



Newsletter

Volume 26, Issue 1

May 2007

Special points of interest:

- Advocacy
- Family to Family
- AT&T Classic
- Board of Directors
- Teen/Young Adult Support Group

Inside this issue:

NEW BOD..... 1
 Women and Depression..... 1

AT&T..... 3

CIT..... 4

Oh What a Year..... 5

Family to Family Class..... 6

Advocacy..... 7

Outreach..... 8

Win/Win Advocacy..... 9
 Fashion Center Place..... 9
 Balance..... 9

Presidents Corner..... 10

May Speaker..... 11

The Forgotten Ones..... 12
 Deinstitutionalization..... 12

Membership Form..... 14

Calendar..... 15

Introducing NEW NAMI Gwinnett Board of Directors

At the April 3 Annual Meeting the membership voted in our new board for 2007-2008. They are as follows:

- Eric Spencer remains our President.
- Jeff Lee, previously the 2nd VP, is our NEW 1st Vice-President/Program Chair.
- Miriam Ferguson is our NEW 2nd Vice-President/Membership Chair.
- Carol McEntee remains our Treasurer.
- Joy Jeannott is our NEW

Recording Secretary.

- Jennifer Garrison remains our Corresponding Secretary.
- Deanne Beaton is a NEW Director.
- Bruce Bufano is a NEW Director.
- Alan McDaniel is a NEW Director.
- Debbie Taylor, previously the Recording Secretary, is now a Director.

- Diane Turman remains as a Director.

The 2007-2008 Board of Directors will do our best to serve YOU the membership and uphold our core values which are to support, educate, and advocate.

We would like to thank the 2005-2006 board for a job well done. To Debbie Elrod, Claudia Haxton, Daphne Nash, and Lori Wade, we want to extend our thanks and our appreciation for their contributions while they served on the board.

Article by Debbie Taylor



About Mental Illness



Women and Depression

Article from NAMI National's Website

In any given year, 10 to 14 million people experience a clinical depression; women 18 to 45 years of age account for the largest proportion of this group. Clinical depression is a serious medical illness that is much more than

temporarily feeling sad or blue. It involves disturbances in mood, concentration, sleep, activity level, interests, appetite, and social behavior. Clinical depression can develop in anyone, regardless of race, culture, social class, age, or gender. However, across virtually all cultures and socioeconomic classes, women are more likely than men are to experience depression.

Although depression is highly treatable, it is frequently a life-long condition in which periods of wellness alternate with recurrences of illness. Sixty percent of depressed individuals will experience at least a second episode of depression. Of these individuals, 75% to 80% will experience recurrent depression. With each subsequent episode, recurrence risk increases

(Continued on page 2)

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and probability of full remission decreases.

Clinical depression affects two to three times as many women as men, both in the U.S. and in many societies around the world. It is estimated that one out of every eight women will suffer from clinical depression in her lifetime. Women also experience higher rates of seasonal affective disorder and dysthymia (chronic depression) than men. While the rate of bipolar disorder (manic depression) is similar in men and women, women have higher rates of the depressed phase of manic depression and women are three times more likely to experience rapid-cycling bipolar disorder.

What causes the higher rate of depression in women?

The explanation for the gender gap in susceptibility to depression most probably lies in a combination of biological, genetic, psychological, and social factors.

Biological factors

There appear to be important links between mood changes and reproductive health events. Gender differences in rates of depression emerge when females enter puberty and remain high throughout the childbearing years and into late middle age. Hormonal factors seem to play a role in some of the mood disturbance experienced by women. Twenty to 40 percent of menstruating women experience premenstrual mood and behavioral changes. Approximately 2 to 10 percent of women experience Premenstrual Dysphoric Disorder, a severe form of premenstrual syndrome that is characterized by severely impairing behavior and mood changes. As many as 10 percent to 15 percent of women experience a clinical depression during pregnancy or after the birth of a baby. There also appears to be an increase in depression during the perimenopausal period, but after menopause, this does not appear to be the case. Differences in thyroid function between men and women may also contribute to the gender difference in the prevalence of mood disorders.

Another biological factor that may contribute to gender differences in depression can be linked to circadian rhythm patterns, the complex system that regulates sleep and activity over each 24-hour period. Depressed women report more hypersomnia (excessive sleeping) than do men. Gender differences in the activity of neurotransmitters including serotonin and the effects of estrogen on these neurotransmitters may also be linked to the gender disparity in rates of depression.

Genetic factors

Some forms of depression run in families. There is a 25 percent rate of depression in the first-degree relatives (mother, father, siblings) of people with depression and greater prevalence of the illness in first-degree and second-degree female relatives. But depression also occurs in people who have no family history of the disease. The genetic contribution to risk for depression is not something specific to women.

Men and women from families with depression are both at greater risk than those who come from families with no depression.

