NAMI Blue Ridge Family Alliance Newsletter May 2008

Upcoming Meetings Visitors Welcome

Informal Support Group Meetings

First Thursdays from 5:30-7:00pm

May 1 ● June 5
July 3 ● August 7 ● September 4

Speaker Meetings

Thursday, May 15, 5:30-7:00pm

Wellness Recovery Center

As part of Virginia's move toward community-based services for the mentally ill, Virginia has started creating crisis stabilization units. The Region Ten Wellness Recovery Center (WRC) is one of the first of these, providing an alternative between hospitalization and traditional outpatient services. Mark Farrington, Director of the WRC, will discuss the accomplishments and lessons learned during the first year of its operation. We will also tour the WRC.

Please note that no speaker meetings will be held in July and August, but support group meetings will be held as usual.

***** Location *****

BRFA/NAMI meetings are held at the new Region Ten location at 500 Old Lynchburg Rd. From I64 Exit 120, take 5th Street Extended south (away from Charlottesville) for about a mile to Old Lynchburg Rd on the right. (You passed the new county office building on your left.) Turn right on Old Lynchburg Rd and then right again at the first driveway. The new Board Room is in the administrative building at the rear of the property.

ANNOUNCEMENTS

The BRFA/NAMI June Picnic

The BRFA/NAMI June Picnic will be June 19th (the 3rd Thursday of the month) as usual - 5:30 - 7:00pm at the BlueRidge Clubhouse. It is a potluck picnic - please bring something for your family and enough for one or two others. Water, soft drinks and cookies will be provided.

Peer to Peer

The Blue Ridge Family Alliance/NAMI is sponsoring a new class this summer -- the Peer to Peer class. This is a unique, experiential learning program for people with any serious mental illness who are interested in establishing and maintaining their wellness and recovery.

Peer to Peer consists of 9 two-hour units and is taught by a team of three trained "mentors" who are personally experienced at living well with mental illness. Myra Anderson, Paul Frederick, and Andre Lewis, members of the Blue Ridge Clubhouse, were trained in Richmond this Spring and are in the process of advertising their first session now.

It will begin on June 7th and run through August 2nd. If you know of anyone who might be interested please contact BRFA/NAMI President, Sally Rinehart at srinehart0945@comcast.net or 434-296-2519.

While NAMI covered the cost of the training, the Blue Ridge Family Alliance will be responsible for providing the materials for this class and mentor support.

NAMI-Blue Ridge Family Alliance

[a 501(c)(3) organization]

Charlottesville, VA 22903

Voice Mail: (434) 970-1257

OFFICERS

Sally Rinehart
President

Mike Kelley
Vice President
Irene Hagerty
Secretary

Jenny Nowlen
Treasurer

BOARD MEMBERS

Virginia Germino
Clyde Gouldman
Margaret Grove
Irene Hagerty
Pat & Ted Keats
Mike Kelley
Jenny Nowlen
Sally Rinehart
Shelah Scott

HONORARY BOARD
Julie Curry

Treasurer: Jenny Nowlen
132 Westwood Circle
Charlottesville, VA 22903
E-mail: jn8v@virginia.edu

NEWSLETTER

Editor: April Ballard
Circulation: James and Shelah Scott

This newsletter is published bi-annually. Persons wishing to contribute an original article are asked to contact the editor.

Monticello Avenue site
http://avenue.org/brfa

Charlottesville Community Calendar
www.chvillecalendar.com

MESA – MUTUAL EDUCATION SUPPORT AND ADVOCACY

You are invited to a **free** course for family members of persons with mental illness

Workshops will be held on Tuesdays from 6-8pm from September 2, 2008 to November 18, 2008

The MESA (Mutual Education Support and Advocacy) Family Workshops are a series of classes for parents, siblings, spouses and adult children of individuals with mental illness. A major goal is to reduce stress in the lives of families through education on mental illness, coping strategies and community resources and through the support which develops among participants. The workshops have been on going in communities throughout the state since 1987. They are co-led by family members and mental health professionals, highlighting that both have special knowledge and skills to share.

