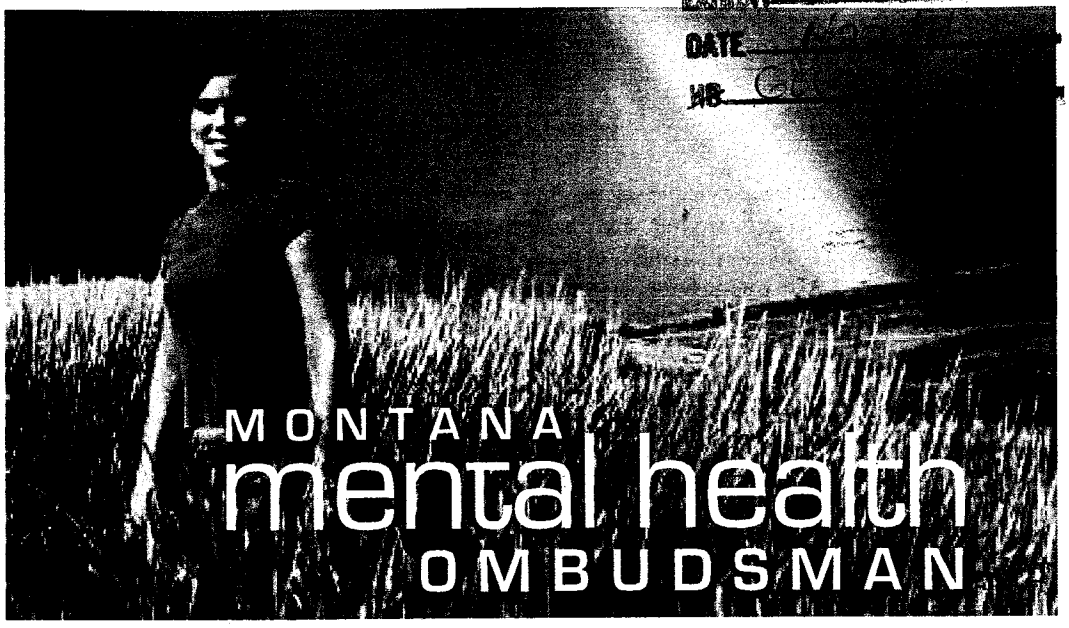
EXHIBIT 3
DATE
HB



MONTANA mental health OMBUDSMAN

ANNUAL REPORT **2010**

ALICIA PICHETTE
MENTAL HEALTH OMBUDSMAN

WHAT IS THE ROLE OF AN OMBUDSMAN?

An ombudsman is appointed to serve a constituency; to investigate constituent complaints and attempt to resolve them; and, to make recommendations for changes to policies or procedures to improve effectiveness and efficiency of services. The Office of the Ombudsman can act as a mediator to assist constituents with conflict resolution and other problems.

The Ombudsman office is open from 8 a.m. to 5 p.m. Monday through Friday.

Toll free: 1-888-444-9669

Fax: 406-444-3543

E-mail:
govmhombudsman@mt.gov

Web:
www.mhombudsman.mt.gov

message from the ombudsman

As Montanans we pride ourselves on our pioneer spirit, frontier ingenuity and how strong we can be when we connect, neighbor-to-neighbor. When, as Montanans we talk about mental health and the ability to recover a life of wellness after a diagnosis of mental illness, "independence" and "self-reliance" are the words most often used. It is a quest for self-sufficiency that leads not people, but us, to seek the promise of community living; to services and incentives that ensure each Montanan who needs them can gain easy and continuous access to the highest quality mental health treatment and services. Access to a life 'recovered.'

An estimated 26.2 per-cent of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year. Applied to Montana's population of just under 1 million, this figure translates to about 250,000 people with a diagnosable mental disorder in a year. While mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion of the population; about 6 percent, or 1 in 17, people suffer from a serious mental illness. It is the leading cause of disability for individuals aged 15 to 44. Nearly half of all adults with a mental illness report their symptoms began by the age of 14; and three quarters saw symptoms by their mid 20s. Underscoring the notion that mental disorders manifest early in life, recent research conducted by the National Institute for Mental Health—NIMH found that symptoms of anxiety disorders can begin to emerge by age 6, behavior disorders by age 11, mood disorders by age 13, and substance related disorders by age 15.

