa Bomhoff, 200 S.W. 42nd St. Des Moines, Iowa 50312 or E-mail: bomhoff@mchsi.com

[Treatment Advocacy Center Editor's Note: Preliminary research should be looked at with a skeptical eye. Many times something at first touted as a major breakthrough is never heard of again. After all, studies that disprove budding advancements rarely receive much attention.

Let us fervently hope that is not the case with the new test for schizophrenia and other brain disorders being developed at the University of Minnesota. Not only would that capability be invaluable, the researchers claim that the test is simple and 100% accurate.]



SCIENTIST'S SIMPLE TEST DETECTS BRAIN ILLS

Brain Test Could Help Make Earlier Diagnoses

A Technique Developed by a U of M Scientist Shows Promise in Detecting Several Neurological Disorders for Which There is No Other Single Test.

By Maura Lerner, MINNEAPOLIS STAR TRIBUNE, August 23, 2007

A University of Minnesota scientist has discovered a way to detect Alzheimer's disease, schizophrenia and other brain disorders by using a device that tracks magnetic signals in the brain.

Although the research is still in its early stages, it could lead to a relatively quick and painless test for a wide range of conditions that affect the brain, experts say.

The scientist, Dr. Apostolos Georgopoulos, calls it an "elegantly simple test" that has been surprisingly accurate so far in assessing nearly 300 patients and healthy volunteers.

He and his research team used a technology known as MEG (magnetoencephalography) at the VA Medical Center in Minneapolis to study people's brains as they stared at a point of light for 45 to 60 seconds.

In a study published Wednesday, they found that they were able to identify six types of disorders "with 100 percent accuracy."

They included patients with Alzheimer's, chronic alcoholism, schizophrenia, multiple sclerosis, Sjogren's syndrome (an autoimmune disease) and facial pain.

What they found, Georgopoulos said, is that each disease affects the brain differently, and alters the way brain cells communicate with one another.

There are no such tests for most brain diseases, which can be difficult and time-consuming to diagnose. They're usually identified over time by observing behavior, such as memory loss in Alzheimer's patients, and other external symptoms.

Georgopoulos, a regents professor of neuroscience known internationally for his work on how the brain affects movement, said even he was surprised by the apparent accuracy of the test. "It's just too good to be true," he said in an interview. But the results have continued to hold up, he said, even after they concluded the initial study, which involved 142 patients.

"We're approaching our 300th subject," he said, "and it looks better and better."

A tool for tracking treatments?

If it pans out, the new test could be used to diagnose brain disorders earlier, monitor their progress and track the effectiveness of new drugs and treatments.

"I think it has that potential," said Georgopoulos, who also heads the Brain Sciences Center at the VA hospital.

Tim Denison, a senior engineer who specializes in brain devices at Medtronic Inc., agrees. "I believe that if it works out how he's

described it in the paper ... it could definitely help identify [diseases] much earlier and with greater precision," he said.

At the same time, he and other scientists agree that more research is needed to prove its value.

"This certainly is an innovative technique," said Dr. John Richert, executive vice president for research at the National MS [multiple sclerosis] Society in New York. But "it's not yet clear how helpful this technique will be as a diagnostic tool."

He noted that there were only four MS patients in the study, and they appeared to have advanced disease. He wonders if the test could identify patients at earlier stages, when it's tougher to diagnose. "We need to know a lot more about this study and what it's detecting before we will know how useful it will be," he said.

Currently, there are only several hundred MEG devices in the world, used mostly for research, Georgopoulos said. But that could change, he said, if the tests prove as effective as they seem.

Georgopoulos developed a method for analyzing the results, and holds a patent for it that he shares with the university and the VA. They have licensed that technology to a startup company, Orasi Medical Inc., in Edina.

His research team plans to study the technique with other disorders, such as depression, autism, fetal alcohol syndrome, Parkinson's disease and post-traumatic stress disorder.

The MEG device at the VA hospital cost about \$2 million, including the specially built room that houses it on the fourth floor. Because of its powerful magnetic force, it must be sealed in a vault-like space.

No risk to patients

For patients, though, there is no risk of radiation or other dangerous exposure, Georgopoulos said. They lie on a gurney as a helmet covers the top of the head. By tracking tiny magnetic fields produced by electrical activity in the brain, the superfast device can monitor the way the brain cells communicate with one another. After only a minute, it has tens of thousands of bits of data, which can be analyzed by computer for distinct patterns.

Georgopoulos said he got the idea after testing the device on 10 healthy volunteers and was struck by how identical their brain patterns were. When he tried the test on chronic alcoholics, who had agreed to be volunteers, the results were distinctly different.

Eventually, he tested it on volunteers with six separate conditions, and found that each group had its own distinct pattern.

Wednesday's study was published online by the British Journal of Neural Engineering.



Shelters take many vets of Iraq, Afghan wars Also housing those from earlier eras

By Anna Badkhen, Boston Globe Correspondent | August 7, 2007

NORTHAMPTON -- After Kevin returned from Iraq, he spent most nights lying awake in his Army barracks in Hawaii, clutching a 9mm handgun under his pillow, bracing for an attack that never came.

His fits of sleep brought nightmares of the wounded and dying troops whom Kevin, a combat medic, had treated over 16 months of suicide attacks and roadside bombings. He kept thinking about an attack that killed 13 of his comrades. He hated himself for having survived.