Psychosocial factors

Psychosocial factors that may contribute to women's increased vulnerability to depression include the stress of multiple work and family responsibilities, sexual and physical abuse, sexual discrimination, lack of social supports, traumatic life experiences, and poverty.

Several studies of depression among college students and within the Amish community of eastern Pennsylvania have shown no gender difference in the rates of depression, suggesting that greater social equality may lead to more equal rates of depression in men and women.

Psychological make-up plays an important role in one's vulnerability to depression as well. Thus, individuals with low self-esteem, pessimistic views, and tendencies towards stress are prone to clinical depression.

Studies also indicate that sexual and physical abuses are major risk factors for depression. Women are twice as likely as men to have experienced sexual abuse. A recent study found that three out of five of the women diagnosed with depressive illnesses had been victims of abuse. In one major study, 100 percent of women who had experienced severe childhood sexual abuse developed depression later in life.

Does pregnancy influence depression?

Although it once was thought that women experienced low rates of mental illness during pregnancy, recent research reveals that over 10% of pregnant women and approximately 15% of postpartum women experience depression. As many as 80 percent of women experience the "postpartum blues," a brief period of mood symptoms that is considered normal following childbirth. However, the related hormonal and biological changes associated with pregnancy or giving birth may initiate a clinical depression. Or, the changes in lifestyle associated with caring for a young infant may constitute a set of stressors that have mental health consequences for the mother. There is a three-fold increase in risk for depression during or following a pregnancy among women with a history of mood disorders. Once a woman has experienced a postpartum depression, her risk of having another reaches 70 percent.

One woman in a thousand experiences a postpartum psychosis—a medical emergency in which the woman may inflict harm upon herself and/or her baby. The first episode of bipolar disorder in women frequently occurs following the birth of a child.

Are there gender differences in the course of a depression?

According to one large national study completed about a decade ago, there are no differences between men and women in the course of *major* depression. Although men and women generally exhibit similar symptoms of depression, women report more atypical symptoms including anxiety, somatization (the physical expression of mental processes such as aches and pains with no physiological cause), increases in weight and appetite, oversleeping, and expressed

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anger and hostility.

How about gender differences in the response to treatment of depression?

Psychotherapy

Psychotherapy is an effective treatment for depression. Studies have shown that interpersonal therapy and cognitive/behavioral therapy can be very effective for the treatment of mild to moderate depression. Women and men appear to respond equally well to these forms of depression-specific psychotherapy. Psychotherapy may be particularly useful for women patients when they are trying to conceive, during pregnancy or while nursing because it allows the woman to avoid possible effects of the medication on the developing fetus or nursing infant.

Antidepressant medications

there is no clear evidence of gender differences in the effectiveness of antidepressant medications; although, women experience more adverse side effects than do men. Selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Paxil, Luvox and Lexapro have fewer side effects and have been found to be particularly useful and effective in women patients. Some doctors suggest increasing doses of antidepressant drugs premenstrually, as the menstrual cycle may alter drug-absorption rates.

Bright light therapy

Bright light therapy has been used successfully for seasonal affective disorder, but there is as yet no evidence that it is useful for other forms of depression.

Alternative treatments

Other treatments such as acupuncture and nutritional supplements (omega-3-fatty acids) may be helpful in specific circumstances. Women should always talk to their primary care provider or mental health specialist before beginning any treatment for their depressive symptoms. Together, they can choose most appropriate treatment for the specific kind of depression the woman is experiencing.

Is it safe to take antidepressants during pregnancy?

Because of the potential risk to the developing fetus or newborn, the costs and benefits of the use of antidepressants must be weighed carefully for women who are pregnant, breast-feeding, or trying to conceive. Most large-scale studies have not shown any significant increase in birth defects in children of women using either tricyclic antidepressants (Anafranil, Elavil, Pamelor) or SSRIs (Prozac, Zoloft, Paxil, Luvox, Lexapro) during pregnancy. Like all treatments for depression, this is something that each woman should discuss with her physician, weighing the possible risks and benefits of various approaches to treating her depression.

MAOIs (Nardil, Parnate) may adversely affect the developing fetus and lead to complications during delivery. Lithium (commonly prescribed for bipolar disorder) has been linked to an increased incidence of birth defects; however, many healthy babies have been born to mothers using this medication.

Doctors should choose the lowest effective dose of medication and select drugs with the least sedative and anticholinergic (rapid heartbeat, high blood pressure, slow digestion, dry mouth, constipation, and urinary retention) potency because of possible adverse effects on the newborn. In patients with severe depression, doctors must weigh the risks and benefits in both the mother and the infant of medication as compared to not administering drug therapy.

