Mid-Shore Mental Health Systems inc.

July 19, 2013 Issue 29, Volume 2

WEEKLY NEWSLETTER

Behavioral Health Resource on the Eastern Shore for Local Trainings, Events, Program Information, and More!

GREAT CHESAPEAKE Balloon Festival

August 2 & 3, 2013

Sponsored by Tri Gas & Oil to benefit Talbot Paramedic Foundation

Event will take place on Mistletoe Drive, Easton, Maryland featuring 11 Hot Air Balloons including a tethered balloon and a walk-about balloon for kids and adults.

Admission and parking for the event will be $5 per carload for Friday and Saturday each. Food and beverages will be available for sale during the events. The public is invited to bring lawn chairs and blankets.

Balloon Burner Bake Off is planned for August 1st Thursday 5PM at Scossa's Restaurant. details....

Schedule of Events- Festival location is Mistletoe Drive at Glebe Road Industrial Park at Route 322:

Friday evening
-- 5-9PM One balloon tether - one balloon walkabout.
-- 6:00PM Skydivers
-- 6:30PM Five balloons will fly out
-- 8:40PM-9PM Balloon Glow

Saturday morning:
-- 5:45AM Pilot briefing
-- 6:00AM Presentation of Colors by Sheriff's Office
-- 6:30AM Balloon Launch
-- 8:00AM Chic-Filet will present a "Cow Drop"
-- 9:00AM Festival ends

PASSENGER FLIGHTS will be booked in advance and at the festival. This year we are expecting many passengers wanting to fly. Book your flight now by calling 410-442-5566. The fee for a balloon flight of 30-45 minutes will be $200 per person. Cash payment of the full $200 will be made by the passengers directly to the pilot at flight time.

BALLOON GLOW So what is a balloon glow?
The hot air balloon festival event now known as a balloon glow was invented in Albuquerque in 1979, when local pilots inflated balloons on Christmas Eve night as a thank you to local residents. The sight of balloons lit from within at night like giant holiday ornaments is breathtaking, and glow events are now held all over the world.

TETHERED balloon rides. A hot air balloon, tethered to the ground, will offer rides ($20 adults $10 children under 12) up to 60 feet in the air.

WALK-ABOUT Balloon. A large balloon will be partically inflated on the ground. Children and adults will be able to venture into the center of this colorful balloon ($2 children and adults).

A limited number of sponsorships are available.
Persons or businesses interested in sponsoring the event may contact Talbot Paramedic Foundation President Wayne Dyott at 410-310-3921.

28578 Mary's Court, Suite 1
Easton, MD 21601

Phone: (410) 770 - 4801
Fax: (410) 770 - 4809

Visit Our Website:
www.msmhs.org

"Like" us on : www.facebook.com/midshorementalhealthsystemsinc

Inside this issue:

We are pleased to welcome a new Youth Engagement Specialist to the MSMHS team: Rowan Powell. She comes to us with a passion for helping others and a history of volunteer service, internships and employment in doing so. She will begin work at the end of the month and will be a great addition to the Youth M.O.V.E. Eastern Shore Chapter. Welcome Rowan!

For All Seasons

Licensed mental health clinician(s) for OMHC to work with children, adolescents, adults. FT/PT, flexible schedules, Talbot and Caroline Counties.

Email/FAX letter of interest, salary requirements and resume to Dick Goldstein, For All Seasons, (410) 820-5884, dgoldstein@forallseasonsinc.org.

Home Visiting Position

Queen Anne's County Dept. of Health has a full time contractual position for a Home Visitor for the Healthy Families Program to serve Kent County, Maryland. Position Requires: Bachelor's degree from an accredited college or university in nursing, social work, psychology, education, counseling or related field. Preferred candidates will have experience providing early childhood services to families and children. Strong writing skills required; fluency in Spanish a plus. Please fax resume to C. Simpson @ 443-262-9530, or mail to C. Simpson, QACDH, 206 N. Commerce Street, Centreville, MD 21617. Deadline is 07/24/2013 for resumes.

Come One! Come All!