To envision a future when anyone with a mental illness can live a life of recovery, a future when mental illness is detected early, when any person with a mental illness discovered at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and recapturing the hope of a life to live well, is to envision recovery.

Recovery refers to a process which provides people support so they may live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability; to recapture the hope of a well life—a good life. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

independent and self-reliant

Advances in research, technology, and an understanding of how to treat mental illnesses provide powerful means to transform the mental health system. In a transformed system, consumers and family members have access to timely and accurate information that promotes self-education, self-monitoring, and accountability. Health care providers rely on the most current knowledge to provide optimum care for the best outcomes. Reimbursement is directed toward those services that promote recovery and accountability.

This year the Ombudsman report shares information on efforts to transition public mental health services to a philosophy of Recovery, and adds recommendations for continued advancement. ■

finding home: recovery times two

Arriving in Montana from another state, kicking around and being homeless for the first couple of years; I realized that there was no future in continuing to live that way. When I discovered public mental health services through the Mental Health Center, I realized that recovering from mental illness could happen—it would take work and help but it could happen. Although there were a couple of false starts I kept trying, this time I was truly determined to work toward recovery. With the help of a dedicated APRN, I began to understand that having a mental health diagnosis and understanding my mental illness meant my life could be better. In the past taking medication for an illness I didn't know about or understand didn't make sense. With help from the recovery program at the center, I now understand how the medications address my illness, and how group sessions provide me information about goal setting, to achieve a livable life and move toward a future. Now that I have taken responsibility for achieving a healthy life, the case manager at the Center has helped me identify my employment strengths and using past work experience helped me recognize that I do want to work. Even though the job market is difficult now, my goal is to work at a meaningful, good paying job. My recovery plan is for 2 years, 5 years and beyond. I don't like looking back, but I would like it if people who know me 'now' could look back to see me 'then' —it has been a long journey.

—Jim

Note: The recovery stories of these two people are just beginning. Their short and long range plans are to continue setting recovery goals; become engaged to each other by the end of 2010; buy a home; have a wedding; and, live their lives.

After a job related accident left me with an injury that required higher and higher doses of medication to address the pain, I experienced a psychotic episode and landed at the Montana State Hospital. The doctors at the Hospital determined that I was addicted to morphine. It took three months to clear the morphine out of my system and be discharged to a group home in this community. It took two and half years of work with my APRN and the therapist at the Center to finally get my medications 'right', so I could begin to feel well. Now I live in my own apartment and am looking forward to returning to work. Attending group sessions at the Mental Health Center has given me the education I need to understand my illness, identify and set long range goals for my life and achieve independence. With the help of the recovery programs at the Center, I have become a person again. My two year plan includes working at a job in this community, and my five year plan includes saving to buy a home.

—Linda

recovery

I set out on my own journey of transformation in 2006, the year that was mostly spent hospitalized for Major Depression. It was a year of admits and discharges, and trial, and many perceived failures. But this was just my initiation into the Montana mental health system. Four years later I now work and advocate in the mental health system. And it was this journey that is Recovery.

There is a lot of talk these days about Recovery. And the State of Montana has made great strides in achieving a system that embraces the Recovery Model. But the single greatest step that has been instrumental in my own personal recovery is the fact that I got to participate in a community. Not just peers with a mental illness, but peers that reflect what peers should be; a diverse group of people from different aspects of society. Local Advisory Councils, Service Area Authorities, Mental Health Oversight and Advisory Council, Mental Disabilities Board of Visitors, and the Mental Health Ombudsman all have been conduits and supports in a system that is complicated to say the least. The interaction with all these people gave me back my confidence, self esteem, and the perspective to move on in my life and become something other than a person with mental illness. And

most importantly I can participate in my greater community in activities and issues that have nothing to do with a mental illness.

I consider myself one of the successes of the mental health system. It is a system that has tried exhaustively from every angle to change things for the better. Legislators are better educated. State administrators and Mental Health Centers work more cooperatively. There is more openness. Clients, patients, advocates and stakeholders from all venues now come to more of a consensus. Communities are taking a larger role in the care of their citizens. There are many programs that enhance the care given in local communities. The value of being treated in your hometown has taken root. Recovery happens in community. There is an air of possibility in the wind.

