VOLUME 2, ISSUE 4

JANUARY—FEBRUARY 2009

# The Recovery Route

**MISSION**

***TO IMPROVE THE LIVES OF PEOPLE LIVING WITH MOOD DISORDERS***


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## *CRISIS INTERVENTION TRAINED POLICE OFFICERS VISIT DBSA-OK, INFORM CONSUMERS*

I bet you've always wondered exactly who comes to your house when 911 is called because of a mental illness crisis? Or maybe you want to know what the officers that respond have in mind when they get to you? How do you know they won't just call you crazy and haul you off to jail?

DBSA-OK dispelled some old rumors, myths and misconceptions concerning the police and consumers. On Wednesday, February 18th, DBSA-OK invited Sgt. Terry Tilley of the Midwest City Police Department Crisis Intervention Team and Captain Robert Nash of the Oklahoma City Police Department Crisis Intervention Team to visit with our facilitators and consumers.

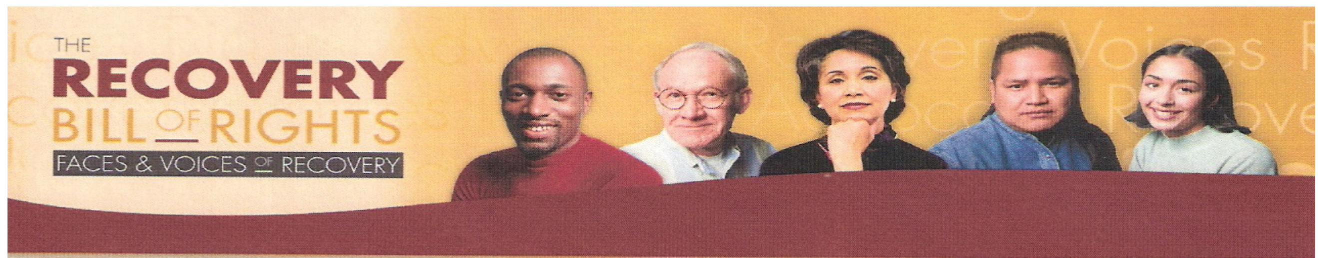
CIT Officers are regular police officers that have an additional 40 hours of training specifically in Crisis Intervention. During this training, officers are taught about the different mental illnesses they may encounter, their characteristics and what to expect. Yet the officers are taught something else that is more important than that– they are taught to respect the consumer. They role-play different scenarios they will usually encounter so they have an understanding of what the consumer is going through. They talk with psychiatrists and counselors and learn about the many illnesses. Police officers are not required to take this training. Becoming a CIT Officer is a personal choice. Most officers that take the training do so because they *want* to, not because they have to. Once the training is complete, you will know a CIT officer because of the applet on their shoulders stating CIT.

Did you know that when you or a family member calls 911 because of a mental illness crisis, you should ask for a CIT officer? That way, you get someone who truly wants to help you avoid (gasp) jail and who wants you to feel better as soon as possible. If that means sitting and talking with you for three hours, that's what they will do. If it means taking you to the local crisis center they will do that. CIT Officers want to make sure your needs are met while making sure you are not a harm to yourself or someone else.

Some cities in Oklahoma do not have CIT officers. In that instance, you can have the dispatcher ask a nearby city for one of their CIT Officers. What should you do if your locality doesn't have CIT Officers? Write your State Representative! Tell them CIT Officers are needed in your area.

Also, local CIT Officers are available to speak to your group. If you want one to visit, contact Rave at the DBSA-OK state office and she will get the numbers to you!

# *RECOVERY BILL OF RIGHTS*




**We will improve the lives of millions of Americans, their families and communities if we treat addiction to alcohol and other drugs as a public health crisis. To overcome this crisis, we must accord dignity to people with addiction and recognize that there is no one path to recovery.** Individuals who are striving to be responsible citizens can recover on their own or with the help of others. Effective aid can be rendered by mutual support groups or health care professionals. Recovery can begin in a doctor's office, treatment center, church, prison, peer support meeting or in one's own home. The journey can be guided by religious faith, spiritual experience or secular teachings. Recovery happens every day across our country and there are effective solutions for people still struggling. Whatever the pathway, the journey will be far easier to travel if people seeking recovery are afforded respect for their basic rights:

1. **We have the right to be viewed as capable of changing, growing** and becoming positively connected to our community, no matter what we did in the past because of our addiction.
2. **We have the right—as do our families and friends—to know about the many pathways to recovery, the nature of addiction** and the barriers to long-term recovery, all conveyed in ways that we can understand.
3. **We have the right, whether seeking recovery in the community, a physician's office, treatment center or while incarcerated, to set our own recoverygoals,** working with a personalized recovery plan that we have designed based on accurate and understandable information about our health status, including a comprehensive, holistic assessment.
4. **We have the right to select services that build on our strengths,** armed with full information about the experience, and credentials of the people providing services and the effectiveness of the services and programs from which we are seeking help.
5. **We have the right to be served by organizations or health care and social service providers that view recovery positively,** meet the highest public health and safety standards, provide rapid access to services, treat us respectfully, understand that our motivation is related to successfully accessing our strengths and will work with us and our families to find a pathway to recovery.
6. **We have the right to be considered as more than a statistic,** stereotype, risk score, diagnosis, label or pathology unit—free from the social stigma that characterizes us as weak or morally flawed. If we relapse and begin treatment again, we should be treated with dignity and respect that welcomes our continued efforts to achieve long-term recovery.
7. **We have the right to a health care and social services system that recognizes the strengths and needs of people with addiction** and coordinates its efforts to provide recovery-based care that honors and respects our cultural beliefs. This support may include introduction to religious, spiritual and secular communities of recovery, and the involvement of our families, kinship networks and indigenous healers as part of our treatment experience.
8. **We have the right to be represented by informed policymakers** who remove barriers to educational, housing and employment opportunities once we are no longer misusing alcohol or other drugs and are on the road to recovery.
9. **We have the right to respectful, nondiscriminatory care from doctors** and other health care providers and to receive services on the same basis as people do for any other chronic illness, with the same provisions, copayments, lifetime benefits and catastrophic coverage in insurance, self-funded/self-insured health plans, Medicare and HMO plans. The criteria of "proper" care should be exclusively between our health care providers and ourselves; it should reflect the severity, complexity and duration of our illness and provide a reasonable opportunity for recovery maintenance.
10. **We have the right to treatment and recovery support in the criminal justice system** and to regain our place and rights in society once we have served our sentences.
11. **We have the right to speak out publicly about our recovery** to let others know that long-term recovery from addiction is a reality.

**ENDORSED BY:** American Association for the Treatment of Opioid Dependence, Inc. • American Society of Addiction Medicine • Community Anti-Drug Coalitions of America • Ensuring Solutions to Alcohol Problems • Entertainment Industries Council • Johnson Institute • Join Together • Legal Action Center • NAADAC, the Association for Addiction Professionals • National African American Drug Policy Coalition • National Alliance of Advocates for Buprenorphine Treatment • National Alliance of Methadone Advocates • National Association on Alcohol, Drugs and Disability • National Association of Drug Court Professionals • National Association for Children of Alcoholics • National Association of Addiction Treatment Providers • National Council on Alcoholism and Drug Dependence • National Council for Community Behavioral Healthcare • Rebecca Project for Human Rights • State Association of Addiction Services • TASC, Inc. • Therapeutic Communities of America • White Bison

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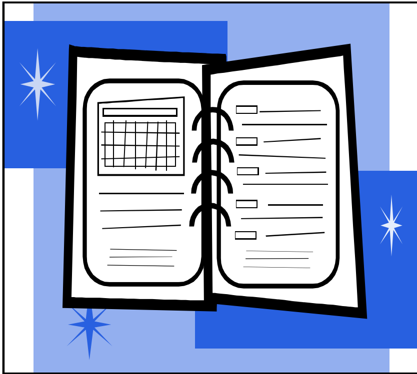
## *UPCOMING EVENTS*



Please mark the following items on your calendar if you wish to attend….and don't forget to call the DBSA-OK office if you must register in advance!

FEBRUARY

2nd DBSA-OK Board Meeting

11– 13th 2nd Annual Combined Mental Health, Prevention & Substance Abuse conference– Embassy Suites, Norman, OK

18th Facilitator Summit– CIT Officers Speak

26-27th SOAR Training– Lawton (SSI/SSDI Outreach, Access & Recovery)

MARCH

2nd DBSA-OK Board Meeting 5pm

4-6th 24th Annual Conference on Minority Aging—Tulsa

12th Metro disABILITY Resource Fair, Shepherd Mall

18th Facilitator Summit

26– 27th SOAR Training– Oklahoma City

31st Disability Awareness Week, Deaf/hard of hearing day UCO, Edmond

APRIL

1st Disability Awareness Week, Physical disability day, UCO, Edmond

6th DBSA-OK Board Meeting 5pm

15th Facilitator Summit– SSDI/SSI Speaker

# *Relationship between the Economy, Unemployment and Suicide*

As reported/prepared by the Suicide Prevention Resource Center, November 18, 2008

Recent economic turmoil, increased unemployment and record foreclosure rates have spurred media inquiries about whether these changes will lead to increased suicides. SPRC conducted a literature review of relevant research published in the past two decades. The review shows that a strong relationship exists between unemployment, the economy, and suicide. A common "chain of adversity" can begin with job loss and move toward depression through financial strain and loss of personal control. In fact, this chain leads to myriad financial, social, health and mental health outcomes—all of them negative. The most common (but by no means the only) mental health outcome is depression, which significantly increases suicide risk. The associated financial outcomes (such as mortgage foreclosures and loss of retirement security) have not been researched with respect to suicide. However, the potential link is that for vulnerable individuals, losses (whether real or anticipated) that result in humiliation, shame, or despair can trigger suicide attempts. These talking points describe the complex interaction between economic cycles, unemployment, and suicide, and provide key messages that promote suicide prevention. We invite you to use these messages in responding to media queries and coverage, or for related suicide prevention activities. We also recommend providing media contacts with At-a-Glance: Safe Reporting on Suicide.