Caroline County Office of Child Support Enforcement

Invites You to Join Us For our 3rd Annual

Family Fun Fest

Focusing on

Positive Parenting

In Cooperation With Caroline County DSS & Our Community Partners

August 2nd

2PM-6PM

School Supplies

Across from Social Services on Market Street, Denton
(The Old Dollar General Lot)

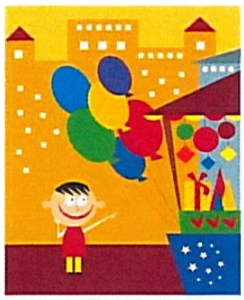
Refreshments

Giveaways

Mini Job Fair

Child Support Awareness Month

August 1st-31st
All month long Open House
Have all of your
questions answered...



Games for the Kids

SAVE THE DATE!

MCF/MD Coalition of Families for Children's Mental Heath
2013 REACH Retreat

When: November 22-24, 2013

Where: Holiday Inn Oceanfront, Ocean City (66th Street)

The mission of REACH is to: Remind yourself to be resourceful, Energize yourself and family, Activate your strengths, Challenge yourself to be empowered, Hear that you aren't alone.

Volunteers Needed!
If you would like to volunteer, contact the REACH Coordinator at jmcgarry@mdcoalition.org.

More details to come…

SAVE THE DATE!

The Eastern Shore Psychological Services Training Academy will be providing two, 3 hour CEU ethics trainings that satisfy licensure renewal requirements on the following dates and locations:

Easton site: Friday, September 20th 1:00PM to 4:15PM

Salisbury site: Friday, October 4th: 9:30AM to 12:45PM

Stay tuned for registration instructions and topic.

DSM-5 Webinars

DSM-5 Changes: Clinical Overview & Business Implications

From the National Council for Behavioral Health & Relias Learning

Date: Wednesday, July 31, 2:00 pm – 3:30 pm EDT
Register FREE at https://www2.gotomeeting.com/register/586647754

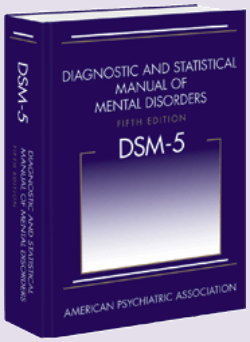
Presenters: Neal Adams, MD, MPH, Deputy Director and Margaret Faye, Senior Associate — California Institute for Mental; Steve Jenkins, PhD, Assistant Professor of Psychology, Wagner College

In May 2013, the American Psychiatric Association released the DSM-5, the latest iteration of the leading diagnostic manual for mental health disorders. Over ten years in the making, the DSM is the foremost resource for psychiatric diagnoses relied upon by individual practitioners, insurers, researchers, and policymakers. We invite executive and clinical leaders to join us for this webinar to review the overall changes, garner resources to help clinicians factor the changes into practice, and review the business implications — how will DSM-5 changes impact your insurance contracts; reimbursement; medical records system; transition plans for ICD-10; and more?

Prepare your organization for the switch through a practical discussion of the issues at hand, with opportunities to submit your questions to the experts before and during the webinar. Check out Relias Learning's online course on the DSM-5 changes. And stay tuned for advanced courses, coming soon.

DSM-5: Comparison and Implications for Addiction Professionals

Due to technical difficulty on July 2nd, NAADAC is offering this free educational opportunity two more times. The presentations are identical:



Fri, July 26, 2013 @ 12-1:30pm EST
(11 CST/10 MST/9 PST)
[Register]

Wed, July 31, 2013 @ 12-1:30pm EST
(11 CST/10 MST/9 PST)
[Register]

This free webinar will examine the similarities and differences under the proposed DSM-5 for alcohol, cannabis and cocaine diagnoses. We will utilize diagnostic information on a sample of more than 7,000 adults and 1,000 adolescents from structured interviews that capture elements of both diagnostic formulations. For no diagnosis or dependence, the new diagnoses will place most individuals into the "no diagnosis" and "severe" group, respectively. However, for those with a current diagnosis of abuse, substantial changes in diagnoses will be outlined. Results also indicate that all criteria are not equal in indicating a more severe condition. Clinical and policy implications will be discussed.