But amid the optimism is a shadow of the unknown. Budgets are straining. People are scared. The fight to save programs will divide and embitter. So this is a time when we need to work hard at keeping the connections we have built. This is a time when we need to strengthen the ties to communities. This a time when we keep educating. Because the loss will not be programs or services. The loss will be people.

We must not forget the things we were working so hard on before this budget crisis, because there is still much work to do to improve the lives of people with a mental illness. Suicide, stigma, local crisis beds, crisis intervention training for law enforcement, medical costs, housing, and employment are just a few of the many issues still on the table.

With my relatively short experience with the Montana Mental Health System, I have seen tremendous improvements in the cooperation of stakeholders. With the prospect of budget shortfalls, now more than ever, we will have to work together to save and improve the lives of Montanans. We must work together to provide the tools of Recovery.

—Patrick Wayne

mental health ombudsman 2010 recommendations

planning:

- Develop a long-term strategic planning method to develop quality service continuum focusing on recovery oriented programs that will serve individuals who have a mental illness or psychiatric disability from early identification through 'elderhood.'
- Continue providing support for Local Area Councils and Service Area Authorities to assure that consumers of mental health services and their families participate as partners to develop policies and best practices for delivering mental health services.

integrating services to end fragmentation and gaps:

- Provide universal access to services by integrating public health services, schools, mental health centers, aging services, juvenile justice, law enforcement and corrections to identify individuals who need mental health services and then provide effective treatment and supports for children, adolescents and adults with recovery as the foundation.
- Prepare for an aging population that has long-term psychiatric disabilities and/or late life mental illnesses by encouraging colleges and schools to offer integrated education programs to healthcare providers who serve older Montanans.

uncompensated care:

- Take advantage of funding flexibility available under the expansion of Medicaid in the Affordable Care Act to ease the burden of uncompensated care in the services delivery system.

medical marijuana:

- Move to resolve the conflicts in existing statute for prescribing, growing and marketing marijuana for use by individuals who have a diagnosed mental illness. Continue to follow research on the impacts of marijuana use by individuals when they have a diagnosed psychiatric disability.

electronic medical records:

- Continue to plan, implement and offer participation incentives to Medicaid providers; hospitals and professional practices which acquire and use electronic health records to improve the quality of health and mental health care.

2003 new freedom commission goals:

- Americans understand that mental health is essential to overall health
- Mental health care is consumer and family driven
- Disparities in mental health services are eliminated
- Early mental health screening, assessment and referral to services are common practice
- Excellent mental health care is delivered and research is accelerated
- Technology is used to access mental health care and information

10 fundamental components of recovery

Self-Direction
By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.

Individualized and person-centered
Individuals identify recovery as being an ongoing journey and an end result as well as an overall model for achieving wellness and optimal mental health.

Empowerment
Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing.

Holistic
Recovery encompasses an individual's whole life, including mind, body, spirit, and community.

Non-linear
Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.

Strengths-based
Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals.

Peer support
Mutual support—including the sharing of experiential knowledge and skills and social learning—plays a valuable role in recovery.

Respect
Self-acceptance and regaining belief in one's self are vital to recovery. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility
Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope
Hope is the catalyst of the recovery process. As a society, we reap the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier nation.

Resources: www.samhsa.gov

MONTANA mental health OMBUDSMAN

ALICIA PICHETTE ▪ MENTAL HEALTH OMBUDSMAN

It is the Mission of the Mental Health Ombudsman to:

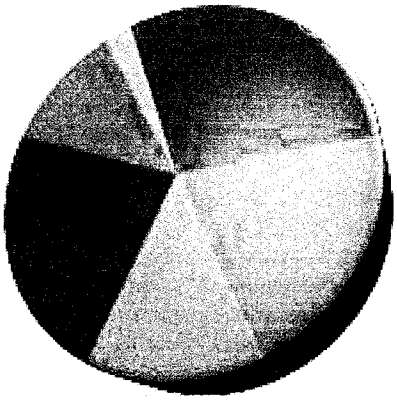
- represent the interests of individuals seeking access to public mental health services
- act as a confidential resource to provide information and assistance
- offer recommendations for system improvement

