



# Greater Des Moines

## AFFILIATE AND SUPPORT GROUP NEWSLETTER

September 2007  
*“Support, Education, and Advocacy”*

**The NAMI Walks For the Mind of America is a little over a month away!**

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

Ways you can help

Join a team, form your own team, or walk individually, raise money, and **WALK WITH US!**

Donate to the walk. Ask family and friends to donate to the walk.  
 Ask your employer or stores you frequent to make a donation.  
 Be a Mile Sponsor for the walk for \$250. Higher levels are also available.  
 Attend the NAMI Walks planning meeting–Sept. 14 at the NAMI Iowa office  
 Volunteer for the day of the walk – we need at least 60-75 volunteers.

<http://www.nami.org/namiwalks/IA>  
[NAMIWALKSIAMGR@aol.com](mailto: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. You can make a difference.

<p><b><u>Education Meetings</u> are generally the 1<sup>st</sup> Sunday of the month from 2 - 4 PM at Iowa Lutheran Hospital, Level B conference room.</b> Dates on Sundays other than the 1<sup>st</sup> Sunday of the month are due to holidays or other special scheduled events. <b>See the page 3 for support groups.</b></p>	<p><b><u>Business and Committee Meetings</u> are the 2<sup>nd</sup> Thursday of the month at 5 P.M. at the NAMI-Iowa Office.</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">1. Business</td> <td style="width: 33%;">4. Education</td> <td style="width: 33%;">6. Fundraising</td> </tr> <tr> <td>2. Marketing and membership</td> <td>5. Advocacy</td> <td>7. Special Events</td> </tr> <tr> <td>3. Support</td> <td></td> <td></td> </tr> </table>	1. Business	4. Education	6. Fundraising	2. Marketing and membership	5. Advocacy	7. Special Events	3. Support		
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3. Support										

	Tues., Wed., Thurs., Aug 28-30	The <b>Third Annual CIT National Conference</b> will be this August 28 <sup>th</sup> -30 <sup>th</sup> in Memphis, TN. See inside for more details and possible scholarships to attend.
<i>Free</i>	Thurs., Aug. 30	<b>Family to Family class</b> starts – see more information on the next page.
<b>Sunday, Sept. 9 2 PM</b>		The topic will be <b>Estate Planning</b> – including information on <b>Special Needs Trusts</b> . Our speaker will be Frank Vavaris, a disability counselor/planner. <b>Nominations due for election in November.</b>
<i>Free</i>	Monday, Sept. 10	<b>Peer to Peer class</b> starts – see more information on the next page.
	Friday, Sept. 14	<b>NAMI Walks Volunteer/Committee Meeting</b> at NAMI Iowa office, 5911 Meredith Drive, Des Moines – 1:00 P.M. to 2:30 P.M.
	Sept. 14-16	<b>Visions for Tomorrow Teacher Training in Des Moines</b> (see inside for more information)
	Sept. 14-16	<b>Family to Family Teacher Training</b> (see inside for more information)
<i>Free</i>	Wed., Sept. 19	<b>Visions for Tomorrow class</b> starts – see the next page for more information.
<b>Saturday October 6 * * * * *</b>		<b>NAMI WALKS FOR THE MIND OF AMERICA</b> Des Moines Waterworks Park – 3 mile walk 8:30 AM check-in 10:00 AM Start time
	Tuesday, Oct. 9	<b>National Day of Prayer for those with Mental Illness</b>
	Tues., Wed., - October 9-10	<i>“Recovery – Under Construction”</i> – the <b>State Mental Health Conference</b> in Ames at the ISU Scheman Center – contact <a href="mailto:becky@trainingresources.org">becky@trainingresources.org</a> or call 309-3315
	Thurs., Oct. 11	<b>National Depression Screening Day</b>
	Thurs., Oct. 11	<b>Bipolar Awareness Day</b>
	Nov. 1-4	Training for Consumers to become a support group facilitator for <b>NAMI Connections Support Recovery Groups.</b>
<b>Sunday, November 4 2 PM</b>		<b>Part 2 - Understanding Social Security and the Appeal Process</b> – our speaker will be Steve Moats. <b>2008 Elections</b> for Officers & Board Members
	Nov. 16-18	Visions for Tomorrow Teacher Training in _____
	Thursday, Friday Nov. 29-30	NAMI Iowa Fall Conference at the Hilton Garden Inn, just off I-35 at 86 <sup>th</sup> St., in Johnston.

## Family to Family - the next class starts Thursday, August 30.

**Family to Family Education** - Take the free 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. Curriculum materials are provided by NAMI IOWA. A take home educational packet on PTSD is a new addition to the curriculum.

Call the NAMI office –254-0417 or Teresa - 274-6876 or Sharon 988-5151 to sign up. E-mail is [tbomhoff@mchsi.com](mailto:tbomhoff@mchsi.com) or [msrvliving@hotmail.com](mailto:msrvliving@hotmail.com). Classes will be held at the NAMI Iowa office at the corner of Meredith & Merle Hay – the office is located in a building behind the Quiktrip – 6:30 P.M. to 9 P.M.

## Peer to Peer – the next class starts Monday, September 10

**Peer to Peer Education** - Peer to Peer is a free 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. The classes will be held at the NAMI Iowa office at the corner of Meredith & Merle Hay – the office is located in a building behind the Quiktrip – 7 to 9 P.M.

## Visions for Tomorrow - the next class starts Wednesday, September 19.

Sign up for the next “**Visions for Tomorrow**” class. **What is Visions for Tomorrow?** VFT is a free educational program for people who are raising or working with children and adolescents who have behavioral disorders or mental illnesses. The curriculum is designed to help parents, foster parents and other caregivers face the day-to-day challenges; learn the facts; and find support, resources, and strategies to cope. The 12 workshops of the parent course are usually taught over a series of eight class sessions. There is no charge to attend VFT classes or workshops. Curriculum materials are provided by NAMI IOWA.

### Workshop topics include:

- 1) Understanding How the Brain Works
- 2) AD/HD, Oppositional Defiant Disorder, Conduct Disorder, Borderline Personality
- 3) Bipolar Disorder, Depressive Disorders, Suicide
- 4) Schizophrenia, Schizoaffective Disorder, Autistic Spectrum Disorders, Tourette Syndrome
- 5) Anxiety Disorders, Reactive Attachment Disorder, OCD, Eating Disorders
- 6) Empathy, Sharing Our Unique Life Experiences (SOUL)
- 7) Organization of Data and Record Keeping, Communication Skills
- 8) Problem Management, Coping and Self-Care
- 9) Transitions, Rehabilitation
- 10) Recovery, Detours, Alternative Treatments, Types of Therapy
- 11) Stigma, Advocacy, Judicial System
- 12) Graduation

Call Diane 273-5054 or Susan 242-7556 or the NAMI office 254-0417 to sign up – E-mail: [itsdianej@aol.com](mailto:itsdianej@aol.com). Classes will be held at the NAMI Iowa office at the corner of Meredith & Merle Hay – the office is located in a building behind the Quiktrip – 9:30 A.M. to 11:45 A.M.