A component of the NAADAC Institute Webinar Series and produced in partnership with The Change Companies

[More Information]

Integration Innovations: A Discussion with Federal Agencies (Webinar Part I of II)

Wednesday, July 31, 1:00-2:30 pm EDT

Federal investment in healthcare reform efforts continue to demonstrate the importance of behavioral health and primary care, screening for mental illnesses and addictions, and access to behavioral health and primary care treatment in communities nationwide. Join the SAMHSA-HRSA Center for Integrated Health Solutions and the AHRQ Academy for Integrating Behavioral Health and Primary Care to learn about two innovative federal investments in programs and technical assistance resources that support the integration of primary care and behavioral health services.

The first in a two-part series, this webinar will ensure you know:

- Key activities of federally funded programs and projects and their role in healthcare redesign.
- How to access practical resources available through federal projects to support state and local integration efforts.

Register Today to learn how these federal initiatives can strengthen your local integration efforts. Participation is free, but space is limited. Closed captioning is available.

Part II of this webinar series will feature the work of other federal agencies within the U.S. Department of Health and Human Services.

It's Just Good Medicine: Trauma-Informed Primary Care

Tuesday, August 6, 2013 , 1:00 pm -2:30 pm EDT

In the United States, 61% of men and 51% of women report exposure to at least one traumatic event in their lifetime, with many reporting more than one. For individuals with mental illnesses or substance use disorders, traumatic life events are the rule rather than the exception. These adverse life experiences have been found to be a risk factor for a variety of serious health conditions and are likely to contribute to an individual's avoidance of and discomfort with medical procedures in primary and specialty care.
Register Today

As HRSA-funded safety-net providers expand their behavioral health capacity to serve clients, trauma-informed care will increasingly become an integral part of good medicine.

After participation, attendees will:

- Understand the prevalence of adverse life experiences and their effect on a person's physical and behavioral health.
- Recognize how a history of adverse life experiences affects an individual's engagement and use of primary care services and strategies to promote an individual's comfort and engagement with primary care.
- Understand how to integrate a trauma-informed care perspective day-to-day practice in a practical, feasible way that aligns with the practice of good medicine.
- Know how to access and use trauma-informed tools designed for primary care settings.

Registration is free but space is limited to the first 1000 attendees.
Closed Captioning Available Upon Request

TO: NAMI Maryland Supporters, Experts, & Affiliate Leaders
RE: NAMI Maryland 2013 Annual Conference Workshop Proposals
DATE: July 17, 2013

We have begun to put together the program for the 2013 Annual Conference, which will be held at the Sheppard Pratt Conference Center in Towson, MD on October 18-19, 2013. A special Awards Dinner will kick off the conference on Thursday, October 17th. The two-day conference that follows will be attended by a widely diverse group of attendees. Workshops will be practical, skill-building sessions tailored for specific audiences including mental health, substance use, and other service providers, criminal justice staff, local NAMI affiliate leaders, individuals with mental illness, family members, and interested community members. We plan to have multiple concurrent workshops in the following broad categories:

1. Practical Information and Resources for community and health providers, individuals with psychiatric disorders, their friends, relatives, and employers. Topics can include: accessing benefits, treatments for specific disorders, etc.)
2. Practical Information and Resources about and for "Special Populations" (Veterans, Minorities, Children, Young Adults, and other underserved populations)
3. Practical Information and Resources about and for providers and advocates working with 'co-occurring' issues; substance use, physical health, HIV/AIDS, developmental and behavioral disorders
4. Health Care Reform, Substance Use and Behavioral Health Integration, other Advocacy Issues: how it Affects YOU.
5. Advocacy Training
6. Accredited training for law enforcement and corrections staff
7. NAMI Affiliate and organizational resources NAMI Program Leader Skills Trainings and Refreshers

Please use the attached form to submit your proposal.

- All workshop proposal forms need to be returned by August 19, 2013.