2010 Statistics at-a-glance

Inquiries to Mental Health Ombudsman

INQUIRY TYPE

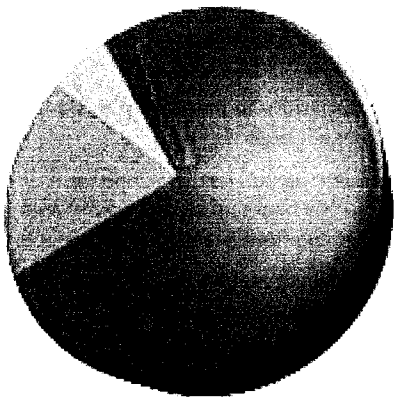
- Access to services.....23%
- Complaints.....22%
- Legal and criminal justice.....15%
- Availability of services.....11%
- Treatment & Medical care.....10%
- Social Security.....8%
- Employment, Financial & Housing....6%
- Discrimination & Rights.....3%
- Other.....2%



Services provided

SERVICE TYPE

- Coaching/information.....71%
- Referral.....20%
- Informal assistance.....6%
- Other (includes investigtions).....3%



MONTANA mental health OMBUDSMAN

ALICIA PICHETTE
MENTAL HEALTH OMBUDSMAN

Ms. Pichette was appointed to the post of Mental Health Ombudsman in 2009. She comes to the office with nearly 30 years experience as a public servant and advocate for individuals with disabilities. Her public service experience includes being a field representative for Congressman Pat Williams, serving as Montana's Deputy Insurance Commissioner and, as an interim Lewis and Clark County Commissioner. She describes her work as the Ombudsman as "incomparable—an uncrowded mile."

BRIAN GARRITY
PROGRAM SPECIALIST

Brian joined the staff in October, 1999, and works half-time. Over the years, Brian has participated in various mental health related advisory councils, work groups, and advocacy organizations. Brian has been a long-time advocate for people with mental illness, a role enhanced by his own open history and perspective as an individual with mental illness. Brian is married and has an 11-year old Samoyed dog, Snowball.

The Ombudsman office is open from 8 a.m. to 5 p.m. Monday through Friday.

Toll free: 1-888-444-9669

Fax: 406-444-3543

E-mail:
govmhombudsman@mt.gov

Web:
www.mhombudsman.mt.gov

Graphic design by Luke Poran, Element Design.

Teenage Brain: A work in Progress

A brief overview of research into brain development during adolescence

New imaging studies are revealing—for the first time—patterns of brain development that extend into the teenage years. Although scientists don't know yet what accounts for the observed changes, they may parallel a pruning process that occurs early in life that appears to follow the principle of "use-it-or-lose-it". Neural connections, or synapses, that get exercise are retained while those that don't are lost. At least, this is what studies of animals' developing visual systems suggest. While it is known that both genes and environment play major roles in shaping early brain development, science still has much to learn about the relative influence of experience versus genes on the later maturation of the brain. Animal studies support a role for experience in late development, but no animal species undergoes anything comparable to humans' protracted childhood and adolescence. Nor is it yet clear whether experience actually creates new neurons and synapses, or merely establishes transitory functional changes. Nonetheless, it's tempting to interpret the new findings as empowering teens to protect and nurture their brain as a work in progress.

The newfound appreciation of the dynamic nature of the brain is emerging from MRI (magnetic resonance imaging) studies that scan a child's brain every two years as he or she grows up. Individual brains differ enough that only broad generalizations can be made from comparisons of different individuals at different ages. But following the same brains as they mature allows scientists a much more fine-grained view into developmental changes. In the first such longitudinal study of 145 children and adolescents, reported in 1999, NIMH's Dr. Judith Rapoport and colleagues were surprised to discover a second wave of overproduction of gray matter, the thinking part of the brain—neurons and their branch-like extensions—just prior to puberty. [1] Possibly related to the influence of surging sex hormones, this thickening peaks at around age 11 in girls, 12 in boys after which the gray matter actually thins some.

Prior to this study, research had shown that the brain overproduced gray matter for a brief period in early development – in the womb and for about the first 18 months of life – and then underwent just one bout of pruning. Researchers are now confronted with structural changes that occur much later in adolescence. The teen's gray matter waxes and wanes in different functional brain areas at different times in development. For example, the gray matter growth spurt just prior to puberty predominates in the frontal lobe, the seat of "executive" functions—planning, impulse control and reasoning. In teens affected by a rare childhood onset form of schizophrenia that impairs these function, the MRI scans revealed four times as much gray matter loss in the frontal lobe as normally occurs. [2] Unlike gray matter, the brain's white matter—wire-like fibers that establish neurons' long-distance connections between brain regions—thickens progressively from birth in humans. A layer of insulation called myelin progressively envelops these nerve fibers, making them more efficient, just like the insulation on electric wires improves their conductivity.