Soon he was drinking so heavily that the Army discharged him. He moved back in with his parents in Narragansett, R.I., and drank even more, until they asked him to leave. Less than two years after

he returned, Kevin became one of a growing number of veterans of the Iraq and Afghanistan wars who are now homeless.

"I lived in my car, at the Wal-Mart parking lot," said Kevin, who asked that his last name not be published because he is considering reenlisting. He has been staying at a homeless shelter in Northampton since early July.

Kevin's tailspin encapsulates a little-researched consequence of the wars in Iraq and Afghanistan. As more troops return from deployments, social workers and advocates expect the number of the homeless to increase, flooding the nation's veterans' shelters, which are already overwhelmed by homeless veterans from other wars.

"It's a major problem that's not going away anytime soon," said Cheryl Beversdorf, director of the National Coalition for Homeless Veterans in Washington, who estimates that hundreds, perhaps thousands of troops who fought in Iraq and Afghanistan are living in shelters. Kevin's story illustrates the lagging response of overburdened government agencies to the needs of troops returning from wars, said Jack Downing, who runs the shelter where Kevin and four other veterans of the wars in Iraq and Afghanistan are staying.

"The general public believes that when a vet comes home, he's well taken care of," Downing said. "That's a horrible misunderstanding."

No one keeps track of how many of the 750,000 troops who have been deployed to Iraq or Afghanistan since 2001 are homeless. Peter Dougherty, director of homeless programs for the federal Department of Veterans Affairs, said 300 veterans of these conflicts have asked the agency for help finding shelter in the last 30 months. Beversdorf's agency has helped 1,200 homeless veterans of the current wars.

This reflects only a fraction of the total number of homeless Iraq and Afghanistan veterans, said Amy Fairweather, who works with Iraq war veterans at Swords to Plowshares, a private organization based in San Francisco that assists veterans. Last year, her agency's five shelters in California helped 250 such veterans, she said.

She said it is impossible to know how many veterans have not asked for help and are "crashing on their friends' couch, in a car, in a park . . . [or are] people who live in a church."

Social workers say combat trauma is responsible for the plunge into homelessness for many veterans returning from Iraq and Afghanistan. Unable to cope, veterans turn to alcohol and drugs, lose their jobs and the support of their family and friends, and end up on the streets, said Larry Fitzmaurice, whose homeless shelter in Boston is currently providing beds to seven veterans of the Iraq war.

Mental problems "really interfere with the ability to maintain a stable relationship, to maintain a secure employment," Fairweather said.

Army studies have found that up to 30 percent of soldiers coming home from Iraq suffer from depression, anxiety, or posttraumatic stress disorder.

Dougherty and other specialists who work with homeless veterans say the pattern of homelessness has changed. The approximately 70,000 veterans of the war in Vietnam who became homeless usually spent between five and 10 years trying to readjust to civilian life before winding up in the streets, he said. Veterans of today's wars who become homeless end up with no place to live within 18 months after they return from war, according to Dougherty.

Dougherty said the Department of Veterans Affairs is supposed to recognize and address combat trauma and help the new generation

of veterans readjust in civilian life. But he acknowledged that many veterans "become homeless because there is not a support system."

"There are more services available to veterans returning today, but I still don't think there's enough," said Allison Alaimo, who works at the shelter for homeless veterans operated by Massachusetts Veterans Inc. in Worcester. Alaimo said her shelter has hosted a few veterans of the wars in Iraq and Afghanistan since 2001.

Joe, who also stays at the Northampton shelter, sustained a traumatic brain injury during the invasion of Iraq in 2003, when he manned a 155mm howitzer for the Third Infantry Division.

"My first time killing somebody was very devastating," he recalled, saying that he fired at a minivan carrying a family of 12 unarmed civilians. "Just one woman survived."

Joe said he spent his first year back drinking, abusing drugs, and going AWOL from his military base at Fort Stewart, Ga. He said he was trying to shut off the horrible fits of screaming and violence brought on by his brain injury and his memories of the most disturbing moments of his war.

"Two months after I'm back from Iraq I'm shooting heroin," said Joe, staring into space at the shelter, where he has been staying for three months. Since he was discharged from the Army in 2004, he has been living in shelters and abandoned houses and staying with relatives and friends. He stole and dealt drugs to support his habit. He asked that his full name not be used because he has a criminal record.

Kevin said that at least two of his friends have become homeless since his deployment with the 25th Infantry Division ended in 2005. One stayed in Hawaii, "because you've got beaches you can sleep on," Kevin said. The other, he said, moved to the Salt Lake City area, "because out there, if you're homeless, you get meals, you get money" from Mormon charities.

As the wars continue, the number of homeless veterans is "going to radically swell," Downing said. Downing and others who work with homeless veterans said the government is not prepared to assist those troops; a recent report by the Government Accountability Office said there are some 200,000 homeless veterans and only 15,000 beds for them at shelters. At least 9,600 more beds are needed, the report said. No government agency provides permanent housing for homeless veterans, said Beversdorf.

"We're just the fallout, you know?" Joe said in the garden of the shelter. Under the trees, several homeless Vietnam War veterans stood in the shade, smoking in silence. "We fall through the cracks."

Army Releases Suicide Report

According to a report released by the U.S. Army, 2006 marks the highest rate of military suicides in 26 years. The Army Suicide Event Report, which tracks suicide attempts and completions and the factors involved, showed the majority of suicides in 2006 involved firearms and the most common contributing factors were failed personal relationships and occupational, legal and financial problems.

Suicide is the third leading cause of death among Army National Guard Soldiers. For more information on suicide prevention, including crisis telephone numbers, visit the Army's Suicide Prevention website.