(Proposals may be considered after this date on an ad hoc basis- based on topic and slot availability)

Feel free to make as many copies of the form as needed. As well as the proposal, please submit supplementary information, such as articles, speaker biographies, etc. Click here for the Workshop Proposal Form. Please submit your form to: namimdevents@namimd.org

Recommendations to consider:

- Keep in mind that the more complete and detailed your proposal is, the easier it is for us to make a determination. This includes correct spelling of names, degrees, titles, addresses and telephone numbers of the workshop panelists. Much of the information we are requesting will be used in the program.
- Please let us know in which category or categories above you feel your workshop fits. We recommend including an explanation as to why you think the particular topic, handout materials, and/or speakers will provide useful information that a conference attendee can share within their own networks, including professional or social networks as well as affiliate members.
- Please also disclose if information regarding: health and/or mental health disparities co-occurring substance use, behavioral and physical health, diversity or multicultural issues will be addressed in the workshop in any way.

The number of presenters for any one workshop must be limited to a maximum of 4. We encourage you to include individuals living with a mental illness and family members as presenters. The length of workshops will be one

hour. To provide a longer time frame, you may request 2 back to back workshops, but we cannot guarantee availability. You may apply for more than 1 workshop on different topics.

NAMI Maryland does not pay honoraria, cover expenses of presenters, or reimburse for materials used in workshops. If you wish to attend other workshops at the conference, presenters must pay the conference registration fee. Limited scholarships are available for presenters who can demonstrate need, in which case registration fees are waived and lunch provided only on the day they present.

We would also very much like to have your input on other possible workshop presentations: feel free to forward this form to other potential presenters.

www.namimaryland.org
10630 Little Patuxent Pkwy, Suite 475
Columbia, MD 21044
410.884.8691- Office
410.884.8695- Fax

Join us for this special webinar:

What Families and Individuals with Mental Illness Should Know about Evidence-Based Supported Employment
Wednesday, July 24th, 4:00-5:00 p.m.

After the spots are filled we will be posting the recording and presentation on the NAMI Maryland website. Register below.

Employment plays an important role in all of our lives, including the lives of individuals diagnosed with mental illness. This webinar will discuss the important role of employment in recovery, as well as introduce participants to the eight principles of Evidence-Based Practice (EBP) Supported Employment (SE).

Learn what research shows is the most effective approach to using employment in recovery from mental illness and substance use.

Learn what programs in your community already provide EBP SE and how you can work with to expand these services to your neighborhood.

Speakers:
Bette Stewart*, Training Specialist University of Maryland School of Medicine and Johnson & Johnson-Dartmouth Community Mental Health Program, Family Advocacy Team Leader and*
Don Reed*, Johnson & Johnson-Dartmouth Community Mental Health Program, Family Advocacy Co-Team Leader*

Register for the Webinar

This audio portion of the webinar is a long-distance number that you must dial in. The number will be provided to you upon registration. If long-distance is not an option for you, a recording will be made available on the NAMI Maryland website.

Webinar spots are limited to the first 90 people. After those spots are filled we will have a waiting list.

PRESS RELEASE

Mental Health First Aid Added to Federal Registry of Evidence-based Programs

Contact Meena Dayak at MeenaD@TheNationalCouncil.org or call 202.684.3728

Washington DC (July 18, 2013)—The federal government this week added Mental Health First Aid to the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP), a searchable database of mental health and substance abuse interventions to help the public find programs and practices that may best meet their needs and learn how to implement them in their communities. All interventions in the registry have been independently assessed and rated for quality of research and readiness for dissemination.

"The National Council and our partners — the states of Maryland and Missouri — brought Mental Health First Aid to the U.S. in 2008 because of the evidence supporting its effectiveness," said Linda Rosenberg, President and CEO of the National Council for Behavioral Health (National Council). Mental Health First Aid USA was adapted from the original program created in Australia in 2001. The program is now in more than 20 countries and every state in the U.S.

"Inclusion in NREPP affirms what we hear every day from people with mental illnesses and addictions and those who want to help them — the program succeeds in elevating knowledge about mental illnesses, increasing comfort in talking to people in distress and crisis; and understanding that help is available and treatment is effective," added Rosenberg, who reiterated that the National Council is committed to ongoing evaluation studies and continuous quality improvement for Mental Health First Aid.

Mental Health First Aid is an in-person training designed for anyone to learn about mental illnesses and addictions, including risk factors and warning signs. Similar to CPR, participants learn a 5-step action plan to help people who are developing a mental health problem or in crisis. It is a low-cost, high-impact program that emphasizes the concept of neighbors helping neighbors.