Advancements in MRI image analysis are providing new insights into how the brain develops. UCLA's Dr. Arthur Toga and colleagues turned the NIMH team's MRI scan data into 4-D time-lapse animations of children's brains morphing as they grow up—the 4th dimension being rate-of-change. [3] Researchers report a wave of white matter growth that begins

---

[1] Giedd JN, Blumethal J, Jeffries HO, et al. Brain development during childhood and adolescence: a longitudinal MRI study. *Nature Neuroscience,* 1999: 2(10): 861-3.

[2] Rapoport JL, Giedd JN, Blumenthal H, et al. Progressive cortical change during adolescence in childhood-onset schizophrenia. A longitudinal magnetic resonance imaging study. *Archives of General Psychiatry,* 1999 56(7): 649-54.

[3] Thompson PM, Giedd JN, Woods RP, et al. Growth patterns in the developing brain detected by using continuum mechanical tensor maps. *Nature,* 2000: 404(6774): 190-3.

at the front of the brain in early childhood, moves rearward, and then subsides after puberty. Striking growth spurts can be seen from ages 6 to 13 in areas connecting brain regions specialized for language and understanding spatial relations, the temporal and parietal lobes. This growth drops off sharply after age 12, coinciding with the end of a critical period for learning languages.

While this work suggests a wave of brain white matter development that flows from front to back, animal functional brain imaging and postmortem studies have suggested that gray matter maturation flows in the opposite direction with the frontal lobes not fully maturing until young adulthood. To confirm this in living humans the UCLA researchers compared MRI scans of young adults 23-30 with those of teens, 12-16. [4] They looked for signs of myelin, which would imply more mature, efficient connections, within gray matter. As expected, areas of the frontal lobe showed the largest differences between young adults and teens. This increased myelination in the adult frontal cortex likely relates to the maturation of cognitive processing and other "executive" functions. Parietal and temporal areas mediating spatial sensory, auditory and language functions appeared largely mature in the teen brain. The observed maturation of the frontal lobe conspicuously coincides with the typical age-of-onset of schizophrenia—late teens, early twenties—which, as noted earlier, is characterized by impaired "executive" functioning.

Another series of MRI studies is shedding light on how teens may process emotions differently than adults. Using functional MRI (fMRI), a team led by Dr. Deborah Yurgelun-Todd at Harvard's McLean Hospital scanned subjects; brain activity while they identified emotions on pictures of faces displayed on a computer screen.[5] Young teens, who characteristically perform poorly on the task, activated the amygdale, a brain center that mediates fear and other 'gut' reactions, more than the frontal lobe. As teens grow older, their brain activity during this task tends to shift to the frontal lobe, leading to more reasoned perceptions and improved performance. Similarly, the researchers say a shift in activation from the temporal lobe to the frontal lobe during a language skills task, as teens got older. These functional changes paralleled structural changes in temporal lobe white matter.

While these studies have shown remarkable changes that occur in the brain during the teen years, they also demonstrate what every parent can confirm. The teen age brain is a very complicated and dynamic arena, one that is not easily understood.

---

[4] Sowell ER, Thompson PM, Holmes CH, et al. In vivo evidence for post-adolescent brain maturation in frontal and striatal regions. *Nature Neuroscience,* 1999, 2(10); 859-61.

[5] Baird AA, Gruber SA, Fein DA, et al. Functional magnetic resonance imaging of facial affect recognition in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry,* 1999; 38(2): 195-9

Illuminating 13 Myths of Schizophrenia

By: Margarita Tartakovsky, M.S.