The first six weeks focus on learning about mental illness and the last six weeks focus on skill building and include meetings with local people related to mental health services -- for example, magistrates, doctors or nurse practitioners, social security disability workers, and police officers.

You are welcome to join classes in session. We hope to offer MESA at least twice a year.

Location: Region Ten Administrative Offices
502 Old Lynchburg Road
Charlottesville, VA 22903
434-972-1800

The MESA Family Workshops are a project of the Virginia Chapter of the National Alliance for the Mentally Ill (www.NAMI.org)

To register, call Shannon Wright at 434-970-1451 or email shannonw@regionten.org

NAMI WALKS

Its time to start getting excited for this year's walk! It is not too early to register your team or to start recruiting sponsors!

Location: Innsbrook - Richmond, VA
Date: October 4, 2008
Distance: 5 K

Check-in: 9:30 am
Start Time: 10:30 am
Website: http://www.namivirginia.org

For more information about this event, please contact:

Farleigh Fitzgerald
ffitzgerald@nami.org
Phone: 804-658-9868

To volunteer as a BRFA/NAMI Volunteer Coordinator, please contact BRFA/NAMI President, Sally Rinehart at srinehart0945@comcast.net or 434-296-2519.

BRFA/NAMI

The Blue Ridge Family Alliance is a tax exempt **501(c)(3) organization.** All memorial and honor gifts are tax-exempt.

Many Not Sick Enough for Services

Funding Has Fallen for Those With Non-Severe Disorders

Excerpted from the Washington Post
By Chris L. Jenkins
February 17, 2008

Funding for services for mentally ill people such as Seung Hui Cho has decreased nearly 10 percent in Virginia since 2000, eroding key programs for thousands of people with non-severe mental disorders, documents and interviews show.

For a decade, Virginia officials have increased state resources for the complicated needs of the severely mentally ill and patients recently discharged from state-run mental hospitals.

But that has come at a price. Money for people with less serious disorders, who live in the community but need mental health treatment, has been reduced after adjusting for inflation. These people are not eligible for Medicaid, the government health care program for the poor and disabled, because they make too much money or have too many resources, and they often aren't covered by private insurance.

In a handful of jurisdictions, almost exclusively in Northern Virginia and Hampton Roads, officials have tried to make up for inadequate state resources with local money. But in most cases, agencies have eliminated or reduced dozens of services, including outpatient treatment, leaving many to deal with their illnesses any way they can.

It is unclear how many people are affected by decreased funding because the state has no way of tracking those who seek services but don't receive them. But as Virginia officials sort out the future of the mental health system after last year's deadly shootings at Virginia Tech, one of the persistent challenges is how to allocate money for the vast and varied issues that confront the state's 118,700 mentally ill residents who receive community services.

Cho's rampage at Virginia Tech in April has heightened long-standing concerns among lawmakers, state officials and advocates that the system has funding holes and other problems that must be addressed. Now, for the first time in a decade, state officials have begun to address the shortfall for this population by appropriating money specifically for these kinds of outpatient programs.

Gov. Timothy M. Kaine (D) has included $42 million in the state's budget, including funds to expand the number of caseworkers and psychiatrists who can address people's mental health issues in their beginning stages.

State lawmakers have included budget amendments to add even more money. Those amendments will be considered today as lawmakers craft the budget. But because of the erosion of programs this decade, the state is still a long way from filling all the gaps in services for this group.

"The bottom line is that in most places, there's very often nothing available unless you're at rock bottom, coming out of a state hospital, or you show up and are basically a danger to someone else," said Byron Stith, a mental health outreach coordinator in Richmond who serves as a member of the state Supreme Court's Commission on Mental Health Law Reform.

Even as the General Assembly begins to modify the state code to address the gaps in the system exposed after Cho killed 32 people and himself, the major issue will be how to increase access to services. Until then, many argue, the system will continue to fail.

"Everything revolves around adequate funding . . . there's really no way around it," said Mira Signer, the Virginia director of the National Alliance for Mental Illness. "We have to find a way of helping prevent people from reaching a point of crisis, but we can't lose

sight of those people who are most seriously at risk so that they don't become worse."