## Iowa Peer Support Training Academy Trains 48



The Iowa Peer Support Training Academy recently completed training the 2<sup>nd</sup> (2007) class of peer support specialists. The first class was held in 2006.

6 from the 2006 class completed the train the trainer program and helped to teach the 2007 class of 42 peer support specialist candidates. Participants came from 20 communities across the state. Training is based on the Georgia model consisting of 28 different teaching modules.

Here are a few examples of how Peer Support Specialists are showing their value - in emergency rooms helping people in crisis, in community mental health centers in 1 on 1 counseling situations with their peers, and assisting insurance companies to help clients and follow up to make sure they are receiving adequate care after leaving the hospital. Peer support specialist services are reimbursable through Medicaid.

If you are interested in becoming a peer support specialist, please call 515-243-2000 and talk to Jim Addy or go to <http://www.sppg.com/home/peersupport.php>.

## 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 [lowaGH@aol.com](mailto:lowaGH@aol.com) or call 965-9799 - or contact Grace Sivadge 961-6671. Meetings are at Park Avenue Christian Church, 3219 SW 9<sup>th</sup> 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

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

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

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

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

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

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

**Coping After a Suicide Support Group** – Polk Co. Crisis and Advocacy Services – Contact: Chris 515-286-3887  
Meeting day – 2<sup>nd</sup> Thursday of each month 6-7:30 P.M. and last Saturday of each month 9-10:30 A.M. Meeting place is 525 5<sup>th</sup> 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.



**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 16<sup>th</sup> 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

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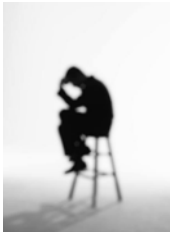
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## DE-CRIMINALIZING MENTAL ILLNESS

M.J. Stephey, *Time* magazine 8-8-07

"Psycho." "Freak." "Jason from the horror movie." These are the answers that psychologist Habsi Kaba gets from Miami police officers when asked to describe people with mental illness. Such stereotypes are surprisingly common, says Kaba, and not just within law enforcement. But these

misconceptions are especially dangerous when they're held by police, who are often forced to make split-second, life-or-death decisions about mentally ill suspects. "The worst thing you can have is power and lack of knowledge," Kaba says.

Just ask Mike, 31, who knows firsthand. Mike suffers from schizophrenia, bipolar disorder and depression. Since the age of 17, the Los Angeles native has been repeatedly arrested during psychosis for nuisance crimes like disturbing the peace, only to serve his time, fall off his medication and get arrested again. On three separate occasions, his hallucinations were so severe he tried to commit suicide by provoking the police to shoot him. Though he is receiving treatment, rising health care costs and declining federal help mean Mike will likely end up in jail again.

L.A. Police Lieutenant Richard Wall told Mike's story to members of the House Judiciary Committee in March, in support of the 2007 Second Chance Act, which aims to reduce recidivism, in part with better mental health treatment for prisoners returning to society. Prisons, Wall testified, have become the nation's "de facto" mental health care provider. According to the Federal Bureau of Justice Statistics, there are currently 1.25 million inmates like Mike, with debilitating disorders ranging from schizophrenia to post-traumatic stress disorder, abandoned in the U.S. prison system instead of receiving treatment in hospitals.

"If you think health care in America is bad, you should look at mental health care," says Florida state judge and criminal mental health expert Steve Leifman. More Americans receive mental health treatment in prisons and jails than hospitals or treatment centers. In fact, the country's largest psychiatric facility isn't even a hospital, it's a prison - New York City's Rikers Island, which holds an estimated 3,000 mentally ill inmates at any given time. Fifty years ago, the U.S. had nearly 600,000 state hospital beds for people suffering from mental illness. Today, because of federal and state funding cuts, that number has dwindled to 40,000. When the government began closing state-run hospitals in the 1980s, people suffering from mental illness had nowhere to go. Without proper treatment and care, many ended up in the last place anyone wants to be.

"The one institution that can never say no to anybody is jail," Leifman says. "And what's worse, now we've given [the mentally ill] a criminal record."

Most police officers aren't trained to deal with people suffering from severe mental illness. But because they are the first to respond to calls involving psychiatric crises, police are in a unique position to fix the crippled system. That effort is now under way, thanks to Crisis Intervention Teams (CIT), which are being adopted by a growing number of police departments across the country. The concept was pioneered by the Memphis Police Department in 1988 after an officer was shot and killed by a person suffering from schizophrenic hallucinations. Working with the National Alliance for the Mentally Ill and two local universities, Memphis police trained and organized a unit of officers specifically to deal with people in psychosis - a mental state commonly suffered by patients with severe mental illness in which their thoughts don't match up with

reality.

In these cases, normal police procedures often increase the chances of violence, confusion and even death. So, police officers are taught to approach psychotic suspects in a different way: by speaking softly, rather than shouting commands, repeating phrases, holding hands palms-up instead of holding a gun or badge, and wearing plainclothes instead of uniforms. These actions may seem minor, says Kaba, who is the CIT training coordinator for the Miami Police Department, but they go a long way in breaking down the barriers - psychological and otherwise - that often exist between the mentally ill and police.

The ultimate purpose of the CIT program is perhaps empathy. Using a device called Virtual Hallucinations, officers can begin to understand what it's like to be in the grip of a severe and untreated mental illness. Made by the pharmaceutical company Janssen, the rig and headphones simulate the disturbing and disorienting environment of a psychotic episode. After using the rig, Lt. Wall of the LAPD says he was struck by the idea of being exposed to such chaos all the time. "It's just a scary thing," Wall says, "I can do it and walk away from it." Those with serious mental illness, however, cannot.

Community members like John Kowal, 54, work with CITs to provide officers with a more intimate knowledge and understanding of psychosis. Kowal, who suffers from bipolar disorder and alcoholism, has been working with Miami's Police Department and inmates as a "peer specialist." His duties range from consultant to mediator to companion. "I can bond with [mentally ill inmates]. I can say, 'Hey, I was in jail. I take medicine. It's worth it,'" Kowal says. "I don't go by a book. I'm like a friend."

Likewise, the program challenges stereotypes of law enforcement officers as trigger-happy bullies. "Just like police don't understand people with mental illness, we don't understand them," Kaba says. "They're social workers, they're brothers and sisters, they're priests. They play every role out there."

Some officers initially dismissed the CIT program as run-of-the-mill sensitivity training or extreme political correctness, but Cindy Schwartz, director of Florida's Eleventh Judicial Circuit Criminal Mental Health Project, says those same officers now marvel at the program's success. The CIT model has received numerous awards from nationally recognized mental health organizations, law enforcement agencies, and humanitarian groups for treating mental illness as a disease, not a crime. Such change cannot come too soon.