Studies have found that people trained in Mental Health First Aid reduce negative perceptions and attitudes about people with mental illness and addictions. Mental Health First Aiders have more confidence in helping others and a greater likelihood of advising people to seek professional help. "People often don't seek care for their addictions and mental illnesses because they don't know where to go or what to do. Mental Health First Aid gives them local resources and points them in the right direction," Rosenberg explained.

Mental Health First Aid USA has been delivered to more than 100,000 Americans through a network of 3,500 instructors. The training is intended for people from all walks of life, including social and human services agency staff; law enforcement and corrections officers; nursing home staff; outreach workers; volunteers; school staff, counselors, and nurses; clergy and members of faith communities; employers and human resources professionals; and families.

Thousands of communities nationwide offer public Mental Health First Aid trainings. One notable community — Harford County, Maryland — has a community-wide effort to train social services, military, first response, transit, and school staff in Mental Health First Aid.

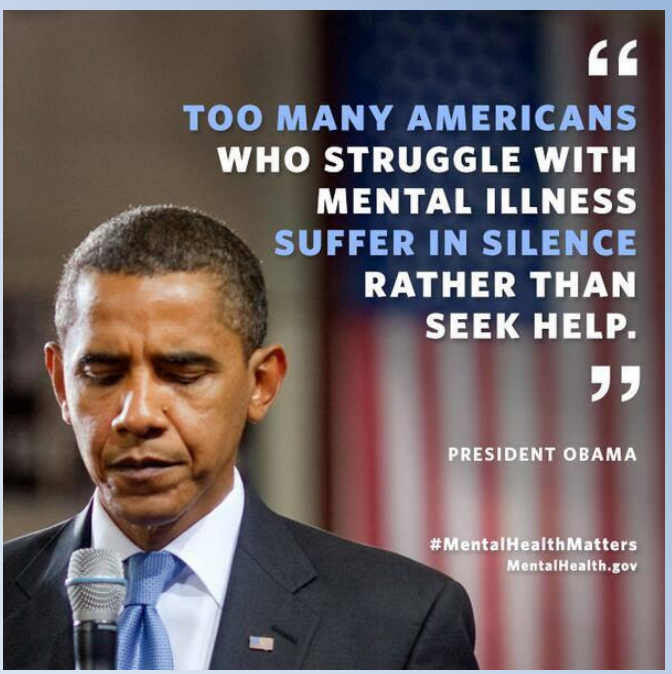
"Everyone on our team needs to be trained in Mental Health First Aid," says Sharon Lipford, Deputy Director, Harford County Department of Community Services. "It's a tool that should be available at every level of the community. No one should ever be embarrassed to ask for help. As a county, we are working to make sure that help is easy to find."

Read how Mental Health First Aid is changing lives and strengthening communities in the special National Council Magazine issue. To get involved in Mental Health First Aid, find a course in your community or learn how to become an instructor.

Campaign aims to bring mental illness out of shadows

By Ron Manderscheid, Ph.D., EXECUTIVE DIRECTOR, National Association of County Behavioral Health and Developmental Disability Directors

President Barack Obama and Vice President Joe Biden hosted a National Conference on Mental Health at the White House June 3. This event was part of the Administration's effort to launch a national conversation to increase understanding and awareness of mental health. Obama delivered opening remarks and Biden gave closing remarks.



The conference brought together people from across the country. Included were representatives from federal, state, county and municipal governments, mental health advocates, educators, health care providers, faith leaders, and individuals and family members who have struggled with mental health problems. They all gathered to discuss how we can all work together to reduce stigma and help the millions of Americans struggling with mental health problems to recognize the importance of reaching out for assistance.

In his opening remarks, Obama underlined his hopes for a national dialogue. "We must bring mental health out of the shadows. We know that treatment works and that recovery is fully possible. There should be no difference between seeking care for a broken arm and seeking care for depression," he said.

Discussion panels were led by Health and Human Services (HHS) Secretary Kathleen Sebelius and Education Secretary Arne Duncan. Both highlighted the importance of support from friends, family and community in the willingness to seek care. The latter panel also explored the critical role of social media in reaching young people who communicate routinely using these tools.