Talking Points

Unemployment is bad for your general health.

• Unemployment is associated with an array of poor health outcomes, including death by nearly all causes (except cancer and cardiovascular events). In the U.S., where a large portion of the population accesses healthcare through employment, this connection may be even stronger than in countries where government-financed healthcare is the norm. Unemployment contributes to suicide risk, but does not "cause" suicides on its own.

• Employment status is but one of dozens of factors that interact dynamically within individuals, communities, and societies and affect the risk for suicide.

• Although unemployment is associated with increased rates of suicide, many individuals may have lower rates of employment because of mental health and/or substance abuse problems, which are also associated with increased suicide rates. Unemployment causes financial strain and can lead to depression and other problems as individuals perceive a loss of personal control.

• Economic circumstances themselves are insufficient to cause a suicide; in fact, we do not know of any single factor that is sufficient on its own to "cause" a suicide. Stressors such as the loss of a job, a home, or retirement security can result in shame, humiliation or despair, and in that context, can precipitate suicide attempts in those who are already vulnerable or do not have sufficient resources to draw on for support. In most, but not all cases, mental health problems are among the factors that increase vulnerability.

• Unemployment (and resulting financial strain) is associated with depression, substance abuse problems and marital turmoil, all of which are independently linked to suicide risk. We can expect a sharp downturn in the economy to increase suicide risk, especially among working-age adults and older adults whose retirement security is threatened.

• Widespread increases in unemployment, usually in the context of unstable or declining economic opportunity, are strongly linked with increases in suicide rates; the largest changes in the economic cycle generally produce the largest increases in suicides. These links between unemployment and suicide are especially strong for working-age men, but show up in other groups as well, including women. Suicide rates tend to decrease with rising optimism and opportunity.

• In times of economic instability, anxiety over the possibility of losing a job, home or retirement nest egg may affect the employed, as well. Leaders and their organizations can take steps to lessen the impact of the economic downturn.

• Helpful messages should:

o Temper sensational bad economic news with realism. In truth, we do not know how steep,

Cont'd pg 5

## *From Sandy's Chair*

Now is the time to make our voices heard to the legislators of our state. All members of the Oklahoma State Senate and House of Representatives are invited to a series of 'Coffee Chats' with the Coalition of Advocates, Room 412A, State Capitol Building at 8:15-9:00am. The date set for OK-DBSA is Thursday, March 26. If you will send or call in the names of your legislators, the office will send them special invitations. If you think that your legislators are coming , you need to come also to meet with them.

This will be followed in early April by the 'Day At The Capitol.' A firm date hasn't been decided upon yet.

The Board of Directors at OK-DBSA has decided to set aside some money for scholarships for members of our support groups. This may be used for conferences, trainings, etc. More on this next newsletter.

## *Suicide, Cont'd.*

deep, or long the downturn will be.

o Encourage community-based organizations and groups to increase levels of all

types of support to those most affected by the economy, with the goal of relieving financial strain.

o Help those affected cope effectively, including seeking help from others.

• Organizations in the public and private sectors should help make key services more accessible, especially high-quality, comprehensive transition services for the unemployed and assistance for homeowners threatened by foreclosure. Individuals in distress can take action to reduce their own levels of distress.

• Individuals can engage in activities that relieve anxiety and emotional distress and focus on managing areas in their lives where they still have some control. For instance, people can strengthen their connections with family members and friends, schedule regular times for healthy and relaxing activities, and seek reemployment training.

• Individuals who need additional help and support should seek the advice of a faith leader, doctor, or community health or mental health clinic.

• Individuals who feel they are in suicidal crisis (or are concerned about someone who is) should call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). Ordinary individuals can make a difference by becoming aware of the warning signs of suicide and helping those who may be in danger get help.

• Warning signs of suicide can be downloaded at http://www.sprc.org/featured_resources/bpr/PDF/AASWarningSigns_factsheet.pdf.

• The media can help spread the word about preventing suicide. When reporting on suicide, the media should follow nationally recognized recommendations developed through work of the Annenberg Public Policy Center and leading experts (http://www.afsp.org/media or http://www.sprc.org/library/at_a_glance.pdf), since some types of reporting can contribute to copycat suicides and contagion. This is an important time to advance our work on the National Strategy for Suicide Prevention.

• Public and private organizations at all levels have a role in preventing suicide—suicide prevention is "everyone's business." For suicide prevention ideas, read the National Strategy for Suicide Prevention (http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/).

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**WE'VE BEEN THERE, WE CAN HELP.**

## *IDEAS*

DBSA-OK wants to know from you what you would like to see in our newsletter. Is the current format easy to read? Would you like more personal stories from consumers? What is it that YOU want to know?

Please drop us a line any way you can– phone, email, regular mail or through our website. We are here to help you– tell us what you need.