<http://www.armyg1.army.mil/HR/suicide/default.asp>

To find more information and resources for PTSD, visit <http://www.military.com/benefits/resources/ptsd-overview>.

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
- 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.



State Mental Health Planning Council



The State Mental Health Planning Council is looking for volunteers to serve on the council in the category of parents of children/adolescents with severe emotional disorder.

Teresa Bomhoff, President of NAMI Greater Des Moines, and Diane Johnson, Vice-President of NAMI Greater Des Moines, both serve on the council.

If you are interested, please contact Sue Bakker at sbakker@dhs.state.ia.us and ask for the MHPC Application.

Did You Know?

NAMI E-Join is a nationwide online membership initiative that began June 20, 2007. E-Join will allow visitors to NAMI's Web site to join online, using a credit card, for a universal dues rate of \$35/annually. The money is sent to the state and local affiliate.

Provider Education

NAMI IOWA and Magellan Behavioral Care of Iowa offer the Provider Education Course - a 10-week training providing behavioral health practitioners with a penetrating, subjective view of mental illness presented through lecture, discussion and handouts.

The Provider Education Course has been completed at Magellan's offices in Des Moines and at the Mental Health Institute at Independence.

The course helps providers realize the hardships that families and consumers endure and appreciate the courage and persistence it takes to find ways to reconstruct lives.

CEU's were arranged for social workers, mental health counselors, marital/family therapists, registered nurses, and certified alcohol/drug counselors.

The Provider Course emphasizes the involvement of consumers in the challenging work of provider-staff training. The teaching team consists of five people: two family members trained as

NAMI Family-to-Family Education Program teachers; two consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and a mental health professional who is also a family member or consumer.

The course reflects a new knowledge base, the "lived experiences" of coping with a brain disorder or caring for someone who struggles with this life-long challenge. Including this deeply personal perspective creates an appreciable difference in the program's content. It adds a means of teaching the emotional aspects and practical consequences of these illnesses in addition to the academic medical information in the course.

The Provider Education course is designed for line staff at public agencies working directly with people with severe and persistent brain disorders.

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

If you are interested in having the Provider Education course at your business or organization – please go to our website www.nami.org/sites/NAMIGreaterDesMoines and click on educational courses to reach an application form or call the NAMI Iowa office at 254-0417.



Parents and Teachers As Allies

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

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

This 2 hour in-service program is for parents, teachers and other school professionals, school nurses, social workers, medical residents, education majors at colleges, juvenile probation officers, court appointed advocates – CASA volunteers, and many others.

The program is presented by an education professional who is also a family member, a facilitator/family member, a parent or caregiver of a child with mental illness, and a mental health consumer that experienced the early onset of mental illness.

Components

Welcome and Introductions
Early Warning Signs of Mental Illnesses
Family Response
Living with Mental Illness
Group Discussion
Closing Remarks and Evaluation

Children with mental illness face a double whammy: they don't get diagnosed soon enough, from fear and misunderstanding. By the time they finally do, a good portion of their childhood may be

needlessly lost, and they may be denied the opportunity to live full and productive lives.

Only about 20% of children and adolescents with mental disorders are identified and receive mental health services. Children of color have less access to treatment and often receive poorer quality care.

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

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

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

It can take up to 8 years from the onset of symptoms before a child is identified and gets treatment.

Eight years is far too long and the consequences are devastating – not just for families, but for society as a whole. We know that unidentified and untreated mental disorders mean the loss of critical development years, school drop out and failure, involvement with the criminal justice system, and the ultimate tragedy – suicide.

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

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



MENTAL HEALTH IN THE SCHOOLS ACT INTRODUCED IN HOUSE

Representative Janet Napolitano (D-CA) has introduced the companion version to S. 1332, the Mental Health in Schools Act sponsored by Senators Edward Kennedy (D-MA), Pete Domenici (R-NM) and Michael Enzi (R-WY) (see the [Bazelon Center's June 29 Policy Reporter](#)).

The bill would increase funding for the Safe Schools-Healthy Students program to enable states to expand school-based mental health services for children in K-12. It allows for a flexible, state-based approach to creating a comprehensive mental health school-program and promotes formal collaboration between families, schools, welfare agencies, and substance abuse and mental health systems.

The [legislation](#) also encourages schools to implement positive behavioral interventions and supports (PBIS) into their school curriculum. See a [summary of the bill](#) and a letter at www.Bazelon.org.

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.loeb sack.house.gov/>



Senators Question Use of Military Personality Disorder Discharge

Federal Daily 7-2-07

A bipartisan group of senators asked Dept. of Defense Secretary Robert Gates to launch a review of the military's personality disorder discharge process following published reports that the procedure is being used as an excuse to discharge service members with service-related injuries to avoid paying benefits.

The Dept. of Defense indicates that over 22,500 personality disorder discharges have been processed within the past 6 years. Although they represent a small percentage of overall discharges, their potential for inappropriate use is enormous.

The senator's letter says there are indications that personality disorder discharges are being used as a tool to discharge expeditiously U.S. service personnel who have service-connected injuries, such as Post Traumatic Stress Disorder or Traumatic Brain Injury. Even more troubling is the perception that the U.S. military is using these discharges to avoid disability and medical benefits payments.

The problem for veterans discharged with a "personality disorder" finding is that the military considers their medical problems "pre-existing and not a result of their active duty. Personnel discharged under these provisions cannot collect disability benefits and may not receive medical care from the Dept. of Veterans Affairs for these "pre-existing" illnesses.