In his closing comments, Biden highlighted the role that the Affordable Care Act will play in extending mental health and substance abuse health insurance to millions of Americans who currently lack it. He also reflected on his own personal health issues and family tragedies, as well as those of his former colleagues in the U.S. Senate. These experiences have given him a much greater appreciation of getting early treatment for mental and substance use conditions.

Biden indicated that stigma can be reduced in two important ways: by adding mental and substance use screenings to traditional annual physicals, and by integrating behavioral health and primary care. Finally, he thanked all conference participants for their lifetime of commitment to improving behavioral health care.

Tools for Future Use

Also on June 3, HHS launched a new website, www.mentalhealth.gov, to continue the conversation begun at the conference. The purpose of the website is to provide mental health information and resources for individuals struggling with mental health problems or their friends and family members, educators and other community members. Specifically, the site features information regarding the basic signs of mental health problems, how to talk about mental health and ways to find help.

Another important purpose of the site is to keep the conversation about mental health going by aggregating and sharing information about what organizations and people across the country are doing to raise awareness about mental health in their communities.

To that end, HHS will use http://storify.com to aggregate and share information about mental health. Through Storify, HHS will be able to capture YouTube videos, photos and other multimedia made publicly available by other organizations, and share this content with others on the MentalHealth.gov Storify channel: http://storify.com/mentalhealthgov.

Storify will automatically capture many posts that use the hashtag #MentalHealthMatters. Please contact HHS if you regularly use other Twitter hashtags in mental health posts or if you will be using a specific hashtag to amplify an event you are organizing to raise awareness about mental health, and they may be integrated into future social media plans.

Viewpoint: My Case Shows What's Right — and Wrong — With Psychiatric Diagnoses

By Maia Szalavitz @maiasz
May 17, 2013

Over the course of my life, I have been given no fewer than five different diagnoses for mental illnesses, under the diagnostic system laid out in psychiatry's "bible," the DSM. But it was a sixth diagnosis— one that ironically will no longer appear in the edition being rolled out this week, DSM-5— that probably most accurately describes what is genuinely different about me. I'm sharing this because my experience is a case study for explaining why the latest revision to the manual is raising such ire.

My journey from diagnosis to diagnosis illustrates both the pitfalls and the promise of psychiatry and why we can expect to improve some ways in which we identify mental illness, and why there are other aspects of diagnosing these conditions that will remain unsatisfactory without further scientific advances.

Dr. Allen Frances, who chaired the publishing process for the previous revision, the DSM-IV, and is critical of the DSM-5 in his new book, *Saving Normal*, published an editorial in the *Annals of Internal Medicine* highlighting some of his issues with the latest revision. Citing the "crisis in confidence" in psychiatry over diagnosis, he calls on physicians to "use the DSM cautiously, if at all." DSM 5, he argues, is overrun with "diagnostic inflation"— for example, labeling grief as depression and placing the 40% of college students who binge drink at risk of diagnosis equivalent to alcoholism.

Frances isn't the only one who has concerns about DSM-5. Last week, the the director of the National Institute of Mental Health, Dr. Thomas Insel, posted a blog in which he announced that even for research purposes, the DSM had outlived its usefulness. "NIMH will be re-orienting its research away from DSM categories," he wrote. The problem, he said, is that the DSM is based on subjective descriptions of collections of symptoms that tend to occur together — but not on the physiological or psychological mechanisms that cause them.

As Insel put it, "Unlike our definitions of heart disease, lymphoma or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measures. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain." In other words, such a system could mistake heartburn for a heart attack and classify both as the same type of problem. Unfortunately, as he also admits, there isn't a better system: NIMH is seeking to develop one based on brain research, but this does nothing for patients who need help now.

I can attest to that. My multiple diagnoses are the rule, not the exception, and one criticism of the DSM structure is that if you qualify for one diagnosis, you typically also qualify for others. Which one should be treated? Or do they all require interventions? And what if the therapies conflict with each other? You see the problem.