It's safe to say that no mental disorder is more shrouded in mystery, misunderstanding and fear than schizophrenia. "The modern-day equivalent of leprosy" is how renowned research psychiatrist E. Fuller Torrey, M.D., refers to schizophrenia in his excellent book, *Surviving Schizophrenia: A Manual for Families, Patients, and Providers.*

While 85 percent of Americans recognize that schizophrenia is a disorder, only 24 percent are actually familiar with it. And according to a 2008 survey by the National Alliance on Mental Illness (NAMI), 64 percent can't recognize its symptoms or think the symptoms include a "split" or multiple personalities. (They don't.)

Aside from ignorance, images of the aggressive, sadistic "schizophrenic" are plentiful in the media. Such stereotypes only further the stigma and quash any shred of sympathy for individuals with this illness, writes Dr. Torrey. Stigma has a slew of negative consequences. It's been associated with reduced housing and employment opportunities, diminished quality of life, low self-esteem and more symptoms and stress (see Penn, Chamberlin & Mueser, 2003).

So it's bad enough that people with schizophrenia are afflicted with a terrible disease. But they also have to deal with the confusion, fear and disgust of others. Whether your loved one has schizophrenia or you'd like to learn more, gaining a better understanding of it helps demystify the disease and is a huge help to those who suffer from it. Below are some pervasive myths — followed by actual facts — regarding schizophrenia.

1. Individuals with schizophrenia all have the same symptoms.

For starters, there are different types of schizophrenia. Even individuals diagnosed with the same subtype of schizophrenia often look very different. Schizophrenia is "a huge, huge range of people and problems," said Robert E. Drake, M.D., Ph.D, professor of psychiatry and of community and family medicine at Dartmouth Medical School.

Part of the reason that schizophrenia is so mysterious is because we're unable to put ourselves in the shoes of someone with the disorder. It's simply hard to imagine what having schizophrenia would be like. Everyone experiences sadness, anxiety and anger, but schizophrenia seems so out of our realm of feeling and understanding. It may help to adjust our perspective. Dr. Torrey writes:

Those of us who have not had this disease should ask ourselves, for example, how we would feel if our brain began playing tricks on us, if unseen voices shouted at us, if we lost the capacity to feel emotions, and if we lost the ability to reason logically.

2. People with schizophrenia are dangerous, unpredictable and out of control.

"When their illness is treated with medication and psychosocial interventions, individuals with schizophrenia are no more violent than the general population," said Dawn I. Velligan, Ph.D, professor and co-director of the Division of Schizophrenia and Related Disorders at the Department of Psychiatry, UT Health Science Center at San Antonio. Also, "People with schizophrenia more often tend to be victims rather than perpetrators of violence although untreated mental illness and substance abuse often increase the risk of aggressive behavior," said Irene S. Levine, Ph.D, psychologist and co-author of *Schizophrenia for Dummies.*

3. Schizophrenia is a character flaw.

Lazy, lacking in motivation, lethargic, easily confused...the list of "qualities" individuals with schizophrenia appear to have goes on and on. However, the idea that schizophrenia is a character defect "is no more realistic than suggesting that someone could prevent his epileptic seizures if he really wanted to or that someone could 'decide' not to have cancer if he ate the right foods. What often appears as character defects are symptoms of schizophrenia," write Levine and co-author Jerome Levine, M.D., in *Schizophrenia for Dummies.*

4. Cognitive decline is a major symptom of schizophrenia.

Seemingly unmotivated individuals most likely experience cognitive difficulties with problem solving, attention, memory and processing. They may forget to take their medication. They may ramble and not make sense. They may have a tough time organizing their thoughts. Again, these are symptoms of schizophrenia, which have nothing to do with character or personality.

5. There are psychotic and non-psychotic people.

The public and clinicians alike view psychosis as categorical — you're either psychotic or you're not — instead of symptoms residing on a continuum, said Demian Rose, M.D., Ph.D, medical director of the University of California, San

Francisco PART Program and director of the UCSF Early Psychosis Clinic. For instance, most people will agree that individuals aren't simply depressed or happy. There are gradients of depression, from mild one-day melancholy to deep, crippling clinical depression. Similarly, schizophrenia symptoms are not fundamentally different brain processes, but lie on a continuum with normal cognitive processes, Dr. Rose said. Auditory hallucinations may seem extraordinarily different but how often have you had a song stuck in your head that you can hear pretty clearly?