Reviewed by Ellen Frank, Ph.D., Danielle Novick and Azadeh Masalehdan November 2003

AT& T Golf Classic (formerly known as BellSouth Golf Classic)

The AT&T Golf Classic is one of NAMI Gwinnett's annual fundraisers. The concession tents are open from May 15 through May 20.

This will be our eighth year working at the concession tents.

Diane Turman is the chairperson for the Classic again this year. She did such a wonderful job last year, which was a record breaking year for funds raised.

Listen for Diane's call; she will be calling for your help. Or you may call her at 404-861-0093 or email at turmanator22@comcast.net to volunteer.

Each time slot is four hours long. Look at your calendars and ask your family and friends to help us at our concession tent. There are several jobs available (grill/cooks, cashiers, supply/runners, and customer service). Not only is this a great way to make money for activities such as the Consumers' Christmas and our Educational programs, but it is a wonderful opportunity to meet and get to know other NAMI Gwinnett members.

Article written by : Debbie Taylor

I sincerely appreciate your patience for this newsletter. We decided to delay the publication of the newsletter so we could introduce the NEW Board of Directors and to gather more information.

Again Thanks, Debbie Taylor

CIT

NAMI Gwinnett will be hosting another Crisis Intervention Training (CIT) on April 30 through May 4 at the Gwinnett County Detention Center (jail).

NAMI Gwinnett needs people to act as host for this session. Contact Daryl Myers at 770-963-2809 for information.



The Nation's Voice on Mental Illness

We're on the web

www.nami.org/sites/namigwinnett

Single Point of Entry


Georgia Crisis & Access Line

1-800-715-4225

Access mental health, addictive disease, and crisis services 24/7

Online at mygal.com



Sponsored by the
Georgia Department
of Human Resources 

Officers

Eric Spencer, President

Jeff Lee 1st Vice President/Program Chair

Miriam Ferguson, 2nd Vice President/Membership Chair

Carol McEntee, Treasurer

Joy Jeannott, Recording Secretary

Jennifer Garrison, Corresponding Secretary

Directors

Deanne Beaton

Bruce Bufano

Alan McDaniel

Debbie Taylor

Diane Turman

Moving

To ensure that you continue to receive the National, State, and NAMI Gwinnett mailings, please notify us whenever you have a change of address.

Oh, What a Year!

2006 was a year of change and a year of accomplishments. Volunteers were the primary reason that NAMI Gwinnett was able to expand its programs. Having successful fund raisers enable us to finance these programs. The changes which NAMI Gwinnett experienced, were a positive step for our members and for the people who live with a brain disorder. The Board of Directors wishes to thank all of the members, supporters, and volunteers who helped make 2006 a special year. The accomplishments that we achieved in 2006 uphold our mission to support, educate, and advocate for those in the mental health community.