My symptoms started in early childhood and were linked to a collection of both positive and negative attributes. I was both obsessively interested in ideas and completely overwhelmed by my senses. Loud sounds, itchy clothes, new tastes, being held and any type of novelty that wasn't intellectual disturbed me. I started reading at age three and withdrew into a whirl of academic achievement and social awkwardness. I had obsessive, repetitive behavior such as ritually counting certain actions like swinging on the swings — although I mostly managed to hide it, except for in being unable to shut up about my weird interests.

Given those symptoms, today I would almost certainly be diagnosed with Asperger's Syndrome, the one diagnosis DSM-5 seems to have tightened, merging it into the spectrum of conditions that constitute autism (Asperger's doesn't even appear in the index as a separate condition).

At the time, however, the diagnosis didn't exist. So instead of being seen as having some type of disorder, I was labeled as "selfish" and "gifted." I folded both of these characteristics into my identity, convincing myself they made me a "bad person," who might only redeem the fact that she preferred ideas to people by achieving overwhelming intellectual success.

While some argue that medicalizing labels like those in the DSM only do harm, my case was probably one in which they might have helped. Had I known I had Asperger's for example, I wouldn't have felt so bad about my bossiness and apparent disregard for other people — I would have realized that they were part of a brain difference that came with both advantages and disadvantages, not a matter of moral deficits. I would have also been explicitly taught how to do better in ways I could understand.

By the time I got to junior high school, I desperately wanted friends but had no idea how to make them, and my frustration made me unhappy. My social cluelessness also made me a target for bullies and by high school, I was quite depressed. That, however, was not something people expected in teens at the time.

Enter drugs, of the nonpsychiatric variety. In high school, I discovered that getting high not only gave me comfort and a sense of belonging, but an obsession that wouldn't bore others when I pursued it endlessly. Instead of isolating me, this obsession allowed me to connect. By my second semester of college, I was addicted to cocaine and by the end of sophomore year, I was injecting heroin and had to leave Columbia University.

At this point, I finally started getting diagnosed — properly— when prison was a real possibility. When I chose to enter rehab at 23, I was correctly diagnosed with cocaine and heroin dependence — not exactly a difficult categorization to make of an 80 pound woman covered with track marks who tested positive for both drugs. Those were my first two official diagnoses and they were accurate. Score one for DSM.

But about halfway through my 28-day inpatient stay, I had what cannot have been more than a five minute visit with the program's psychiatrist. Although I doubt he could have picked me out of a line up later that day, within two minutes of questioning me, I was diagnosed as bipolar and prescribed lithium. It is certainly true that I have a habit of talking quickly and while detoxing from cocaine and heroin, I absolutely had severe mood swings. However, I have never had anything close to a real manic episode and didn't suggest otherwise in the conversation.

Bipolar is a classic example of the DSM's diagnostic inflation. It is now possible to be diagnosed with types of the disorder that do not include what was once its defining characteristic — becoming so elated or agitated that you lose touch with reality. It is quite likely that I met the criteria for a type called bipolar II — a disorder where you have periods of depression that alternate with periods of upbeat mood that do not cross the line into mania. But the diagnosis didn't accurately characterize what was actually happening to me at the time, which was basically that my already odd brain was recovering from several years of severe addiction.

Later, I would pick up several other diagnoses: in early recovery, a therapist noted my obsessive tendencies and added the obsessive-compulsive disorder (OCD) label and when I suffered a new bout of depression, that, too, got added to the list.

So, what did the DSM do for me? I collected diagnoses, but none of them— aside from the one I never officially received — fully described my real problems. The addictions were real— but they didn't simply arise because I took drugs. I took drugs because I didn't know how to deal with the depression and social isolation of what I now suspect is Asperger's. The addiction treatment system failed to correctly identify my underlying issues and gave me a label with little consideration.

Indeed, if I'd held on to the bipolar diagnosis, I could have been severely harmed by inappropriate medications. The OCD diagnosis at least accurately characterized my obsessive nature — but virtually everyone with Asperger's could also be diagnosed OCD; it doesn't provide the whole story. Like the addictions, the depression was certainly real but it, too, was probably secondary to the social isolation caused by the Asperger's. However, my treatment for depression with antidepressants was probably the most useful therapy I received: it actually reduced the sensory and emotional overload I'd tried to address by self-medicating with the illegal drugs.