The overall impact of the change in priority over the past several years has been a drastic shift in who gets services in Virginia.

In Richmond, for instance, the local behavioral health authority no longer provides services for mentally ill people who qualify for Medicaid and aren't considered to have serious problems. That is because city money has fallen over the past five years and all of the city's dollars are geared toward mentally ill people who need expensive monitoring.

The same goes for many other jurisdictions, particularly in rural communities. Rural agencies report that they often can't even meet the demands of mentally ill clients who have been discharged from state hospitals.

In all, mental health agencies statewide are running a waiting list of 5,700 people for these community services.

That has some advocates concerned that the state is not moving aggressively enough to make up for years of slippage. Signer has called on the legislature to add $25 million to Kaine's funding proposal.

Lawmakers said that given other funding priorities, they can make up for past shortages only incrementally.

"Would it be nice to have the revenue available to address the immediate needs as well as to strengthen other parts of the community system? Yes. But you can't turn an aircraft carrier on a dime," said Del. Phillip A. Hamilton (R-Newport News), who chairs one of the House committees reviewing much of the legislation on mental health issues.

But even before the Virginia Tech shootings, the problem of getting help to such people as Cho was a concern. The state's mental health inspector general said in a report to legislators months before the shootings: "Community-based support and clinical services provided in the community do not have adequate capacity. As a result emergency service programs deal with crisis situations that could have been prevented if the [mentally ill person] had received more intensive . . . services."

For people with mental illness, it can mean long, difficult stretches with no treatment. With diagnoses of bipolar disease, post-traumatic stress disorder and other ailments, Yukiko Moynihan, 28, an Arlington County store clerk, has cycled through five hospital psychiatric wards in the past 23 months, according to her hospital records. She has been referred to the Arlington Community Services Board twice, according to two hospital discharge documents. Each time, she was given an appointment and told that she would be able to see a therapist in three weeks.

"As soon as you're out of the hospital, waiting for your appointments, you have all this time between the time you saw your hospital doctor and a new therapist," she said.

"And all that time when you're out alone . . . there's just too much time," she said. "Things can get bad that quickly."

In 1998, the state spent $45 million for basic mental health community services and $3 million for services targeted at those with severe conditions. Now, the state spends $51 million for community services and $86 million for those with such severe conditions as schizophrenia, bipolar disorder and severe depression. That is a 9.3 percent decrease in community services funding over seven years after factoring in inflation, according to an analysis by The Washington Post based on figures provided by the state.

In Cho's case, the New River Valley Community Services Board was responsible for sending a staff member to a commitment hearing, like the one Cho had 16 months before the shooting. No staff member attended, largely because that service had been cut, said Harvey Barker, the executive director. Also, no one from the board followed

up on the order requiring Cho to seek outpatient treatment. Barker said the agency didn't have the staff at the time to keep up with someone such as Cho.

"We hardly get any funding from the localities to staff these kinds of services," Barker said. "And all of the state money is used for the more serious population."

State officials acknowledge that the funding structure helps those with severe disabilities and who are poor but not those who fall in between.

"The intensive services that many individuals with serious mental illnesses need are very expensive, and that affects our ability to care for those who don't fit into that category," said Raymond Ratke, deputy commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. "The issue is stretching the dollars to meet the needs of people with serious mental illnesses while at the same time trying to serve those with less serious illnesses."

2008 Annual Dues Notice *****
Please Respond By June 1st

To update our mailing list, we need your help! You can help by returning the application form included herein. We will be deleting from our mailing list the names of those who have not responded during the past year.

NAMI - BRFA Membership Application Form

I (We) wish to join ____ or renew ____membership in:

_____ NAMI dues $ 35 (NAMI, NAMI-VA and NAMI-BRFA newsletters)

_____ NAMI-BRFA dues $ 5 (BRFA newsletter only)

I wish to support NAMI-BRFA's work to improve the quality of life for people with serious mental illnesses. I have enclosed my tax-deductible donation of $___________.