Last December, the Advocacy Center for Persons with Disabilities filed a federal lawsuit against the state of Florida, alleging that it was violating the civil rights of hundreds of mentally ill convicts and inmates awaiting trial by leaving them jailed and without treatment. "We reached a crisis point," says Leifman, the Florida judge, of the state's inability to address mental illness. "We have hundreds of defendants languishing in jail." It got so bad that two mentally ill inmates in a Pensacola, Fla., jail died after being brutally subdued by guards. And in Clearwater, Fla., a schizophrenic inmate gouged out his eye after waiting weeks for a hospital bed.

In June, New York legislators passed a bill outlawing solitary confinement for mentally ill inmates after a study found that such isolation - to which mentally ill prisoners are often subjected - worsened psychiatric symptoms and often led to self-mutilation or suicide attempts.

When it comes to mental health care in the U.S., Leifman says, history is repeating itself. During the 1800s, long before state-run

agencies existed to treat mental illness, families would simply drop their loved ones off at jails or prisons, where their conditions remained untreated. Then came state-run hospitals that Leifman refers to as "horror houses" given that patients were usually either neglected or abused - experiments involving drugs and electroshock therapy inspired movies like *One Flew Over the Cuckoo's Nest* and finally drew the public's attention to the civil rights abuses of people with mental illness. There appeared a glimmer of hope in 1963, when President Kennedy, in what would be his last public bill-signing, authorized \$3 billion to create the first national network of mental health facilities. But after Kennedy's assassination, the country turned its focus to Vietnam and not one penny went into the project.

"It's the one area in civil rights that we've gone backwards on," says Leifman, noting that nearly half of the nine floors in Miami-Dade's County Jail are mental health wards, even though the building is "more like a warehouse than a facility." He decries the conditions that these inmates face, including vermin-infested, decrepit buildings that lack adequate ventilation, lighting and water supplies. Leifman also laments the amount of taxpayer dollars used to fund such an inadequate system. Florida taxpayers spend \$100,000 each day to house the mentally ill in prison; moreover, studies show that people with mental illness stay in jail eight times longer than other inmates, at seven times the cost.

"We can't really build our way out of the problem. It's not just about state hospital beds or jails," Leifman says. "We need to really take a hard look at how we're dealing with the problem overall."

#### Did You Know?

At the Heroes in the Fight Luncheon on June 5 at the Hilton Garden Inn – NAMI Greater Des Moines was chosen to be one of the recipients of a \$500 donation. THANK YOU!

#### Federal Legislative Issues

[www.nami.org/advocacy](http://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.braley.house.gov/>

<http://www.loeb sack.house.gov/>

#### Senate Passes Children's Health Insurance Bill

August 6, 2007 – NAMI E-news

Thanks to your support, the Senate passed legislation reauthorizing the State Children's Health Insurance Program (SCHIP) on August 2 by a vote of 68-31. The House passed a similar bill on August 1. This vote sends the SCHIP bill to a House-Senate Conference Committee that is expected to begin its work in September.

NAMI supports both the House and Senate versions of the SCHIP bill. Both contain equitable coverage requirements for SCHIP plans with respect to mental illness treatment. In addition, the House bill contains a broad range of improvements to mental health benefits under the Medicare program and an amendment to block potentially damaging regulations limiting community-based mental health services under Medicaid.

#### Mental Health Parity S. 558 and HR 1424

July 19, 2007

Enactment of a parity law this year is within reach.

The House bill, H.R. 1424, moved forward with the Committee on Labor and Education adopting a modified version of the bill in a July 18th meeting. Two other House committees must still act on the bill, and in the Senate, that bill's sponsors are still working to resolve issues to enable that body to pass S. 558, the "Mental Health Parity Act of 2007".

In the Senate, the sponsors (Senators Domenici, Kennedy and Enzi) have worked to tighten S. 558 since it won committee approval in February, and Senator Kennedy (D-MA) is working toward offering a modified version of the bill on the Senate floor.

S. 558 would close loopholes in existing law and provide full parity for both treatment limits (such as day and visit limits) and out-of-pocket costs (such as copayments and deductibles) for some 113 million Americans in health care coverage sponsored by larger employers (over 50 employees, as in current law).

Importantly, the bill, as modified, preserves a wide range of state laws including those that mandate provision of mental health benefits, those requiring coverage of specific mental disorders, and those providing broader patient protections.

H.R. 1424, as amended by the Education and Labor Committee includes new language clarifying the relationship between federal and state law. It provides that nothing in the bill is to be construed to preempt any provision of state law establishing any consumer protections, benefits, methods of access to benefits, rights, or external review programs.

#### Housing and Homelessness Funding Details for FY 08 can be found in S 1789 – the Transportation-HUD appropriations bill

This includes -

- Section 811 funding for HUD for
  - New capital advance and project based grants to local nonprofit disability organizations to expand the inventory of accessible supportive housing serving individuals with severe disabilities – including severe mental illness.
  - Renewal of expiring tenant based rent subsidies
  - Renewal of existing project based subsidies
- Section 8 rental voucher funding which hopefully alleviate the extremely long waiting lists of people living on SSI to access rental assistance.
- McKinney-Vento Homeless Funding – includes funding for permanent housing
- Includes funding for new rental vouchers for homeless veterans, including those returning from Iraq.

#### Mental Illness Research and Services funding details for FY 08 can be found in HR 3043 and S 1710

This includes funding for –

- National Institute of Mental Health (NIMH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Mental Health Block Grant – which sends money to each state in support of their mental health system.
  - PATH – state grants for outreach and engagement of homeless individuals with mental illness.
  - Children's Mental Health
  - Garrett Lee Smith Suicide Prevention
  - Protection and Advocacy – the increase in funding over last year is directed to programs to improve conditions for people with mental illness in jails and correctional facilities and promote prevention and jail diversion programs.
  - Jail diversion grants

### Dept of Justice Appropriations Act – S 1745 – for FY 08

The bill includes \$10 million for programs under the Mentally Ill Offender Treatment and Crime Reduction Act – including pre-booked diversion, training of law enforcement and post sentence re-entry.

### Social Security Administration Appropriations Bill

The Social Security Administration is struggling to cope with an unprecedented backlog of disability appeals. It is estimated that 738,000 cases are awaiting hearings, with an average wait time of 505 days. Additional funding is directed to clearing the backlog in disability claims.



### Act Now to Strengthen the ADA

Contact your Congressman

July 25, 2007

When the Americans with Disabilities Act (ADA) was signed in 1990, there was great hope that this law would help overcome the pervasive discrimination that people with mental illness and other disabilities face in the workplace and elsewhere.

A series of court decisions since enactment have weakened the impact of this landmark law. For example, a 1999 decision by the U.S. Supreme Court held that people with mental or physical impairments whose conditions are stabilized by medications or other corrective measures are not disabled within the meaning of the ADA.

This opens the door to discrimination by permitting employers to decide that an individual is too disabled to work while preventing this individual from filing an ADA complaint because he or she is not disabled enough to qualify for its protections. This is not what Congress intended when it passed the ADA.