- Held three state-wide facilitator training classes. These training classes were for NAMI CARE and NAMI family support group facilitators. Great job Deanne Beaton and Lori Spencer!
- Hosted Four Crisis Intervention Training (CIT) classes for law enforcement officers in Gwinnett County as well as neighboring counties. Approximately 120 officers and 911 dispatchers have attended CIT. A special thank you goes out to Daryl Myers and Eric Spencer for coordinating these training sessions. We also want to thank Jennifer Garrison, Rena Philips, Wayne Taylor and Diane Turman for speaking to the officers and dispatchers from the consumer and family member perspective.
- Taught three Family to Family classes. One class was held in the fall of 2006. Due to the number of people enrolled in the 2007 winter Family to Family class, there were two classes which started in February 2007. To Lois Damron, Carol McEntee, Debbie Taylor, Diane Turman, and Brenda Vinson, NAMI Gwinnett appreciates your time and effort needed to teach this 12 week class.
- Started conducting weekly NAMI C.A.R.E. and NAMI family support meetings. Thanks to all of the facilitators' making these weekly support meetings possible. The trained and NAMI certified facilitators are: Joy Jeannott, Jeff Lee, Louise McKinnon, Rena Phillips, Eric Spencer, Erica Spencer, Lori Spencer, Debbie Taylor, Diane Turman, Deanne Beaton, Wendy Casper (in training), Jennifer Garrison, Alan McDaniel, Sam Rapier, and Lori Wade.
- Hosted the Consumer Thanksgiving luncheon at the Day Treatment Center. A special "thank you" goes out to Lois Damron. We also want to thank all of the volunteers who worked on the committee, who helped serve the meal and who helped with entertainment. Everyone who attended the luncheon had a fantastic time! For those who might not remember, Lois also coordinated the 2005 luncheon.
- Provided Christmas goody bags and wish list gifts for the people attending the Day Treatment Centers. Thanks to all of the volunteers who helped assemble the goody bags. Thanks to Carol McEntee for coordinating this effort.
- Started the Personal Care Box at the Day Treatment Center. This box provides laundry detergent, facial tissue, toilet tissue, and other personal care items for those who cannot afford to purchase these items.
- Re-activated the Advocacy Committee. It has been several years since we have had a functioning advocacy committee. Alan McDaniel is focusing on the legislative issues. Jennifer Garrison is focusing on the outreach programs. Thanks to both of you for your efforts in this area.
- Transformed the Hospitality Committee. Because of their efforts, we now have dinner available for the first Tuesday of the month support meeting. Lori Spencer, thanks for chairing this committee. We want to thank Helen Barclay, Lois Damron, Claudia Haxton, Patsy Illick, Joy Jeannott, Alan McDaniel, Louise McKinnon, Charles and Nancy Mills, Rena Phillips, and Wayne Taylor for organizing these meals, making phone calls, and being there to greet the guests and members.
- Held the second annual Bicycle for Bipolars. The proceeds from this fund raiser helped purchase much needed items for the Day Treatment Center. The research portion of the proceeds has been donated to the NAMI Research Gala. Eric Spencer thanks for chairing this event once again. Thanks also go out to Wayne Taylor for organizing the refreshments and to Debbie Taylor for the "behind the scenes work".
- Participated in the 2006 Bell South Classic. The proceeds from this fund raiser went to consumer programs such as Thanksgiving luncheon, Christmas, and to purchase shoes for several people at the Day Treatment Center who desperately needed them. A big "thank you" to Diane Turman for chairing this event. We want express our "thanks" to all of the volunteers who worked at our concession tent. Great job!
- Participated in the 2006 NAMI WALK. The proceeds from this fund raiser were for our education programs such as the Community Help Book and the NAMI Gwinnett brochures. Debbie Taylor thanks for the great T-shirt design. To all of the walkers who joined this event, great job!
- Publishing our quarterly newsletter and maintaining the NAMI Gwinnett web-site. Debbie Taylor once again has provided our membership with a top notch newsletter. Because of Jennifer Garrison's writing gift and Debbie's commitment to identify more information pertaining to brain disorders, our web-site is more inviting and more informative. A big "thank you" goes out to Debbie and Jennifer for all of their continuous work within the publication area.

As you can see, it takes volunteers to make our support organization fulfill its objectives. So become a volunteer and let's make 2007 the best year ever.

Article Written by: Carol McEntee and added to by Debbie Taylor

NAMI FAMILY-TO-FAMILY EDUCATION PROGRAM

FREE for family members, partners and friends

Of individuals with

Major Depression

Bipolar Disorder (Manic Depression)

Schizophrenia and Schizoaffective Disorder

Panic Disorder and Obsessive Compulsive Disorder

Co-occurring Brain Disorders and Addictive Disorders

A series of 12 classes structured to help caregivers understand and support individuals living with a serious brain disorder while maintaining their own well being. The course is taught by a team of trained NAMI family member volunteers who know what it's like to have a loved one struggling with one of these brain disorders. There is no cost to participate in the NAMI Family-to-Family Education Program. Over 80,000 people in the U.S., Canada and Mexico have completed this course. We think you will be pleased by how much assistance the program offers. We invite you to call for more information.

Classes Start: June 7, 2007

Lawrenceville Presbyterian Church

800 Lawrenceville Hwy

Lawrenceville, GA 30045

7:00 - 9:30 p.m.

Co-Teachers: Carol McEntee, Debbie Taylor

(770-339-1149) (770-633-4012)

For caregivers only

This NAMI Family-to-Family Education Program is sponsored by NAMI

Registration required Classes limited to 18 persons

Registration Form for Family to Family Education Program

Mail to:

NAMI Gwinnett

Family to Family

P.O. Box 464053

Lawrenceville, GA 30042-4053

or

Email to your contact info to:

debtay16@bellsouth.net

Carol.mcintee@equifax.com

or

You may call us at the above numbers with your

Contact information.

Name

Address

Phone

Email

NAMI Gwinnett Advocacy Committee News

Good day to all of you! Hope you are all well. This is the first, but not the last, article of 2007 by the Advocacy Committee.

First, let me update you on the members of the committee.

Alan McDaniel – Chairman

Deanne Beaton

Diana Campbell

Jennifer Garrison

Ronnie Schmucker

We will formally introduce the members at the May general meeting. Please feel free to introduce yourselves to us at any time. Also, feel free to offer suggestions and ask questions at any time. I believe that, with the exception of Jennifer, we are all so new to this that we will be learning from the ground up as we go through the remainder of this year.

There is one other person who has voiced an interest in joining the committee but, since the recent death of her son, she has elected to have us just keep her “in the loop” for now. As I understand it, she has experience dealing with the

legislators down at the capital, so we certainly look forward to her joining us when she feels up to it. For the sake of her privacy, I can't give her name at this time.