Name___________
____

Address_________
____

Please make checks payable to **NAMI-BRFA** and mail:
c/o Jenny Nowlen, Treasurer
132 Westwood Circle
Charlottesville, VA 22903

Telephone (optional) __________________and/or e-mail _______________________________

NOTE: We welcome everyone to our meetings, but newsletter mailings go only to dues paying members.

AFTER VIRGINIA TECH

In Richmond, A Minimalist Response To Maximum Trauma

Editorial excerpted from the Washington Post, February 19, 2008

A wave of recent school shootings, including the bloody attack in Illinois last week, is again prompting calls around the country for reforms. But in Virginia, where the bloodiest rampage of all took place last spring at Virginia Tech, the initial demands for legislative and regulatory improvements have yielded disappointing results. Other states that have grappled with senseless killings can now look to Richmond as an example -- one not to emulate -- of minimal response to maximum trauma.

The General Assembly's first failure was to leave open an outrageous loophole in state law that enables anyone, including ex-cons, escaped felons and those suffering from severe mental illnesses, to purchase firearms from private dealers at gun shows without undergoing a background check of any kind.

Never mind that most such checks in Virginia take a few minutes at most. That was still too much for the gun lobby, which called in its many chits in Richmond to kill legislation that would have closed the loophole. Virginia lawmakers not only left open the door for a potentially dangerous person to buy a weapon, they also thumbed their noses at many of the Virginia Tech victims' families, who had urged that the loophole be closed.

Legislators then turned their attention to the state's laws governing involuntary commitment, which are among the most restrictive in the nation. Some lawmakers had paid lip service to relaxing the commitment standard so that sick individuals who do not necessarily pose an "imminent danger" to themselves or others could be detained for treatment. Other states have adopted more flexible standards under which people can be detained who are likely to become dangerous if not treated, or whose condition is rapidly deteriorating, or who are incapable of making rational decisions about their treatment. The effect of those reforms is to provide treatment to people before they are in extreme crisis -- in other words, before it may be too late.

Rather than adopting one of those reforms, however, Virginia lawmakers seem likely to make what amounts to little more than a cosmetic change in the standard for involuntary commitment. In keeping with a modest recommendation by the state Chief Justice's Commission on Mental Health Reform, legislation now heading toward enactment would still bar detention unless there were a "substantial likelihood" that an individual would hurt himself or others in the near future. Other reforms, legislative and regulatory, go a little further toward tightening up the mental health system to ensure that sick people get the help they need as patients, and that background checks for weapons purchases -- when they are done -- screen out mental health patients. But the standard for involuntary commitment is the heart of the matter. And Virginia has flunked the test.

Mentally ill unfairly portrayed as violent

By Dr. Ronald Pies | February 25, 2008 |
Excerpt from the Boston Globe

The man had his hands around my neck so quickly I didn't have time to react. I was a second-year resident in psychiatry. He was an impulsive loner with a history of alcoholism who, unbeknownst to the staff, had returned to the inpatient unit intoxicated.

Fortunately, before the man could do serious harm, three patients had pulled him off me. In 25 years of psychiatric practice, this was the first and last time any patient laid a hand on me in violence.

And yet, in recent weeks, the news has been full of horrendous stories involving killers with known or suspected mental illness. As I write this, the nation is still reeling from the shootings at Northern Illinois University. Press reports now indicate that the shooter had a long history of mental illness and had recently stopped taking antidepressant medication.

To make matters worse, three psychotherapists have been assaulted or murdered in the past month. The most brutal attack involved a Manhattan psychologist murdered by a man who also gravely injured a psychiatrist. The New York Times reported that the accused man blamed the psychiatrist for having him institutionalized 17 years ago; apparently, the psychologist was not the intended victim. And only a few weeks ago, a social worker in Andover was killed, allegedly by her 19- year-old patient, during a visit to the man's home.

What do these attacks say about mental illness? Surely they create the impression that individuals with mental illness are a dangerous and violent lot. And as professor John Monahan and colleagues at the University of Virginia School of Law wrote recently, "the more a member of the general public believes that mental disorder and violence are associated, the less he or she wants to have an individual with a mental disorder as a neighbor, friend, colleague, or family member."