"Like many veterans' advocates, we are skeptical about an administrative process that suddenly diagnoses military personnel who have long and honorable military careers," the letter said.

But that's not all. Military personnel given a personality disorder discharge who have not fulfilled their service contracts can find themselves forced to repay thousands of dollars in re-enlistment bonuses back to the federal government, the senators note. "This can result in debilitating debt for military personnel and their families" the letter said "many of whom supported our forces over many years of service and endured significant strain as a result of frequent and protracted combat deployments."

Specifically, the senators ask that Gates conduct an independent review of the discharge process, implement appropriate measures to prevent abuse and support the creation of a Dept of Defense Special Discharge Review Board to assist in reviewing petitions from military personnel who have already been discharged.

"It seems our troops are facing an enemy overseas and then a bureaucratic enemy at home," said Mikulski. "I will not abandon our troops – on the battlefield or after they come home needing care."



2008 PRESIDENTIAL ELECTION ACTION CENTER

We are sending you this website for those interested about the current presidential election. NAMI does not take a side in regard to a particular candidate.

This is one site where you can find useful information and participate in the process.

<http://www.aapd.com/News/election/peac2008.php>

Did You Know?

One out of every four families has a member who suffers from a serious mental illness.



Our mental illness mess: The cost in dollars and more

Cost of mental illness: Dollars, more
Diane Suchetka, Plain Dealer- Ohio-7-14-07

The millions of mentally ill Americans who can't get the care they need are costing the rest of us \$100 billion to \$300 billion a year.

Our taxes buy them food stamps, homeless shelters, prison cells and emergency room visits.

Our workplaces lose money every time they call in sick or bungle an assignment.

Some of us, like students at Virginia Tech and Cleveland Heights police officer Jason West, pay with a life.

The real story is the lack of treatment for people who are mentally ill, says David Shern, president of Mental Health America, formerly the National Mental Health Association.

"How long can we tolerate this?" he asks. "How much more carnage are we going to allow?"

What America needs to do, Shern and others argue, is pay for early treatment on the front end. Doing that will save us the exorbitant cost of tragedy on the back end.

As Shern says: "It's pretty clear we waste enormous amounts of money on untreated mental illness. And those costs are real. We pay for them every day."

Here are some ways:

At the jailhouse

On any given day, about 2,000 inmates pack the Cuyahoga County Jail. Jail Administrator Ken Kochevar estimates 15 percent are seriously mentally ill.

"If the average inmate is costing us \$80 a day, the mentally ill inmate is costing us twice that, and they're here for a much, much greater time," Kochevar says.

That's because they sit in cells, often for weeks, waiting for psychiatric evaluations. And once those evaluations are complete, defense attorneys frequently insist on second opinions. So they wait again.

Their medication drives up costs, too.

Cuyahoga County spends \$1 million a year on prescription drugs for inmates. The biggest chunk -- 40 percent -- goes to those with mental disorders.

It's tough to put a dollar amount on how much untreated mental illness costs the jail. But if the inmate population were cut by 15 percent, that would lop \$9 million off the jail's \$60 million annual budget.

"If we had intensive treatment services in the community, then we wouldn't be forced to operate a mental hospital here," says Kochevar. "We're a jail. . . . Don't ask us to do all these specialized services."

In the prison system

Ohio prisons spend millions of dollars every year treating mental illness.

State prisons use our tax money to pay the salaries of 538 psychologists, therapists and other mental health workers. They spend \$13 million a year to bring in outside psychiatrists. Another \$8 million pays for psychotropic drugs.

All together, the Ohio Department of Rehabilitation and Correction will spend \$68 million this year on nearly 10,000 prisoners with a

diagnosable mental illness. That's 19 percent of the state's 50,000 or so inmates.

After they're released, she says, prisoners rarely get little more than the 14-day supply of medication they're handed when they walk out of their cell.

"As people leave our system, it is extremely difficult to access community mental health services," Nixon-Hughes says.

"The mental health systems are strapped. If you listen to what they're saying, they don't have enough money to provide services to people in the community in general."

At the emergency room

When people with mental disorders can't get the care they need, they head to emergency rooms for help.

They seek treatment for psychological disorders, says Dr. Charles Emerman of Cleveland's MetroHealth Medical Center. But often they're searching for help with imaginary physical conditions.

"We see 60-year-old women who think they're pregnant," says Emerman, who oversees emergency medicine at MetroHealth.

People with untreated mental illness drive up health costs in other ways.

Those with major depression, for example, average twice as many visits to primary care physicians, according to one study. Other research shows people with anxiety disorders spend billions of dollars on medical care for heart attacks, back pain, headaches and other symptoms of their untreated illness.

People with mental illness often spend more time in emergency rooms, too. That's because hospitals don't always have enough psychiatric beds, Emerman says. So psychiatric patients eat up expensive ER space -- sometimes for days -- while they wait for space in a psychiatric ward.

"The answer," he says, "is fairly straightforward. You improve the funding for mental health, then people can get routine care rather than ending up in an emergency room for a crisis."

At county social agencies

People with untreated mental illness burden county social service departments, too.

Studies show that serious mental illness -- with or without substance abuse -- is the most common reason courts take children away from their parents.

It's difficult to determine the exact impact of mental illness on the \$177 million annual budget of the Cuyahoga County Department of Children and Family Services, says director Jim McCafferty.

"I think you can make an argument that anybody who abuses or neglects their kid has a mental health problem," he says.