On July 26th, the 17th anniversary of the enactment of the ADA, the **ADA Restoration Act of 2007** was introduced to the House. This Act is intended to clarify that the ADA is intended to cover people with disabilities irrespective of whether they are taking medications or taking other steps to manage their medical conditions and achieve recovery.

Please contact your Congressman to express your support for this legislation.

**Congress adjourned in August for a summer recess. Final passage of bills will not occur until after Congress returns in September.**



### Unanimous Vote in the Senate for the Passage of the Dignified Treatment of Wounded Warriors Act

July 25, 2007

The Senate, by a unanimous vote, passed the Dignified Treatment of Wounded Warriors

Act which improves health care for veterans and returning injured service members. Senator Mikulski co-sponsored the bill, which was introduced by Senators Carl Levin (D-Mich.) and John McCain (R-Ariz.).

"Our worst fears have come true. It seems our troops are at war in Iraq and Afghanistan, and then at war at home to get the health care they need and deserve," said Senator Mikulski. "We know our military medical doctors and nurses are performing heroically, saving lives on the battlefield and in acute care. But what happens when they come home? If we really want to support our troops, we need more than yellow ribbons; we need action."

The Dignified Treatment of Wounded Warriors Act outlines several

steps to improve and enhance care for our veterans and returning service members. Some of those steps are:

- Enhances health care for veterans and returning service members - Allows medically retired service members to receive the active duty health care benefit for three years.
- It also allows the VA to provide vocational rehab to active duty service members in VA facilities,
- authorizes certain family caregivers at military or VA hospitals to receive medical care and counseling, and
- establishes a DoD/VA Interagency Program Office to develop a joint electronic health record.
- Improves Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD) prevention, diagnosis and treatment
- Requires the DoD, in consultation with the VA, to develop a comprehensive plan, including training and education to reduce the negative stigma.
- It also requires the DoD to establish separate centers of excellence for TBI and PTSD, and
- authorizes \$50 million for improved diagnosis, treatment and rehabilitation of service members with TBI or PTSD.
- Improves the disability system - Adopts the VA presumption that a disease or injury is presumed to be service-related when the member has six months or more of active duty and the disability was not noted at the time the member entered active duty. It requires military departments to use VA standards to make disability determinations.
- It also establishes a board to review disability determinations and increases severance pay for some service members.
- Extends the period of eligibility for care - Extends the period of eligibility for health care from two years to five years after discharge or release for combat veterans of the Persian Gulf War or future hostilities.
- Mandates mental health evaluation - Requires that veterans or returning service members receive initial mental health evaluations not later than 30 days following requests.
- Creates homeless programs - Institutes a demonstration project that will identify service members at risk of becoming homeless after discharge or release from active duty, and will provide referral, counseling and support services to prevent them from becoming homeless.

"Many of the injured men and women coming home from Iraq and Afghanistan are now in their 20s, and many are in need of chronic care. Some will need assisted living; some will need assistance with living," said Senator Mikulski. "We have to think about the next 50 years for our wounded veterans in terms of compensation, care, and how we are going to help families get through this."



### President's Commission on Care for America's Returning Wounded Warriors Issues Six Groundbreaking Patient and Family Centered Recommendations to Serve, Support and Simplify Care

July 25, 2007

Calling its recommendations a "bold blueprint for action" to serve, support and simplify the care for our injured service members, the President's Commission on Care for America's Returning Wounded Warriors today approved six recommendations that make sweeping changes in the delivery of health care and services. The recommendations include the first major overhaul of the disability system in more than 50 years. The Commission called upon the White House and Congress to implement its recommendations as quickly as possible to ensure that those who have served in Iraq

and Afghanistan are able to successfully transition back to civilian life or active duty service.

"Our motto is 'put patients and families first.' The system should work for the patient, instead of the patient working for the system," said Shalala.

"Our injured service members deserve a system that serves their different needs, supports them and their families while they recover and simplifies the delivery of care and services," said Dole. "We will not let these recommendations sit on a shelf. They need to be acted upon now to improve the quality of lives for our brave men and women and their families."

#### 1. *Immediately Create Comprehensive Recovery Plans to Provide the Right Care and Support at the Right Time in the Right Place*

**Recommendation:** Create a patient-centered Recovery Plan for every seriously injured service member that provides the right care and support at the right time in the right place. A corps of well-trained, highly-skilled Recovery Coordinators must be swiftly developed to ensure prompt development and execution of the Recovery Plan.

**Goals:** Ensure an efficient, effective and smooth rehabilitation and transition back to military duty or civilian life; establish a single point of contact for patients and families; and eliminate delays and gaps in treatment and services.

#### 2. *Completely Restructure the Disability Determination and Compensation Systems*

**Recommendation:** DoD maintains authority to determine fitness to serve. For those found not fit for duty, DOD provides a payment for time served. VA then establishes the disability rating, compensation and benefits.

**Goals:** Update and simplify the disability determination and compensation system; eliminate parallel activities; reduce inequities; and provide a solid base for the return of injured veterans to productive life.

#### 3. *Aggressively Prevent and Treat Post-Traumatic Stress Disorder and Traumatic Brain Injury*

**Recommendation:** VA should provide care for any veteran of the Afghanistan and Iraq conflicts who has post-traumatic stress disorder (PTSD). DoD and VA must rapidly improve prevention, diagnosis, and treatment of both PTSD and traumatic brain injury (TBI). At the same time, both Departments must work aggressively to reduce the stigma of PTSD.

**Goals:** Improve care of two common conditions of the current conflicts and reduce the stigma of PTSD; mentally and physically fit service members will strengthen our military into the future.

#### 4. *Significantly Strengthen Support for Families*

**Recommendation:** Strengthen family support programs including expanding DoD respite care and extending the Family and Medical Leave Act for up to six months for spouse and parents of seriously injured.

**Goals:** Strengthen family support systems and improve the quality of life for families.

Approximately two-thirds of injured service members reported that their family members or close friends stayed with them for an extended time while they were hospitalized; one in five gave up a job to to do so.

#### 5. *Rapidly Transfer Patient Information Between DoD and VA*

**Recommendation:** DoD and VA must move quickly to get clinical and benefit data to users. In addition, DoD and VA should jointly

develop an interactive 'My eBenefits' website that provides a single information source for service members.

**Goals:** Support a patient-centered system of care and efficient practices.

A common complaint is lost paperwork. For example, 40% reported having to resubmit paperwork during the disability evaluation process.

#### 6. *Strongly Support Walter Reed By Recruiting and Retaining First Rate Professionals Through 2011*

**Recommendation:** Until the day it closes, Walter Reed must have the authority and responsibility to recruit and retain first rate professionals to deliver first rate care.

**Goals:** Assure that this major military medical center has professional and administrative staff necessary for state-of-the-art medical care and scientific research through 2011.

To reach a new generation of service members, the Commission is distributing its recommendations through "You Tube".

The White House Press Secretary has said the President has no plans to act on this immediately.