Yet the impression that we are awash in a sea of psychotic violence is clearly unfounded. Writing in the Nov. 16, 2006, New England Journal of Medicine, Dr. Richard A. Friedman of the Weill Cornell Medical College notes that only about 3 to 5 percent of violence in the general population is attributable to those with "serious mental illness," conventionally defined as schizophrenia, major depression, or bipolar disorder. The combined lifetime prevalence of these conditions in the US general population is estimated at 19 percent - far larger than their contribution to violence.

Furthermore, it is wrong to tar all emotionally disturbed individuals with the same stereotype-tainted brush.

True: A 1980s study from the National Institute of Mental Health found, using community surveys, that individuals with schizophrenia, major depression, or bipolar disorder were two to three times as likely as those without these illnesses to commit acts of violence. However, to put this in perspective, substance abusers had more than twice the rate of violence as those with these serious mental illnesses.

Moreover, the study found that the vast majority of individuals with serious mental illness were not violent: The lifetime prevalence of violence among people with schizophrenia, major depression, or bipolar disorder was 16 percent, versus 7 percent among people without a mental illness. Those with anxiety disorders had no increased risk of violence.

Even more reassuring is the 1998 MacArthur Violence Risk Assessment Study, led by John Monahan and Henry Steadman, now of Policy Research Associates, which advocates for better mental health services. Unlike the NIMH study, which surveyed people randomly in the community, the MacArthur study evaluated psychiatric patients recently discharged from the hospital. And unlike the NIMH study, which relied solely on self-reports of violence, the MacArthur study used a combination of self-reports, collateral informants, and police and hospital records.

The MacArthur study found that the prevalence of violence among discharged psychiatric patients without a substance abuse disorder was similar to that among community-dwellers who didn't abuse substances. Furthermore, violence by these discharged patients rarely involved vicious attacks on strangers or clinicians. Usually, it resembled violence committed by other community-dwellers, such as hitting a family member inside the home. Lethal violence among the discharged patients was very rare.

In the February 2008 issue of Psychiatric Services, Monahan and Steadman conclude: ". . . for people [with mental illness] who do not abuse alcohol and drugs, there is no reason to anticipate that they present greater risk than their neighbors."

That said, mental disorders do increase susceptibility to substance abuse, and thus indirectly increase risk of violence. Moreover, as Eric Elbogen of University of North Carolina Chapel Hill School of Medicine wrote me in an e-mail, ". . . a subgroup of people with mental illness likely uses alcohol and drugs to 'self-medicate' psychiatric symptoms." In my experience, this behavior may reflect the inadequate, fragmented care often provided to those with mental illness who also abuse drugs or alcohol so-called "dual diagnosis" patients.

The image of the violent mentally ill person must also be tempered by research from Linda A. Teplin, of Northwestern University. Teplin finds that those with mental illness are much more likely to be victims than perpetrators of a violent crime. Among psychiatric outpatients, about 8 percent reported committing a violent act, whereas about 27 percent reported being the victim of a violent crime.

What can be done for the relatively few mentally ill individuals who do become violent? The good news is that adherence to treatment is associated with reduced risk of violence. Research from Elbogen and colleagues finds that as self-reported adherence to outpatient psychiatric treatment increases, violence decreases. Though treatment varied significantly from site to site, Dr. Elbogen tells me that "typically [patients] had a combination of case management, pharmacotherapy, [and] psychotherapy or group therapy."

An understanding and supportive family may also reduce the risk of violence in their emotionally disturbed loved ones. Finally, all of us can support increased funding for comprehensive, compassionate treatment of those with mental illness, substance abuse, or both.

Recent events have shown us that anyone may become the victim of a violent person with severe mental illness. And yet, we must put the violence-mental illness link into perspective. The patient who assaulted me more than 25 years ago was 1 in 1,000. Nearly all those I have treated since have been

nonviolent. Most have coped heroically with unspeakable sorrow and pain. In truth, I would trust many of them with my life.