Often when a parent is charged with abuse or neglect, a family member will step in and raise the children. Relatives of those with mental illness are less willing to help.

McCafferty tells the story of a woman who lost custody of her four children. The county asked her brother to care for them. He said no. He was afraid his sister would find out, come to his home and hurt his children.

"That's kind of an extreme example," McCafferty says. "But we see it happen. They don't want to buy into it if their whole life is going to be disrupted."



What is the Olmstead Decision?

Part 1 was in the September newsletter
Here's Part 2 of 2 – Jack Hyliard

In 1999, the U. S. Supreme Court handed down the Olmstead Decision to answer this question:

Does the Americans with Disabilities Act (ADA) require states to provide treatment in the community for people with disabilities?

In Olmstead, the Supreme Court answered: **No one should have to live in an institution or a nursing home if they can live in their own community with the right supports.**

Not you.

Not your friend with disabilities.

Not your elderly parent.

Not your medically fragile child.

No one.

In 2001, President George Bush issued Executive Order 1327 and directed key federal agencies to ensure compliance with the *Olmstead Decision* by evaluating and revising their policies, programs, statutes, and regulations.

In Iowa, Governor Vilsack named the Department of Human Services (DHS) as the lead agency in Iowa to respond to Olmstead. DHS reported on Iowa's current service system and developed an "effectively working plan" for implementing Olmstead in Iowa. A steering committee was convened and they asked for comment to the proposed plan.

Governor Vilsack approved ***The Iowa Plan for Community Development***.

DHS received a federal **Real Choices Systems Change grant** to fund the activities of that plan, and contracted with the Center for Disabilities and Development for help with implementing the grant.

The steering committee became Iowa's **Olmstead Real Choices Consumer Task Force**. Its members include:

- People with disabilities
- Family members
- Advocates
- State agency representatives
- Service providers
- Other stakeholders

The mission of the task force is to:

- **Address institutional biases and barriers** that shape our service system
- **Prevent institutionalization**
- **Provide** Iowans with disabilities **real choices** about:
 - **Where they will live**
 - **What services they will use**

Institutional biases and related barriers are identified in:

- ***Delivering on the Promise***, the federal report to the President
- ***The Iowa Plan for Community Development***, the DHS report to the Governor
- The evolving **systems redesign recommendations** of the Mental Health/Mental Retardation/Developmental Disabilities/Brain Injury (MH/MR/DD/BI) Commission, for both the children's and the adult service systems.

Implementing Olmstead in Iowa will involve **removing BIASES and BARRIERS**, such as:

- Policies and programs that have an institutional bias
- Regulations that prevent use of natural supports
- Funding of programs, rather than people
- Eligibility criteria that keep people dependent
- Iowa's complex and confusing service system

Example - Policies and programs that have an institutional bias:

Funding from programs like Medicaid, Medicare, and Social Security usually supports institutions rather than community-based services.

- In Iowa, 76% of Medicaid long-term care funding goes to institutions and nursing home, and only 24% goes to community-based programs.
- Current federal Medicaid law makes availability of nursing home services *mandatory* for people who are eligible; community-based services are *optional*

Example – Natural supports:

- 64% of direct care is currently provided by families, friends, neighbors, and other informal caregivers
- 95% of elderly persons who need help with daily living have family members involved in their care

Example - Funding programs, not people:

- People are "slotted into" existing programs. They often cannot choose services to help them accomplish their own goals.

Example - Eligibility criteria that keep people dependent:

They often restrict people from:

- Saving money for such things as a rental deposit, furniture, the purchase of a home
- Earning enough to be self-supporting without jeopardizing health care or other essential benefits

Example – Iowa's complex and confusing service system:

- No core services available in every county
- No coordinated service system: 99 counties, 99 systems
- Poor communication among local, state, and federal service programs

Examples:

- Lack of personal assistance – PAS is not currently covered in Iowa's State Medicaid Plan.
- Lack of transportation services, which prevents people from having access to services.
- Lack of affordable, accessible housing.

Olmstead Real Choices Consumer Task Force priorities for Iowa

- Reduction of institutional bias
- Self-directed, person-centered services
- Federal funding for accessible housing
- Funding of personal assistance services (PAS)
- Availability of clear, accurate information about services and supports

For more information on Olmstead – go to:

www.olmsteadrealchoicesia.org



National Institute on Drug Abuse Studies Highlight New Tools for Use in the Criminal Justice Setting

The National Institute on Drug Abuse (NIDA) is pleased to inform you that a special issue of Criminal Justice & Behavior will feature ten studies that focus on offender risks and needs assessments, treatment interventions and monitoring, community re-entry, special populations and systems integration.

This first wave of studies from NIDA's Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) includes:

- New assessment instruments—
 - including a brief screening/assessment tool that can be used to screen for both drug abuse and mental illness;
 - a tool that addresses treatment motivation; and

- o other surveys that can help with many of the cognitive interventions used in correctional treatment programs.
- A study highlighting the risk factors that affect treatment success, such as anger and hostility, criminal thinking, and attitudes toward education and work.
- A study describing post-release measures that can provide guidance on parole decisions with an integrated approach to support and supervision, looking at needs that extend beyond drug treatment.

The special issue of Criminal Justice & Behavior will be available on-line on August 15, 2007 at <http://cjb.sagepub.com/> or available in hard copy in the September issue. For more information about NIDA's Criminal Justice Drug Abuse Treatment Studies (CJ-DATS), go to: www.cjdats.org.