The problem of multiple diagnoses like mine is one reason NIMH wants to abandon DSM and replace it with a system that looks at the brain systems that are going awry rather than focusing solely on symptoms. That, some experts like Insel believe, can lead to better understanding of how best to treat specific issues in these circuits. So maybe, if someone had recognized and treated my sensory and emotional overload early on, rather than labeling them as signs of selfishness or simply being "gifted" or "different," it might have prevented both the depression and the addiction.

The NIMH's "research domain criteria (RDoC)" classification system however, isn't ideal either. For one, it assumes a pretty robust understanding of the circuitry in the brain that dictates normal function, as well as how these networks go awry in mental illness— and that's a level of knowledge we still haven't achieved. The search for genetic and chemical markers of specific problems has also been hampered by the failure of these problems to line up with DSM diagnoses. There might, for example, be a gene that predisposes someone to "get stuck" on negative thoughts — but it might not show up in studies of people with depression because there are many roads to depression that may not involve that gene. Focusing simply on single symptoms and their genetics in this way may help clarify the situation — as NIMH plans to do — but we are far from having these answers.

And if researchers do eventually trace specific symptoms to their chemical and neural-circuit roots, how will they sort out the variety of unique symptoms and diagnose them properly? The more symptoms that psychiatrists may uncover, the more the combinations of symptoms will multiply and the more difficult it will be for both clinicians and patients to properly interpret the information.

And such genetic and biochemical markers will only take us so far. My problems developed not just because of my genetic

predispositions, of which I'm sure there are many, but because of my environment and my psychological reactions to them. Those responses are sometimes amenable to medication and may indeed require it — but typically, cognitive and social changes are needed as well. A diagnostic system that tries to reduce the brain to biology would be like a computer technician who knows only how to fix hardware but not the software: not very effective if the software is what's acting up.

Frances argues — and I agree — that such biology-based criteria for defining mental illness are still far off, and that for now, the DSM criteria are the best way that doctors can help patients today, in the clinic. But he argues that we need to tighten up the DSM criteria and recognize that college binge drinking, for example, shouldn't lead to a lifelong diagnosis of having had a "substance use disorder" that doesn't categorically distinguish between alcoholism and milder drinking problems.

Such measures could also reduce the over-treatment of conditions that don't require psychiatric care, such as ordinary grief. Yes, the current DSM-based system is no doubt perpetuated by a drug industry that markets both disorders and their treatments, and, as my own case showed, it can lead to incorrect labeling and risky medication treatments. The symptom-based definition of mental illness also encourages labeling of conditions and disorders in a way that implies far more knowledge of mental disorders than is actually the case; government programs, school systems and insurers all rely on being able to tag symptoms with a name to determine eligibility for services. We do need diagnoses: but both psychiatrists and patients alike should recognize that these labels are neither immutable nor perfect

Read more: http://healthland.time.com/2013/05/17/viewpoint-my-case-shows-whats-right-and-wrong-with-psychiatric-diagnoses/#ixzz2ZKkDwwfp

Measuring Mental Illness Recovery Will Require More Precise Instruments

While the ultimate goal in mental health treatment may be a patient's recovery, no available measure seems to be an ideal method for assessing that recovery, though two show considerable efficacy in measuring several key factors, a new study finds.

"No recovery measure can currently be unequivocally recommended...," Mike Slade, Psych.D., Ph.D., a professor at the Institute of Psychiatry, King's College, London, and colleagues report in *Psychiatric Services in Advance*. They came to this conclusion after systematically searching for and evaluating research papers on the subject.However, the best recovery yardstick appears to be the Questionnaire About the Process of Recovery, which was developed in the United Kingdom and measures recovery processes such as connectedness, hope, identity, meaning, and empowerment, the researchers report. The most-published instrument is the Recovery Assessment Scale, developed in the United States, which measures recovery processes such as self-confidence, hope, success orientation, and willingness to ask for help.

Information about individuals who have recovered from serious mental illness can be found in *Psychiatric News* here and here. For more on the topic, see American Psychiatric Publishing's Recovery From Disability: Manual of Psychiatric Rehabilitation.