6. Schizophrenia develops quickly.

"It's quite rare to have a big drop in functioning," Dr. Rose said. Schizophrenia tends to develop slowly. Initial signs often show during adolescence. These signs typically include school, social and work decline, difficulties managing relationships and problems with organizing information, he said. Again, symptoms lie on a continuum. In schizophrenia's beginning stages, an individual may not hear voices. Instead, he may hear whispers, which he can't make out. This "prodromal" period — before the onset of schizophrenia — is the perfect time to intervene and seek treatment.

7. Schizophrenia is purely genetic.

"Studies have shown that in pairs of identical twins (who share an identical genome) the prevalence of developing the illness is 48 percent," said Sandra De Silva, Ph.D, psychosocial treatment co-director and outreach director at the Staglin Music Festival Center for the Assessment and Prevention of Prodromal States (CAPPS) at UCLA, departments of psychology and psychiatry. Because other factors are involved, it's possible to reduce the risk of developing the illness, she added. There are various prodromal programs that focus on helping at-risk adolescents and adults.

Along with genetics, research has shown that stress and family environment can play a big role in increasing a person's susceptibility to psychosis. "While we can't change genetic vulnerability, we can reduce the amount of stress in someone's life, build coping skills to improve the way we respond to stress, and create a protective low-key, calm family environment without a lot of conflict and tension in hopes of reducing the risk of illness progression," De Sliva said.

8. Schizophrenia is untreatable.

"While schizophrenia is not curable, it is an eminently treatable and manageable chronic illness, just like diabetes or heart disease," Levine said. The key is to get the right treatment for your needs. See Living with Schizophrenia here for details.

9. Sufferers need to be hospitalized.

Most individuals with schizophrenia "do well living in the community with outpatient treatment," Velligan said. Again, the key is the right treatment and adhering to that treatment, especially taking medication as prescribed.

10. People with schizophrenia can't lead productive lives.

"Many individuals can lead happy and productive lives," Velligan said. In a 10-year study of 130 individuals with schizophrenia and substance abuse — which co-occurs in nearly 50 percent of patients — from the New Hampshire Dual Diagnosis Study, many gained control over both disorders, reducing their episodes of hospitalization and homelessness, living on their own and achieving a better quality of life (Drake, McHugo, Xie, Fox, Packard & Helmstetter, 2006). Specifically, "62.7 percent were controlling symptoms of schizophrenia; 62.5 percent were actively attaining remissions from substance abuse; 56.8 percent were in independent living situations; 41.4 percent were competitively employed; 48.9 percent had regular social contacts with non–substance abusers; and 58.3 percent expressed overall life satisfaction."

11. Medications make sufferers zombies.

When we think of antipsychotic medication for schizophrenia, we automatically think of adjectives like lethargic, listless, uninterested and vacant. Many believe medication causes these sorts of symptoms. However, most often these symptoms are either from schizophrenia itself or because of overmedication. Zombie-like reactions are "relatively minor, compared with the number of patients who have never been given an adequate trial of available medications," according to Dr. Torrey in *Surviving Schizophrenia*.

12. Antipsychotic medications are worse than the illness itself.

Medication is the mainstay of schizophrenia treatment. Antipsychotic medications effectively reduce hallucinations, delusions, confusing thoughts and bizarre behaviors. These agents can have severe side effects and can be fatal, but this is rare. "Antipsychotic drugs, as a group, are one of the safest groups of drugs in common use and are the greatest advance in the treatment of schizophrenia that has occurred to date," Dr. Torrey writes.

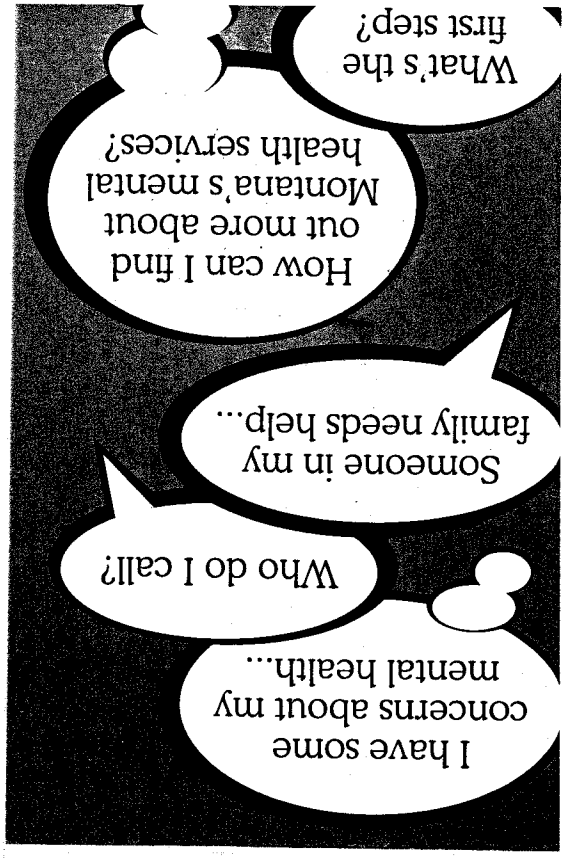
13. Individuals with schizophrenia can never regain normal functioning.