A National Suicide Crisis Hot line planned for Veterans – has begun operations. Staffed by mental health professionals, it will operate 7 days a week, 24 hours a day. The phone number is 1-800-273-TALK (8255).

### VA to Pair Mental Health with Primary Care Units

*Federal Daily 7-23-07*

Acknowledging the pending deluge of returning combat veterans with post traumatic stress disorder and other mental health issues, the Dept. of Veterans Affairs (VA) plan to start placing mental health programs closer to primary care facilities. VA said that the move is meant to address the reluctance of some veterans to talk about emotional problems by increasing the department's mental health presence in primary-care settings.



### BIPOLAR MAY SHRINK BRAIN

By: Psych Central Senior News Editor on Friday, Jul, 20, 2007

Reviewed by: John M. Grohol, Psy.D. on July 20, 2007 at 8:07 am

Researchers discover people with bipolar disorder - or manic depression - suffer from an accelerated shrinking of their brain.

The study shows for the first time that bipolar disorder - a condition characterized by periods of depression and periods of mania - is associated with a reduction in brain tissue and proves that the changes get progressively worse with each relapse.

This discovery has implications not only for the way we research the disease, but may also impact the way this condition is treated.

The University of Edinburgh study is published in the Journal of Biological Psychiatry.

Scientists discovered the loss of grey matter tissue is concentrated in areas of the brain which control memory, face recognition and co-ordination - namely the hippocampus, fusiform and cerebellum respectively.

Dr. Andrew McIntosh, senior lecturer in psychiatry and lead researcher, said:

"For the first time, we have shown that as people with bipolar disorder get older, a small amount of tissue is lost in parts of the

brain that are associated with memory and the coordination of thoughts and actions. The amount of brain tissue that's lost is greater in people with multiple episodes of illness and is associated with a decline in some areas of mental ability.

"Although we do not yet know the cause of this brain shrinkage, it may be that repeated episodes of illness harm the brain and lead to the decline. Another possibility is that the brain changes are caused by stress or genetic factors, which tend to lead both to more frequent illness episodes and to greater brain loss. Further research will be required."



**Wellcome Trust Case Control Consortium (WTCCC)**  
Nature Publishing Group 6-7-07

In the research world, publishing in Nature magazine is a big deal. The WTCCC is a consortium of 50 British research groups. They are conducting genome-wide association studies of 7 common human diseases:

- Rheumatoid arthritis
- Hypertension
- Crohn's Disease
- Coronary artery disease
- Bipolar disease
- Type 1 and Type 2 Diabetes

Genome wide association scans examine the relationship between each DNA position and a particular trait (i.e. diabetes).

There have been 3 recent advances to accelerate the scans.

1. The International HapMap resource
2. Dense genotyping chips which provide sufficient technology and are financially feasible.
3. A large number and well characterized clinical samples from participants.

The strongest signal in bipolar disorder was at chromosome 16p12. There is increasing evidence for an overlap in genetic susceptibility with schizophrenia. Several genes at this location could have pathological relevance to bipolar disorder.

The U.S. equivalent of the WTCCC effort is the Collaborative Genomic Study of Bipolar Disorder of which the U. of Iowa is one of twelve participating institutions -  
**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. A stipend of \$80 is paid for participation.

**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>



**Recovery Oriented Care**

"the issue is not what role recovery plays in treatment but what role treatment plays in recovery."

Allie Franklin, VA American Lake Recovery Coordinator 7-13-07

**What is Recovery?**

Recovery has multiple meanings depending up on the setting. For some it means a return to previous functioning, similar to a "cure." For others it means a "reduction in symptoms." For a growing body of research and practice, the consumer driven model of "Recovery" is being used:

"... a process in which the individual strives to overcome the fact of mental illness and its impact on one's sense of self." Care oriented to these goals is that which "identifies and builds upon each individual's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community"

This definition suggests that in building one's own unique assets, each person will ultimately define recovery in his or her own terms. There are some common components that would be seen across multiple recovery concepts by consumers these are: hope, medication/ treatment, empowerment, support, education, self-help, meaningful activity/ employment, and spirituality.

**What Recovery is Not:**

Recovery is not a program or a class. Recovery is a treatment philosophy that seeks to partner with our clients in order to work towards goals that are meaningful to the veteran. Recovery is not usually a destination, **rather** an ongoing process of self discovery, proactive management and self care. Recovery isn't about what you aren't able to do anymore; it **is** about who would like to be and how you can work to achieve that goal. Recovery is about introducing one's self with roles, relationships, qualities that describe him/her, rather than label an illness as the most important facet of self.



**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](http://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](http://TogetherRxAccess.com) 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. 42<sup>nd</sup> St. Des Moines, Iowa 50312 or E-mail: [tbomhoff@mchsi.com](mailto:tbomhoff@mchsi.com)

**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](mailto: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  
Teacher training will be Sept. 14-16 (see next column)
- For Visions for Tomorrow educational classes  
Teacher training will be Sept. 14-16 (see next column)
- For Peer to Peer educational classes
- For Provider educational classes



Our website is: [www.nami.org/sites/NAMIGreaterDesMoines](http://www.nami.org/sites/NAMIGreaterDesMoines)

- 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.



#### Training for Family to Family teachers and Visions for Tomorrow teachers September 14-16.

##### Who may teach Family to Family?

Are you willing to help family members of adults face the challenges of mental illness and find insight, understanding and empowerment? Applications are being accepted for 2007 Family to Family volunteer teacher training sessions September 14-16 (location to be determined).

Teachers are volunteers who have a family member who has a serious mental illness and agree to teach the course at least once per year for two years. They are persons who are comfortable with emotional issues families face and able to self-disclose regarding guilt, anger, shame, ambivalence and grief. They must submit an application form and signed agreement and have completed three day training, expenses paid by NAMI IOWA.

**CONTACT:** Carol Porch, Family to Family Coordinator, **NAMI IOWA** 5911 Meredith Drive, Ste. E, Des Moines IA 50322-1903 Phone: 319-351-3498 (Carol's home phone) 515/254-0417, 800/417-0417 (outside Des Moines) email:porch@avalon.net or [namieducation@mchsi.com](mailto:namieducation@mchsi.com).

**Who may teach Visions for Tomorrow?** Teachers are volunteers who are parents, extended family, or foster parents who have experience raising a child or adolescent who has a behavioral disorder or mental illness. They attend a weekend training session, expenses paid by NAMI IOWA. The training begins at 6:30 pm on Friday and ends by 2:00 pm on Sunday. Teachers agree to teach the parent course twice in two years and/or present foster parent or caregiver workshops.

**Contact:** Jackie Elfmann, VFT State Coordinator, NAMI IOWA—Alliance for the Mentally Ill of Iowa 5911 Meredith Drive, Ste. E, Des Moines IA 50322-1903 Phone: 515/254-0417 or 800/417-0417 email: [namieducation@mchsi.com](mailto:namieducation@mchsi.com)



#### 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](mailto:sbakker@dhs.state.ia.us) and ask for the MHPC Application.