To bring you up to date on the mental health legislation as of this writing, April 9, 2007, I can share the following information. As you may have heard me mention or received via e-mail, most of the legislation that we supported for this legislative session died in committees. Again, as of this writing, there is hope for only one of the four that I know of:

1. Advanced Directives--died in committee.
2. Ombudsman--died in committee (we have been asking for this since 1986 that I know of)
3. Mental health parity--died in committee.
4. That only leaves us with hope for the Mental Health Service Delivery Commission, SR 363. By the time you read this article, we should know the outcome of this resolution. We hope it will be to our liking.

Thanks, Alan

Outreach Advocacy

A Community Approach to Fighting Stigma

by Jennifer Garrison, Advocacy Committee Member

Throughout my journey of coping while in bipolar disorder's tight grasp, I found that I desperately needed someone in my community of faith to reach out and care for my spirit. Fortunately, I have found certain people representative of that care within the congregations I have been a part of. But for the vast majority of people coping with mental illness in our faith communities, this is not the case. I am the exception. I see a clear and present need for a program in our local churches aimed at increasing understanding of mental illness and those who live despite it within their congregations. It is called "Creating A Circle Of Caring: The Church and the Mentally Ill". This program is a six-part Sunday School-based curriculum, the purpose being to increase knowledge of what mental illness actually is, and present ideas on how members of the class and congregation can act to include and minister to those in the church who cope with mental illness and their families. To that end, with much work

and cooperation among members of churches who participate in this program, the stigma toward mental illness in our faith communities can begin to be eliminated. This is my vision for the future. I hope and pray for a day when no one will have to endure being labeled as "demon possessed", be told to "pray harder", or any of the other things associated with stigma in the church. The "Circle of Caring" books were purchased by the Board of Directors for the purpose of starting a class as described before in local congregations. If you feel that your congregation would be interested in a class such as this, or if you would like to volunteer your time and talents for this program, please feel free to call me at (770) 921-1961, or e-mail me at jengarrison1205@yahoo.com. Thank you in advance for your interest and consideration.

Win/Win Advocacy

There is an expression in the NAMI Family-to-Family course that goes “if you always do what you’ve always done, you’ll always get what you always got”. For years members of NAMI have come to the realization that accessing and receiving the necessary supports and treatments to reach recovery has been steadily declining or outright disappearing. We cannot continue thinking that there isn’t much we can do about it.

Come to our monthly meeting on June 5 and learn Win/Win Advocacy from “SueNAMI” (Sue Marlowe from NAMI Columbus).

She will teach us how to influence many different types of audiences to get what we want and need in the way of mental health services and funding. Advocacy is not as hard to do as you might think. When up to 80 percent of people with a mental illness could reach a recovery, but only 20 percent in Georgia are, people need to learn how to speak out in different ways so that they are heard and are effective. One out of four families are depending on us to do this.

Written by Sue Marlow

Fashion Center Place

The Fashion Center Place has a tentative target date of June 4th, and it's new location will be Beacon Place. Clothes will not be accepted until that date and only Summer type. Also all clothes should be clean and wearable. People

interested in making donations at that time may call me and I will know more as the date gets closer.

Claudia Haxton

770-338-0701

Balance

There's a party in my brain
The DJ wants to keep playing
But I'm tired of dancing
At least in the way he wants me to.
It's my party and I'll cry if I want to
Sometimes I just break down
Just sitting there under the disco ball.
Where is that fine, delicate balance
I'm trying so hard to find

Can I grasp and hold onto it
While my brain takes in the daily grind?
Surely this "even keel" thing
Is not as eluding as it seems
I must look inside myself
And hold onto my hopes and dreams.

Written by Jennifer Garrison

From the President's Corner

Greetings All,

First of all, I would like to thank you for electing me as your President. It is an honor to serve in an organization such as ours. I have served as President for almost two years now, but was not elected as such. As for this term, I accept the responsibility you have entrusted to me by selecting me for this position.

NAMI Gwinnett has changed from when I first came on board. I had two ideas in mind when I accepted the position of President in 2005: 1. The evolution of a NAMI member begins with Support, then through Education, they become an effective Advocate; 2. Members of our Organization can and will thrive if given the opportunity and resources to excel in their areas of interest. To this end, I have made every effort to allow people within our organization to contribute according to their interests and talents. That this policy has been successful is a matter of record attested to by our achievements:

Support: We now have weekly Support Groups for both the consumers and the family members. When you consider the SAFE groups, which are closely associated with our Affiliate, we can say we have 3 Support Group meetings per week. This is more than any other Affiliate in the Country. Yep, that's right.