The National Institute on Drug Abuse is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on the health aspects of drug abuse and addiction. Fact sheets on the health effects of drugs of abuse and information on NIDA research and other activities can be found on the NIDA home page at www.drugabuse.gov.



Families of People With Untreated Mental Illness Disputing a Concept

The "Families of People With Untreated Mental Illness" group has a website at: www.Lackofinsightmi.org, if you are interested in contacting them.

The single most difficult challenge that families of people with severe mental illness face today is their inability to legally intervene in any way when their loved one refuses medication and treatment.

Why do they refuse medication? Because approximately half of the people with severe mental illness have a symptom that keeps them from realizing that they are ill, anosognosia.

And, why would a person who feels that he/she is not ill agree to take a medication, especially when it may have side effects?

Presently, the law "protects" that individual from having to take medications that he or she does not want to take, no matter how psychotic or irrational that individual may be. As long as that individual is not considered to be a danger to self or others, he/she can be as psychotic or irrational as it is possible to be without anybody being able to intervene. Even though this person may become homeless, suffer from delusions, paranoia, etc., there will be no help unless a law is broken or the person becomes a danger to self or others. All of this is allowed to occur in order to "protect" that person's civil rights!

A baby, child and minor teenager may all be American citizens and yet (usually) would not be able to refuse any reasonable care their parent may deem appropriate. Though they are citizens, a reasonable mind understands that they are immature, and thus unreliable as far as making good, sound decisions that would affect their welfare. So, they are a "set" of American citizens that are denied the right, for a period of time, to do as they choose because they are not, or may not be, capable of making good decisions regarding their welfare.

Certain elderly citizens in our country are affected by dementia. Dementia robs these citizens of the ability to make good, sound judgment affecting their welfare. When a legal procedure determines the affected person to be incapacitated, they may be denied "the right" to make certain decisions. Therefore, we have another "set" of American citizens who, perhaps for just a period of time (though most likely for the remainder of their life), will be

denied the right to make certain decisions regarding their own welfare.

Why then, is it such an extraordinary leap to say that there is another "set" of American citizens that, for a period of time, while they are incapable of making rational decisions regarding their own welfare (and, perhaps after a similar hearing as the incapacitation hearing spoken of above), they may be denied the right to choose not to take the medications that they desperately need, to have their sanity restored? There is some likelihood that the person will actually wish to continue taking the medication after he or she feels the improvement that the medication has made.

How many "rational" people "want" to live on the streets? [Approximately 39% of the homeless population has some form of mental illness, with 20 - 25% being seriously mentally ill.] Why should irrational persons be allowed to make such decisions about medications if the other "sets" mentioned, that also have impaired thought processes, are not allowed?

Thus, the same parents who lovingly cared for their minor children, providing them with all things necessary to have a healthy, happy life, suddenly are unable to do anything to help their 18 or 19 year old child (coincidentally, the age when severe mental illness is often first diagnosed), who may have become irrational, psychotic, delusional, paranoid, etc.

Unfortunately, families without the means to challenge this concept legally, which would probably entail taking it all the way to the Supreme Court, will probably have to wait until somebody with "deep enough pockets" to be able to afford such legal representation has the terrible "luck" to have a son or daughter who desperately needs but refuses their medications.

Would that person "allow" their son or daughter to become homeless, abandoned to their delusions, possibly even being incarcerated? But, what parent can bear being put into that position?

Did You Know?

Children (under the age of 18) with SED means children with a severe emotional disturbance. SED is a functional impairment, which substantially interferes with, or limits a child or adolescent role; or functioning in family, school, or community activities; or from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

It is considered appropriate to say a child with SED, but it is not considered appropriate to say a child with mental illness.

Did You Know?

40% to 50% of those with the most severe mental illnesses lack insight into their illnesses. They don't choose to be homeless or aggressive, but instead truly believe the CIA is after them or aliens have invaded their town.

Ansognosia is the term for lack of insight or the impaired awareness of illness.

As used in neurology, anosognosia has been defined as "an impaired ability to recognize the presence or appreciate the severity of deficits in sensory, perceptual, motor, affective, or cognitive functioning (as in Alzheimer's).

In psychiatry, anosognosia usually connotes 3 overlapping dimensions: The failure to recognize that one has a psychiatric disease; the inability to recognize that one's unusual mental events, such as delusions and hallucinations are symptoms of mental illness; and noncompliance with treatment. Other researchers have added additional dimensions to the use of the term, including failure

to perceive the need for treatment, lack of awareness of the benefits of treatment, and lack of awareness of the social consequences of having a psychiatric disorder. –*Treatment Advocacy Center*

Did You Know?

The mental health field is shifting its efforts toward a “recovery-oriented” system that emphasizes consumer choice. This approach will work for many people with mental illness.

However, it will effectively ignore the sickest people for whom informed choice is not an option. This perspective on recovery dashes all hope of rescuing those who are refusing treatment.

In the Virginia Tech case, recommendations to the Governor to revise Virginia's mental health commitment law were as follows:

The panel recommended that the involuntary treatment criteria be improved to “allow involuntary treatment in a broader range of cases involving severe mental illness.” The current standard for involuntary commitment in Virginia for someone with a severe mental illness requires a person to be an “imminent danger to self or others” before he or she can be court-ordered to treatment.

This makes it difficult, if not impossible, to treat someone before they have harmed themselves or someone else, or threatened to do so. About half of states have more humane standards that focus on the person's deteriorating condition and “need for treatment,” rather than requiring them to deteriorate to “dangerousness.”