Our website is: [www.nami.org/sites/NAMIGreaterDesMoines](http://www.nami.org/sites/NAMIGreaterDesMoines)

#### 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](http://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



at

This 2 hour in-service program is for Teachers and other school professionals, school nurses, social workers, medical residents, education majors 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

**To have this program at your school or organization– please contact Diane Johnson 255-8157 E-mail: [itsdianej@aol.com](mailto:itsdianej@aol.com) or [DLJohnson@magellanhealth.com](mailto:DLJohnson@magellanhealth.com)**



## Iris the Dragon Offering a 2 for 1 Book Special

Iris the Dragon books are excellent resources for helping children, families and educators open up a dialogue about the topic of mental health. What

often can be a difficult topic to talk about is made easier with the assistance of the Iris the Dragon Book Series.

“*Catch a Falling Star*” is about a boy Fish, named after his love for fly-fishing, and his star guardian, Iris the Dragon. In the book, Fish starts to experience some of the early signs of mental illness, feeling anxious and confused at times. While no one else understands Fish’s feelings, Iris helps Fish understand and deal with his thoughts and worries by teaching him to relax and telling him her dragon secrets for a healthy brain.

“*Lucky Horseshoes*” features a little girl called Skippy, a baby horse called Little Ben and Iris the Dragon. The book shows Skippy experiencing the early signs of ADHD, which begin to interfere with her school, home life and her dream of taking her horse, Little Ben, to the summer fair. As Iris befriends Skippy, Iris is able to help Skippy deal with her symptoms and boost Skippy’s confidence in her ability to succeed. With the assistance of Iris, Skippy slowly takes on more responsibilities and learns strategies that help her achieve her dreams.

There are also lesson plans and other items for teachers. To help raise the level of awareness and education about mental health, we are offering a 2 for 1 special on all book orders. For every book ordered, you will receive an additional copy of the book. For ordering and more information- Jessica Grass T. 613.267.5601 [www.iristhedragon.com](http://www.iristhedragon.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.

## Epilepsy and Psychiatric Disorders

*Harvard Mental Health Letter May 2006*

It may seem strange today, but there was a time when epilepsy was not clearly distinguished from psychiatric disorders. Psychiatry and neurology were not distinct professions, and the nature of epileptic symptoms was not well understood.

Eventually the origins of epilepsy in the brain were clarified, while psychiatry and neurology went their separate ways. People with epilepsy and their physicians were happy to have an explanation (or partial explanation) that combated the social stigma still attached, in the minds of some, to psychiatric disorders.

But epileptic seizures are a brain malfunction, and so are major depression, anxiety disorders, and psychoses. Although epilepsy is not a psychiatric disorder, its psychiatric dimension is important for treatment and research.

Anti-convulsant medications for epilepsy are also prescribed for bipolar disorder as mood stabilizers – such as Tegretol, Depakote, and Lamictal.

## 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 and the progress of the Mental Health Redesign.

<http://www.legis.state.ia.us/>  
[www.nami.org/advocacy](http://www.nami.org/advocacy)

## New Hiring at the Dept of Human Services – Division of Mental Health and Disability Services

As mentioned in a previous NAMI Greater Des Moines newsletter – the new Director of the Division of Mental Health and Disability Services is Dr. Allen Parks.

It is envisioned that there will be a Bureau Chief for each of the following:

- Children and Adolescents
- Adults
- Older Adults

Pamela Alger started August 10, 2007 as the new Child & Youth Bureau Chief in the Mental Health and Disability Services Division.

Pamela’s contact information is:  
515.281.3234 (land) [palger@dhs.state.ia.us](mailto:palger@dhs.state.ia.us) (email)

Pamela comes from Kansas where she has worked for several years in the mental health field.



## MENTAL HEALTH COURT SUCCEEDS

Editorial - TC PALM (FL), August 3, 2007

There were smiles and tears, handshakes and hugs all around in Circuit Judge Cynthia Cox's courtroom Tuesday afternoon.

The occasion was the third and largest "graduation" for clients in St. Lucie County's mental health court, an intervention program that provides a treatment and counseling alternatives for mentally ill people who otherwise might be caught up in a revolving door at the county jail.

As the 20 "graduates" and their family members stood before Cox, who oversees the program, she said, "All of you should really be proud of how you got here."

Under the six-month program, participants must visit doctors, attend counseling sessions, stay on medications and avoid trouble with the law. They receive therapy, housing and transportation assistance and vocational education and job training.

Since it began in June 2006, the program has handled more than 300 misdemeanor and third-degree felony cases.

On Tuesday, criminal charges were dismissed against all those who had successfully completed the program.

Mental health court began in St. Lucie County as a pilot program for the area and so far has saved the county \$500,000 in the cost of jail stays, according to officials, in addition to providing a far more humane and reasonable method of handling the mentally ill who break the law.

Despite a tight year for finances, Martin County officials have included \$70,000 in their upcoming budget to begin a mental health court.

That effort was led overall by Public Defender Diamond Litty and Chief Judge William Roby and, in the county, by Sheriff Robert Crowder and Commissioner Susan Valliere.

"For me, it's an absolute no-brainer," Valliere said. "It's the right thing to do, the humane thing to do.

In Martin County, an estimated 17 to 20 percent of the 600 people in jail are mentally ill, and jail stays can cost \$125 to \$300 per day, compared to mental health court that can cost about \$33 per day.

In addition, as Crowder said earlier this year, "People with serious mental health issues do not belong in jail. ... They need to be dealt with professionally instead of being warehoused in county jails."

Roby and Litty said they hope to launch mental health court programs in Indian River and Okeechobee counties in the near future and to seek grants to help with funding.

In recent years, the percentage of those with mental illness being housed in county jails on the Treasure Coast has been increasing. Simply providing them with medication has substantially increased the costs of housing them.

Also, because of that increase in inmate population, counties throughout the area have been forced into expanding their jails at major costs to taxpayers.

Mental health court offers a cheaper and more humane way to handle the situation and, as an added benefit, can result in clients becoming productive members of society rather than being a continuing burden.

The program, though in its early stages, appears to be working better than originally hoped. Every county with a similar situation

with housing the mentally ill in jail needs something similar.

As of April 2007, there were almost 92,000 inmates in Florida's prisons and more than 44 percent of them had been in prison before.

It is estimated that 20 percent of the prison population has a serious mental illness and nearly three-fourths of those with mental illness also have a substance abuse disorder.

Mentally ill offenders have a higher than average rate of recidivism.

"With 20 percent of the 10,000 ex-offenders released every year having a significant mental illness, we are paying \$120 million annually for their re-entry into the prison system. That is more than our state spends on all children's mental health services in a year."

"Investing in community-based mental health programs that can provide transitional centers and support staff is the key to tracking, counseling and guiding ex-offenders with mental illness toward safe and healthy actions and away from our prison gates."