Education: Considering the two Family to Family classes currently under way, we have given four classes in the last 12 month period. It is important to note that in January, when the number of people wishing to take the class exceeded the number of seats in a class, instead of turning people away, we were able to pull in additional teachers to have two concurrent classes. This was only possible because of willingness of our members to become trained Family to Family Teachers in sufficient numbers to accommodate this need. Brenda Vinson, as our Senior F2F Teacher, has four other teachers to call upon to help in such a situation.

We have hosted four CIT Training classes in the last twelve months. Over 90 Law Enforcement officers have been trained in classes hosted by

our Affiliate. Additionally, our own Wayne Taylor, who conducts the Consumer Perspective module of the 40 hour training course, is a highly sought after presenter, being requested by many Law Enforcement Agencies for their CIT Training Classes. This guy is known by the GBI, and for all the right reasons.

Advocacy: Alan McDaniel has taken the helm of the Advocacy Committee, and has done an exemplary job of communicating the actions of the state NAMI Organization to our members. As our State Advocacy Efforts become more timely and cohesive, so our efforts at the local level will become more effective. Alan brings an abundance of experience gained in the private sector in organizational skills to this position. Those wishing to make a difference in this area should contact him, so that you can get in on the ground floor of this effort.

Our website is used as a standard for other Affiliates in the State. We have been asked to give a seminar for the other affiliates concerning website design and maintenance. Debbie Taylor is our webmaster. Her work on the website speaks for itself. Also, this newsletter that you're reading is the result of her editorial talents. Her efforts make NAMI Gwinnett visible to the outside world. We received many contacts on a weekly basis as a result of these publications.

Funding: We have set new records in fund raising, due mainly to the efforts of people like Carol McEntee, Diane Turman, Lori Spencer, and Wayne Taylor. Their efforts in the NAMI Walk, AT&T Classic, Macy's Shop for a Cause, and Bicycles for Bipolars events have made our mission possible.

Should you and I sit back and watch these talented people do what they do? We could, and NAMI Gwinnett would do pretty well. These people are truly amazing. But think of what they could accomplish if you and I pitched in and helped them. And believe me; they are going to need the help.

Eric Spencer, NAMI Gwinnett President

May Speaker– Mary Ann Camann

Mary Ann Camann is an Associate Professor in the WellStar School of Nursing, College of Health and Human Services at Kennesaw State University. She has an extensive background in management of clinical services, health-care planning, training, program evaluation, and delivery of clinical services in addition to 16 years teaching on the university level. She has also served as a consultant to clinical agencies and healthcare systems regarding, program development, program evaluation, communication training, and curriculum development. She is also a certified instructor in online education.

The courses she has developed and taught include Leadership and Management in Healthcare, Health Policy, Mental Health Nursing, Comparative Health Policy, U.S. & U.K (taught in partnership with the University of Leeds, U.K.), and Communication for Health Care Providers.

She has managed programs for young adults, community mental health, and geriatric psychiatry, and managed and planned and delivered professional education for a corporate mental health facility. She has been president of the Metro Atlanta Advanced Practice Psychiatric Nursing Group and is

a founding member.

Her recent publications include – Global Mental Health Care – chapter in **Global Health Care- “Outcomes of Care: The use of conceptual models to see the forest and the trees in planning outcome studies”** Topics in Health Information Management, Nov, 2001 – special edition on Outcomes Management. “To Your Health: Implementation of a Wellness Program for Persons with Mental Illness and Treatment Staff” Archives of Psychiatric Nursing, August, 2001.

“Older Adults: The case for comprehensive assessment.” CARING Magazine, January 2001, Vol XX, No. 1 – with Lana Chase. Online Education: One strategy and experience in delivering RN to BSN Education. Georgia Nursing – Aug.- Sept. 37, 2000 – with C. Horne

Dr. Camann earned her doctorate from Georgia State University, and her Masters in Psychiatric Nursing from Emory University.

Outline of her presentation is below

Taking Care

Often people who experience mental illness and their caregivers – become so involved in managing their mental illness that they don't take time for themselves. When the focus of effort is on Recovery as well as treatment - then taking care of one's self takes on greater importance.

The presentation will focus on:

1. The impact of health on Recovery
2. Self-care
3. Recognition of signs of burnout

4. A plan for healthy living
5. Integration – development of a Wellness – Recovery – Action – Plan – based on the work of Mary Ellen Copeland -

Written by Mary Ann Camann

The Forgotten Ones

There are support groups for people with brain disorders, parents of those who have brain disorders, and spouses of those who have brain disorders. Now it is time to offer a support groups for the sibling and children of those who have brain disorders! As siblings and children, we have very little power or control over what is happening to our family members. This results in us having to sit back and watch our parents make the important decisions that in turn affect us, and watch our loved ones suffer through a disorder. Now we can come together and support one another through this difficult time. No one knows how it feels to be powerless as we do. Now we can support each other with the understanding that comes with a common experience of our powerlessness.