The panel recommended that “reports of prior psychiatric history” be presented at the commitment hearing. Current Virginia law instructs magistrates to rely solely on what is happening currently with a person with untreated severe mental illness, ignoring what happened in the past. That means past episodes of violence, psychiatric history, and past treatment are not considered.

Did You Know?

Deinstitutionalization is still going on. Psychiatric hospital closures have proceeded at a furious pace over the last 15 years. During the 1990's, 44 state psychiatric hospitals closed – and most states admit psychiatric bed shortages. Iowa and the City of Des Moines have a shortage of psychiatric beds. There are only 110 psychiatric beds in Des Moines.

Did You Know?

Over 60% of all people who die by suicide suffer from major depression. If one includes alcoholics who are depressed, this figure rises to over 75%.

Depression affects nearly 10% of Americans ages 18 and over in a given year, or more than 19 million people.

More Americans suffer from depression than coronary heart disease (7 million), cancer (6 million) and AIDS (200,000) combined.

About 15% of the population will suffer from clinical depression at some time during their lifetime. 30% of all clinically depressed patients attempt suicide; half of them ultimately succeed.

Depression is among the most treatable of psychiatric illnesses. Between 80-90% of people with depression respond positively to treatment, and almost all patients gain some relief from their symptoms. But first, depression has to be recognized. – *American Foundation for Suicide Prevention*

Did You Know?

There are more suicides than homicides per year in the U.S. – 32,000 to 20,000. 4 times more men complete suicide than women.

Firearms are used in more suicides than homicides.

Veterans account for 21-25% of suicides in the U.S.

373,000 people treated in ER's for self-inflicted injuries.

160,000 persons hospitalized after suicide attempts.

--CDC – 2006 report for the 2005 year

Suicide is the leading cause of death world-wide.

- War deaths 310,000 19%
- Homicide 520,000 32%
- Suicide 815,000 49%

--World Health Organization 2002

Did You Know?

One third to two thirds of the jail and prison population are occupied by those with a mental illness, due to lack of services and access to medications.

The Iowa prisons and jails are presently over-crowded. A new jail is being built in Polk County. There is talk of building another prison in the state to alleviate the over-crowding. It is disturbing to hear that communities look at prisons as economic development.

For the taxpayer, for the ill person and their family, it makes more sense to implement -

- jail diversion practices, such as
 - mental health courts
 - funding adequate community health services
 - creating an adequate emergency response system for those in crisis
- effective re-entry programs for persons with mental illness who are leaving the jail or prison system - to reduce the rate of recidivism.



Crisis Intervention Team (CIT)

Like it or not, when someone is in a mental health crisis, we may have to call law enforcement to help us get our ill relative to a place of safety and to treatment. There is no emergency response team you can call at medical institutions.

In past issues we've talked about Crisis Intervention teams as part of law enforcement. In Des Moines, we have the Mobile Crisis Team. The Des Moines Police Dept. liaison to the Mobile Crisis Unit is Officer Kelly Drane. Kelly completed CIT training with the Story County Sheriff's office this last summer.

The concept of a Crisis Intervention Team started in Memphis, Tennessee and now teams are throughout the United States. When implemented in a police department, usually 20% of a police department are trained. [Here are some of the basics.](#)

Some definitions of a Crisis

- A crucial or decisive point; a turning point
- A sudden change in the course of a disease
- An emotionally stressful event or traumatic change in a person's life
- A point in a story or drama when a conflict reaches its highest tension and a solution must be found

What is an Intervention?

- To compel or prevent an action
- To maintain or alter a condition

What is a Team?

- A number of persons associated together in work or activity
- A group of people on the same side

More definitions of a Crisis

- *Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms.*

- Unless the person obtains relief, the crisis has the potential to cause severe affective, cognitive, and behavioral malfunctioning. --James & Gilliland 1993; 2001
- A crisis is a temporary condition wherein one's usual coping mechanisms have failed in the face of a perceived challenge or threat. -- Everly & Mitchell, 1997; 1999; Everly, 2004
- As the body struggles to maintain a physical homeostasis, equilibrium or balance so the mind struggles to maintain a similar balance and to return to a steady state of psychological functioning. -- Everly & Mitchell, 1997; 1999; Everly, 2004

What is Crisis Intervention?

- Crisis intervention is emotional "first aid" designed to assist the person in crisis to return to independent functioning.
- Crisis intervention is not psychotherapy.
- Crisis intervention is to psychotherapy as first aid is to surgery
- The focus of crisis intervention is not on past crises and not on chronic factors contributing to crisis.
- The focus of crisis intervention is on what is happening here and now.

Who is on a Crisis Intervention Team?

- CIT Officers belong to the larger team of the Police Department.
- CIT Officers are interviewed and selected for the 40 hours of intensive training because they exemplify several characteristics essential to effective team performance - CIT officers have a -
 - Rich life & professional experience
 - Commitment to training and knowledge
 - Attentiveness
 - Good Listening
 - Supportive Skills
 - Assertiveness
 - Ability to analyze
 - Problem solving skills
 - Capacity to remain calm and in control
 - Creativity & flexibility
 - Energy & strength
 - Fast mental reflexes

Basic skills for an effective CIT officer

- Empathic Understanding
- Genuineness
- Acceptance

Describe Empathic Understanding of the CIT officer

- Refers to the CIT Officer's ability to understand another person's feelings and concerns.
- The CIT Officer's efforts at empathic understanding set the stage for the successful resolution of the crisis.
- Empathy is not sympathy.