## USC LAW PROFESSOR BATTLES SCHIZOPHRENIA

Highly Successful Academic Overcomes

Mental Illness Stigma

EUREKALERT.ORG (CA), August 3, 2007

Elyn Saks knows all about success - she was valedictorian at Vanderbilt University, graduated with honors from Yale Law School, was a Marshall scholar at Oxford and today is a respected legal scholar at University of Southern California Gould School of Law.

And, since adolescence, Saks has battled schizophrenia and acute psychosis. After decades of hiding her illness, Saks has published a memoir about her struggles and successes in "The Center Cannot Hold: My Journey Through Madness" (Hyperion, 2007).

Up until now, only Saks' closest friends knew of her condition - which she controls with daily therapy and medication.

"I wanted to write this book to give hope to people who suffer from schizophrenia and understanding to people who don't," said Saks, an expert in the field of mental health law who also holds faculty appointments at the Keck School of Medicine at USC and the University of California, San Diego, School of Medicine in the psychiatry departments. "I hope this story will help implode the myths that surround mental illness. And, honestly, it will be nice not to have this secret anymore."

Schizophrenia affects approximately 1 percent of the world's population - more than 3 million Americans - and is classified by the National Mental Health Institutes as one of the top 10 causes of disability in the developed world. A disorder of the brain, the illness causes psychotic episodes of varying duration and severity. Symptoms of a psychotic episode range from unusual thoughts or perceptions and inability to form coherent thoughts to delusions and hallucinations.

However ironic, the life of Saks' mind has been her salvation. Even as her brain attacks her with fear and hallucinations, it also provides the source of her greatest pride and stability - her work. At USC, she throws herself into writing and spends nearly every waking hour in her crowded office in the law school. Since her arrival at USC in 1989, she has been among the school's most productive and respected scholarly writers.

Edward McCaffery, Robert C. Packard Trustee Chair in Law at USC, was one of the early colleagues Saks confided in.

"Elyn's contributions to the law school - as a scholar, teacher, colleague, and now associate dean for research - are

extraordinary," McCaffery said. "She's an extremely competent person who knows how to deal with her illness. There's nothing to do other than stand and applaud Elyn - and to learn from her."

Saks was in her 40s before she was able to admit to herself that her illness was not going away, and that medication and psychoanalysis would be necessary for the rest of her life.

"For 20 years I struggled with acceptance... Ironically, the more I accepted I had a mental illness, the less the illness defined me - at which point the riptide set me free," said Saks.



### What is the Olmstead Decision?

Part 1 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?

The Olmstead case began with two women who have mental retardation and mental health conditions. Both were living in a Georgia state psychiatric hospital, and wanted to move into the community. Their treatment teams agreed they could be served in the community, but no placements were available.

A lawsuit was filed on their behalf against Georgia's Department of Human Resources. It went all the way to the Supreme Court, and resulted in the ruling now known as the *Olmstead Decision*. This ruling made it clear that the *unnecessary segregation* of individuals with disabilities violates a federal law, the Americans with Disabilities Act.

The ADA protects individuals from discrimination on the basis of a disability. It requires states to administer their programs, services, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Discrimination can occur when:

- People with disabilities can't get needed services unless they live in an institution
- A state's disability services don't offer real choices to consumers

In other words, people with disabilities have the right to services provided in the most integrated setting appropriate to their needs. Community placement must be an option when:

- Treatment professionals determine it is appropriate
- The person wants to leave the institution
- The placement can be accommodated, considering state resources and the needs of other 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.

It is the responsibility of each state to take steps to make community living options available. The key question they must consider is: What is the most integrated setting appropriate to the needs of each individual?

Olmstead mandates that states must make reasonable accommodations in programs and services, taking into consideration:

- Cost

- Available resources
- How the needs of all people with disabilities will be met

Olmstead does not:

- Allow a state to keep institutions at full capacity by denying community placements
- Require the complete redesign of a state's service system
- Mandate the downsizing or closing of institutions
- Require a state to invest unlimited resources to make community living an option
- Require people with disabilities to move from institutions to community settings:
  - If they don't want to
  - Before services and supports are in place in the community

[www.olmsteadrealchoicesia.org](http://www.olmsteadrealchoicesia.org)

Part 2 in next month's newsletter will discuss what Iowa has been doing to address the Olmstead decision.



### Wellness Recovery Action Planning (WRAP)

**Many thanks** to Deb Guthrie for her presentation on Wellness Recovery Action Planning (WRAP) at our August 5 affiliate meeting.

WRAP is a technique for self management of illness and is an emerging best practice.

WRAP was developed from the work of Mary Ellen Copeland. Mary observed the courage of her mother in dealing with her mental illness and later began the gathering of stories of "personal medicine".

Adults, children & adolescents, veterans, and those with dual diagnosis can benefit from WRAP. It requires at least one other person who supports your recovery.

The WRAP key concepts of recovery are hope, personal responsibility, education, self-advocacy, and support. Deb led us through the format and resources for developing a WRAP including the development of a wellness toolbox "personal medicine".

The 5 sections of WRAP are:

1. daily maintenance
2. triggers
3. early warning signs
4. when things are breaking down
5. crisis plan & post crisis planning

Polk County Health Services has information on WRAP on-line at their website <http://polk.ia.networkofcare.org/mh/home/index.cfm>.

Statewide, around 60-70 persons are trained to do basic WRAP facilitation. There is a training being planned in Des Moines next year. We will be sure to let you know when and where the training will be held.

For more information on WRAP – please contact [dguthrie21@mchsi.com](mailto:dguthrie21@mchsi.com) or call 314-4403.

Mary Ellen Copeland's website is [www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com) Ms. Copeland is also the author of *The Depression Workbook* and many other publications.



### Post Traumatic Stress Disorder

*Excerpts from Harvard Mental Health Letter – August 2007*

"It could go on for years and years, and has, for centuries," wrote the author of the Sumerian epic of Gilgamesh in the 3<sup>rd</sup> millennium, B.C., describing the suffering of a character who survived a violent encounter that killed his friend. That terrifying experiences often have lasting psychological

consequences was well known for thousands of years before 1980, when the American Psychiatric Association classified posttraumatic stress disorder (PTSD) as a psychiatric disorder in the third edition of its diagnostic manual (DSM-III). PTSD is one of the few psychiatric conditions to which the manual ascribes a definite cause.

*(Post Traumatic Stress Disorder – cont'd)* War is a mother lode of traumatic experiences and the chief source of the concept of PTSD. In the American Civil War, the symptoms were described as battle fatigue. In WWI, it was called shell shock, and in WW2, combat neurosis or traumatic neurosis. Soldiers in those wars who succumbed to PTSD were sometimes regarded as weak or inadequate, but that view changed as understanding of their experiences improved. Physicians and mental health professionals came to see the symptoms as in a sense, normal responses to abnormal circumstances. By the middle of the Korean War, DSM-1 included a diagnosis of “gross stress reaction,” and DSM-II described a “transient situational disturbance”.