Are you a young adult or teen? Do you need support as a sibling or child of someone with a brain disorder? My name is Erica Spencer and I am a sibling of someone with a brain disorder. I know what it is like to feel alone and powerless. As a NAMI Family Support Group Facilitator, I am proudly announcing a new NAMI support meeting for young adults and teens that focuses on sharing our experience, strength, and hope with one another. This support group will focus on our powerless position in the family when a loved one has a brain disorder.

This support group will begin Tuesday,
May 8th at 7:30

@ Lawrenceville Presbyterian Church

And will continue every Tuesday
thereafter.

Erica Spencer

eface@uga.edu

Deinstitutionalization: The Results and Solutions

Mental Disorders are extremely prevalent: 20% of the population will suffer from a mental disorder at some time in their life (Kaplan & Porter, 2003). Yet with such a high prevalence within the community, a stigma follows anyone who is diagnosed with a mental illness or anyone who sees a therapist. Having a mental illness is seen as a weakness within our community. Those who do not understand the biological causes of such disorders label those who are mentally ill as lazy or irresponsible. To combat this stigma, insurance agencies and the government have been and continue to take mentally ill patients out of the hospitals and place them in the community for care (Kaplan & Porter, 2003). The intent of this policy is benevolent, but the unintended consequences expose their rash reasoning. Institutions cannot use such a simple answer to solve the complex situation that surrounds mental illnesses.

The deinstitutionalization movement intended to give mentally ill patients back their freedom and "destigmatize" them by placing them in the community (Lamb, 1984, p. 902). This helped some, mostly the high functioning patients who infrequently needed hospitalization for stabilization and whose situation usually included long term employment. Others, with chronic mental illnesses, left the hospital and entered a community which did not have sufficient funding to provide the long term needs of these people (Lamb, 1984, p. 902). Thus, their return to the community is characterized by sleeping in the park or under the local bridge. These untreated and

chronically mentally ill patients can have bizarre and disruptive behavior that alienates them from the community: the complete opposite of what the movement intended. Without the necessary funding for housing and treatment, or understanding of the mentally ill, the deinstitutionalization of chronically mentally ill patients leads to adverse affects such as homelessness or death.

For a hospital to release a patient, the hospital must determine that the patient is not a danger to themselves or others (Kaplan & Porter, 2003). Yet, when this determination is made, the patient resides in a positive reinforcing environment and the patient is on the proper medication. Placing a chronically mentally ill patient into the community when they have little structure or proper guidance from a professional creates a situation where the patient is doomed to relapse. Mental Hospitals offer medical care, patient monitoring, respite from family, social networking, food, shelter, and support from a structured environment. To lead a healthy life, a chronically ill patient needs all of which a hospital offers, especially a structured environment away from the family (Lamb, 1984, p. 899). Why then would anyone want to take such a patient out of the hospital when that is the one place they can lead a healthy life?

There is no one answer. First, keeping mentally ill patients in a hospital indefinitely is too costly. Second, most mentally ill

(Continued on page 13)

(Continued from page 12)

patients do not want to be sick and therefore do not want to be in a mental hospital where their reality is inescapable. Third, a certain measure of liberty is in jeopardy when a hospital holds a patient against their will. Forcing all mentally ill patients to remain and live in the hospital is unrealistic. Also, relying on under funded and unprepared community based services to care for chronically mentally ill patients is just as unrealistic. This creates an enigmatic situation with no one solution (Lamb, 1984, p. 899-902).

To find the solution we must look at the clinical survival needs that most patients require outside of the hospital. One of which is a stable environment that is offered in out-patient facilities. These facilities monitor medication, offer social support, and offer clinical therapy (Lamb, 1984, p. 899). If the community presented enough facilities to house patients that are released from care, deinstitutionalization begins to have the intended effect. Such care does exist, yet it lacks sufficient capacity to handle the actual need of the community. For example, such facilities have waiting lists to enter them. An example of such a facility offered in Athens, Ga. is Nuci's place. This organization prevents suicide of musicians by providing obstacle free treatment for depression and other disorders to help the well being of musicians (Volunteer Match, 2007).

The Deinstitutionalization movement has been in affect for five decades and the results can be seen on the streets and parks of every major city. The exact number of the mentally ill homeless is unknown and is impossible to find from the constant movement. The number is estimated to be in the 100,000's (Lamb, 1984, p. 901). How can the government and the community account for so many that need immediate help? Another problem aside from the vast numbers that need help is in compliance. Those who are homeless became so from the government and hospitals that have already failed to reach them. Why should they now trust the very institutions that placed them where they are? According to Richard Lamb M.D.:

The lack of trust and desire for autonomy cause them to not give us their real names, to refuse our services, and to move along because of their fear of closeness, of losing their autonomy, or of acquiring a mentally ill identity. Providing food and shelter with no strings attached, especially in a facility that has a close involvement with mental health professionals, a clear conception of the needs of the mentally ill, and the ready availability of other services, can be an opening wedge that ultimately will give us the opportunity to treat a few of this population. (p. 903)

Reaching this population will take time and an enormous effort from government funding and local funding to support local communities in creating such facilities.