Unlike dementia, which worsens over time or doesn't improve, schizophrenia seems to be a problem that's reversible, Dr. Rose said. There's no line that once it's crossed signifies that there's no hope for a person with schizophrenia, he added.

References

Drake, R.E., McHugo, G.J., Xie, H., Fox, M., Packard, J., & Helmstetter, B. (2006). Ten-Year Recovery Outcomes for Clients With Co-Occurring Schizophrenia and Substance Use Disorders>. *Schizophrenia Bulletin*, 32, 464-473.

Penn, D.L., Chamberlin, C., & Mueser, K.T. (2003). *The effects of a documentary film about schizophrenia on psychiatric stigma.* Schizophrenia Bulletin, 29, 383-391.



RESOURCES

Montana Statewide Suicide Hotline
1-800-273-TALK (8255)

Montana Warm Line
1- 877-688-3377
Non-crisis phone line staffed by primary consumers

Medicaid Recipient Hotline
1-800-362-8312

Aging Hotline/Citizen's Advocate
1-800-332-2272

Advocacy Associations
Montana Mental Health Association
1-877-927-6642
www.montanamentalhealth.com

NAMI of Montana
(National Alliance on Mental Illness)
(406) 443-7871
www.namimt.org

State of Montana Resources
Mental Disabilities Board of Visitors
1-800-332-2272 (Citizen's Advocate)

Addictive and Mental Disorders Division
Mental Health Services Bureau
1-888-866-0328
www.dphhs.mt.gov/amdd/

Children's Mental Health Bureau
(406) 444-4540
www.dphhs.mt.gov/mentalhealth/children

Long Term Care Ombudsman
(nursing homes and assisted living issues)
1-800-551-3191
www.dphhs.mt.gov/sltc/services/aging/ltcombudsman.shtml

State Health Insurance Program (SHIP)
(Medicare beneficiaries)

Our mission

The Mental Health Ombudsman represents the interests of individuals with regard to the need for public mental health services.

We can answer your questions about mental health services:

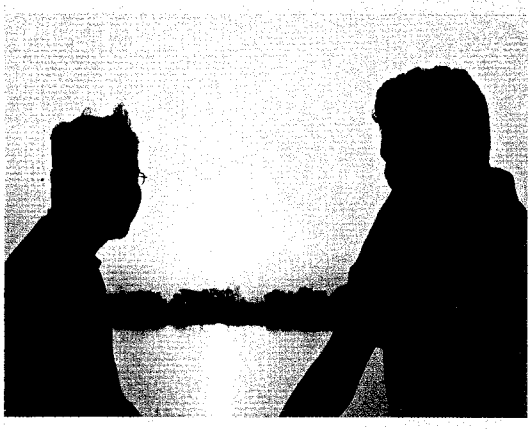
- Services available in the public mental health system
- Resources available for individuals transitioning between services

The Mental Health Ombudsman can assist you by:

- Providing information
- Discussing possible ways to help you resolve a problem
- Contacting individuals or agencies on your behalf
- Connecting you with an agency or organization which can help you

Who can contact the Ombudsman?

- Any individual with mental illness, a family member or friend—anyone seeking assistance or information



Contact us:

Montana Mental Health Ombudsman
Office of the Governor
PO Box 200804
Helena MT 59620-0804

Helena: 444-9669
Toll-Free: 888-444-9669

E-mail: govmhombudsman@mt.gov

Web: www.mhombudsman.mt.gov

We're here to help you.

MONTANA mental health