At the time DSM-III was compiled, professionals had begun to emphasize more lasting effects of trauma. We were in the aftermath of the Vietnam War, and some critics of the diagnosis of PTSD have suggested that it served a political purpose, in effect making the case that war is dangerous to mental health. The creators of DSM-III certainly sympathized with the veterans of a war many regarded as unjustified, and they looked for a pattern in the resulting suffering. At the same time, the women’s movement was drawing new attention to the effects of sexual and physical abuse on women and children. All this history influenced the psychiatric understanding of PTSD.

As the disorder is defined today, it involves 3 kinds of symptoms:

1. Hyperarousal - Individuals with PTSD are irritable, easily startled, and constantly on guard. They sleep poorly and have difficulty concentrating.
2. Re-experiencing or intrusion – They recall the traumatic event involuntarily in the form of vivid memories, nightmares, and flashbacks. They may feel or even act as though it is happening again. Any object, situation, or feeling that reminds them of the trauma may cause intense distress.
3. Avoidance and emotional numbing – They avoid feelings, thoughts, persons, places, and situations that evoke memories of the trauma. They lose interest in their usual activities. They feel estranged from other people and even from their own feelings.

These 3 sets of symptoms have a common theme – fixation on the trauma. The traumatic event dominates and controls the lives of people with PTSD. They have not assimilated the experience, so they repeatedly re-experience it in its original terrifying form. They are both emotionally numb and constantly on guard against a danger that no longer exists because they feel desperately conflicting needs for vigilance and repose.



### 10 Tips for Improving a Loved-One's Mental Health

By the National Mental Health Association

Maintaining mental wellness, enlisting the help of others when you need it and surrounding yourself with a supportive, healthy environment are essential in today’s modern, on-the-go world. Spending time with family and loved ones, engaging in new activities and volunteering are just a few of the ways you can relieve stress and cope with everyday life. For even more ideas, read the list that follows.

1. Get plenty of rest -- Take frequent naps. Not only will they help calm your mind, but they can give you more energy. Make sure to get a full seven to eight hours of sleep each night to sustain a proper balance of physical and mental health.
2. Go for a walk -- Regular exercise is an excellent way to maintain a healthy lifestyle. Enjoying a long walk at a moderate pace allows you to reflect on your day while getting the blood flowing. For an added spin, invite family members and friends to join you for an evening stroll. During bad weather, complete laps inside a local mall or community center.
3. Eat something new -- Whether it’s tackling a new recipe or re-inventing a traditional one, cooking is a great way to eat well and have fun in the process. Invite family and friends to join you once a week for dinner and take turns preparing meals. Kick off special events with a potluck dinner or host an evening filled with international cuisine.
4. Exercise your mind -- Challenge yourself with a jigsaw puzzle, solve riddles or read a good book. Even better, involve others with these activities by reading aloud to kids or helping them with homework at a local library, school or day care center.
5. Spend time with others -- Spending time with family and friends is important. Reach out to someone you haven’t talked to a while and create new memories. Call on a friend or relative to join you as you run errands or complete routine, everyday activities. Doing things together is a great way to raise your spirits and engage those around you in your life.
6. Indulge yourself -- Soothe aching bones and wash away worrisome thoughts with a long bath or hot shower. Enjoy a healthy dessert, sip a cool glass of iced tea or juice when it’s hot outside, or curl up under a blanket and relax when it’s cold.
7. Stay in -- Don’t feel obligated to do everything asked of you. It is okay to say no. To avoid feeling overwhelmed, opt to spend time with yourself once in a while. Watch a movie, paint a personal masterpiece or organize a prized collection of keepsakes.
8. Make the most of leisure time -- Make plans with family members, loved ones and/or a tour group to visit a place you’ve always wanted to go. Join a club, start a new hobby or learn a new skill such as gardening, bird watching or dancing. Whatever you choose to do, make sure it’s something that you truly want to do!
9. Get involved -- Volunteering is a great way to give back. Knowing that you have helped someone else can help you to feel better about yourself. Plus, sharing your time with others is a great way to get out and meet new people with common goals and interests.
10. Take things one at a time -- It’s easy to get caught up in the desire to do and experience new things, but having too much on your plate can be counterproductive. Try making a list. If possible, break large tasks into smaller, more manageable items that can easily be finished. Completing one thing at a time can lead to a greater sense of accomplishment and spur you to do even more!



### Support is Waiting for You

NAMI Greater Des Moines has a bulk subscription to Schizophrenia Digest and to Bipolar magazine. These magazines are available for sale at NAMI GDM affiliate educational meetings for \$1/copy. They are a great source of support for the person with mental illness as well as for family members and friends. They reinforce the concept that we are not alone – and to never give up hope.

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### Smoking marijuana ups risk of schizophrenia: study

Jul 26, 2007 By Michael Kahn

LONDON (Reuters) - Using marijuana increases the risk of one day developing a psychotic illness such as schizophrenia, according to a study that provides some of the strongest evidence yet linking the drug to a mental disorder.

Marijuana is one the most commonly used illegal substances in many countries with up to 20 percent of young people in places like Britain reporting either some use or heavy use, British researchers said, citing government statistics.

Many consider it on par with alcohol or tobacco but the results shows marijuana poses a danger many smokers underestimate, said Stanley Zammit, a psychiatrist at Cardiff University and the University of Bristol, who worked on the study.

The researchers found that marijuana users had a 41 percent increased chance of developing psychosis marked by symptoms of hallucinations or delusions later in life than those who never used the drug. The risk rose with heavier consumption.

"If you compare other substances like alcohol or tobacco it may not be as harmful, but what we are saying is neither is it completely safe," Zammit said in a telephone interview.

Other findings have highlighted the link between marijuana use and the risk of schizophrenia-like symptoms such as paranoia, hearing voices and seeing things that are not there.

But this study marks one of the most comprehensive, thorough and reliable reviews of its kind and should serve as a warning, two Danish researchers wrote in an accompanying comment in the Lancet medical journal, which published the study on Friday.

They said the results mean an estimated 800 cases of schizophrenia in the United Kingdom could be prevented each year by ending marijuana consumption. "We therefore agree with the authors' conclusion that there is now sufficient evidence to warn young people that cannabis use will increase their risk of psychosis later in life," they wrote.

### Silver Ribbon Shows Up at Oscar Ceremony



Ron Howard, who in 2002 won the Academy Award for Best Director of the film, "A Beautiful Mind," (also Best Picture), showed his support for the mentally ill by wearing a silver ribbon on his lapel at the Oscar ceremony. The silver ribbon pin comes from NARSAD Artworks and symbolizes the effort to combat stigma, tear down barriers to treatment and show support for all those who suffer from a brain disorder.

"A Beautiful Mind" is the compelling story of Nobel Prize-winning mathematician John Forbes Nash, who battled schizophrenia.

You can buy a silver ribbon pin, or earrings, or a charm at the monthly NAMI Greater Des Moines affiliate educational meetings.



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

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