Not only can deinstitutionalization create relapses, deinstitutionalization can cause the death of the mentally ill person, or the death of someone around them. According to Torrey and Zdanowicz (1998) 1,000 homicides a year are caused by a seriously mentally ill person who is not taking their medication (p. 1). When a chronically mentally ill person is not on their medication they are three times as likely to use

weapons or harm another person according to a study conducted in 1992 by Bruce Link of Columbia University (Torrey, & Zdanowicz, 1998). These statistics increase stigma among the population in regards to the mentally ill. Yet the need is dire, unless someone is personally tied to the problem at hand it is unlikely that they will feel empathy. Only if the population feels personally threatened will they voice their concern to public officials to create more government funding to support out-patient facilities across the United States.

Deinstitutionalization has a positive intention. However, it is but a link in a chain of events that will lead to better treatment and the de-stigmatization of mental illnesses. For deinstitutionalization to work there must be receiving facilities in all communities in equal numbers to take every patient released from hospitals. Once this occurs, the recurrence rate of destabilization of these individuals will decrease, freeing up even more bed space. Freeing up of costly hospital bed space will release even more funds for community based services. This is how it is supposed to work. What governmental agencies are failing to do is make the initial investment in community service while still paying for hospital space. This allows an organic transfer of patients when they are ready, as opposed to artificial transfers based on quotas.

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Article Written by: Erica Spencer, University of Georgia, April 10, 2007

*To love means loving the unlovable.
 To forgive means pardoning the unpardonable.
 Faith means believing the unbelievable.
 Hope means hoping when everything seems hopeless.*

Chesterton, Gilbert K.

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NAMI Gwinnett is a family based, grassroots, self-help and advocacy organization, dedicated to improving the lives of people with severe mental illness.

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Building a better future for people with mental illness.

NAMI GWINNETT

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 Lawrenceville, GA 30042-4053



The Nation's Voice on Mental Illness

May 2007

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	CIT	1 Speaker CIT	2 CIT	3 SAFE CIT	4 SAFE/ SAFE F & F / CIT	5
6	7	8 Support BOD	9	10 SAFE	11 SAFE/ SAFE F & F	12
13	14	15 Support AT & T	16 AT & T	17 SAFE AT & T	18 SAFE/SAFE F & F / AT& T	19 AT& T NAMI Georgia Conference
20 AT& T	21	22 Support	23	24 SAFE	25 SAFE/ SAFE F & F	26
27	28	29 Support	30	31 SAFE		

June 2007

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1 SAFE/ SAFE F & F	2
3	4	5 Speaker	6	7 SAFE/F2F	8 SAFE/ SAFE F & F	9
10	11	12 Support BOD	13	14 SAFE/F2F	15 SAFE/ SAFE F & F	16
17	18	19 Support	20	21 SAFE/F2F	22 SAFE/ SAFE F & F	23
24	25	26 Support	27	28 SAFE/F2F	29 SAFE/ SAFE F & F	30

July 2007

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3 Speaker	4	5 SAFE/F2F	6 SAFE/ SAFE F & F	7
8	9	10 Support BOD	11	12 SAFE/F2F	13 SAFE/ SAFE F & F	14
15	16	17 Support	18	19 SAFE/F2F	20 SAFE/ SAFE F & F	21
22	23	24 Support	25	26 SAFE/F2F	27 SAFE/ SAFE F & F	28
29	30	31 Support				

Schedule of Events

Speaker Meetings

May 1

7:30pm

Mary Ann Camann

"Taking Care"

June 5

7:30pm

Sue Marlow

"Win/Win Advocacy"

Deli Meal at 7pm before meeting

□

Support Meetings

NAMI C.A.R.E. and NAMI Family Support

Every Tuesday

***Deli Meal at 7pm before meeting

On the First Tuesday of the Month***

□

SAFE

"Survivors Achieving Functional Equilibrium"

Thursdays and Fridays

8:00pm

□

SAFE Family and Friends

"Step Based Support"

Fridays

8:00pm

□

Board of Director Meetings

May 8

June 12

July 10

7:00pm

□

CIT

April 30—May 4

Gwinnett County Detention Center

□

AT & T Classic

Sugarloaf Country Club

May 15-May 20

□

NAMI Georgia Conference

May 19

Mercer School of Medicine, Department of Psychiatry

Macon Georgia

□

Family to Family Class

June 7- Aug 30

7:00pm-9:30pm

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