Helpful approaches – Considerable role playing is done in training To learn these skills

- Focus on the consumer and his/her world—Block out distractions
- Introduce yourself - Example: CIT: "Hi. My name is _____. I'm a CIT Officer with the _____ Police Department. Can you tell me your name?"
- Attend to words, voice tone, and body language
 - Do the consumer's words, voice and body language match?
 - Do the CIT Officer's words, voice and body language match?
- Use restatement and reflection
- Restate what the consumer is saying – Example: Consumer: "I don't know what to do. My family doesn't want me here."

CIT: "You're not sure where you can go for the night. Home doesn't seem like the best place for you right now."

- Reflect the consumer's feelings – Example: Consumer: "I'm sick and tired of them taking my check and then putting me out." CIT: "You're fed up with people trying to take advantage of you."
- Stay away from feelings when it escalates.
- Asking Effective Questions is key to successful crisis intervention.
 - There are two types of questions:
 - Open ended questions
 - Closed questions
 - Open ended questions allow us to get more information.
 - Open ended questions enable us to assess the person's level of dangerousness.
 - Open ended questions allow the officer to assess whether the consumer is in touch with reality.
 - Open ended questions may start with What, How or When and encourage the consumer to tell us more.
 - Ask open ended questions: What—How—When?
 - Open ended questions may request a description: "Tell me about..." "Please tell me..."
 - Avoid why questions: Why questions lead to defensiveness.
 - Closed ended questions start with "Are you..." "Do you..." "Will you..."
 - Request specific information: "Are you thinking of harming yourself?" "Are you hearing voices?"
 - Obtain a commitment: "Will you agree to get in the car?" "Can I call your doctor...family...."
 - Use positive reinforcement – Example: CIT : "I appreciate...Thank you...That's helpful."
- "Owning or I" statements
 - Owning means taking responsibility for what I am thinking, feeling and saying.
 - Essential for communicating what the CIT Officer wants and needs. Example: CIT: "Yes, I understand you are angry and upset but I want you to slow down so I can understand you....."
 - Owning or "I" statements are essential for assisting consumers who need direction.
 - "I" statements are used sparingly since the focus is on the consumer.

Describe Genuineness in the CIT Officer

- The CIT Officer is real
- The CIT Officer is authentic
- The CIT Officer is sincere
- The CIT Officer is free from pretense
- Role Free—not Dr. Phil, not a preacher, not a judge, not Harry Callahan, etc.
- Spontaneous and adaptable to changing situation—not confined to rule book but able to *think outside the box*. Example: CIT: "I'm not sure what we can do. But I'm willing to work with you to figure something out."
- The CIT Officer's words and gestures while interacting with the consumer and others on the scene are consistent and instill confidence in all concerned.
- Immediacy or staying in the "here and now" – Example: CIT: "Stay with me now. Let's work on this together. I want you to stop for minute and take a deep breath...That's good ... Thank you."

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

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

Describe Acceptance in the CIT officer

- The consumer has a right to have his or her own feelings, thoughts, or behaviors.
- The CIT Officer respects the dignity of each person without regard to sex, race, age, sexual orientation, cleanliness, etc.
- Acceptance is not easy when consumer is behaving in bizarre or hostile manner.
- Acceptance diminishes public stigma
 - Public Stigma
Stereotype: *All people with mental illness are dangerous*
Prejudice: *I agree, people with mental illness are dangerous and I'm afraid of them.*
Discrimination: *I don't want to be near them and won't hire one at my job.*
--Corrigan, *American Psychologist*, October 2004, p.617
- Acceptance diminishes self-stigma
 - Self Stigma
Stereotype: *People with mental illness are incompetent*
Prejudice: *I have a mental illness, so I must be incompetent*
Discrimination: *Why should I even try to get a job. I'm an incompetent mental patient.*
--Corrigan, *American Psychologist*, October 2004, p.617
Information for this article is from presentations authored by Dr. Kirchner and Dr. James of the Memphis VA Medical Center.

State Legislation

Here are 3 places on the web to access E-mail to figure out who your legislators are, to contact your legislators, get mailing addresses, and phone numbers.
<http://www.infonetiowa.com/> - Also has the latest on legislation.
<http://www.legis.state.ia.us/>
www.nami.org/advocacy



Please walk with us on Sat., Oct. 6,
at Des Moines Waterworks Park.



Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations

In December 2005, the National Business Group on Health finished their *Employer Guide to Behavioral Health Services*. The year long review looked at the current state of employer-sponsored behavioral health services and developed recommendations to improve the design, quality, structure and integration of programs and service.

The group's report sends a clear signal that mental illnesses are not shameful, and employers and employees alike will experience significant growth through increased attention to and investment in mental health.

Significant among the 12 key findings of the review were that:

- The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years.
- Savings attributed to limiting behavioral health benefits were fully offset by *increased use of other medical services*.

Significant among the recommendations was to equalize benefits structures – to equalize medical and behavioral health benefits.

For more information go to www.businessgrouphealth.org/ or http://www.businessgrouphealth.org/pdfs/fullreport_behavioralhealthservices.pdf

Please send a big **THANK YOU** to
Cindy Gross and Plaza Printers

6762 Douglas Avenue
Urbandale, Iowa 50322

278-4695 www.plazaprinters.net

For their assistance in helping us print this newsletter.



Please walk with us on Sat., Oct. 6, at
Des Moines Waterworks Park.