

Transcription

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Episode 9: On the intersection of mental illness and substance abuse. (Mental Health Series, Part 2)

<https://soundcloud.com/user-760891605/episode-9>

Sound bite: “Your book does such a great job of demonstrating how elusive the beginning of that journey is down the rabbit hole of mental illness and addiction.”

Host intro: Mindy Greiling was a member of the Minnesota House of Representatives for twenty years. She has served on state and national boards of the National Alliance on Mental Illness and is on the University of Minnesota Psychiatry Community Advisory Council. George Realmuto is a professor in the department of psychiatry at the University of Minnesota Medical School. Both George and Mindy are parents of children with brain disease. Mindy’s son, Jim, is 42 and was diagnosed with schizoaffective disorder in his early twenties. George’s daughter, a mother and an award-winning creative, passed away in 2019 as a result of chemical and mental illness. She would be 38 today. Both are here to share their experiences, their expertise, and their hopes for the future of caring for loved ones facing mental and substance use disorders. This conversation was recorded in September 2020.

Mindy Greiling: Hello, this is Mindy Greiling, and I’m really pleased to have with me Dr. George Realmuto who’s going to discuss with me the intersection of mental illness and substance abuse. There’s a huge intersection but yet, the mental health system and the chemical dependency systems don’t intersect nearly as much. Of course, Dr. Realmuto is a professional, he’s a child psychiatrist at the University of Minnesota and knows a lot. He also knows a lot by being a family member like me. Our son Jim, when he was probably in about ninth grade, was starting to dabble in marijuana. And at that time, even us parents didn’t really realize what that could mean in terms of him when he was 21 being diagnosed with schizophrenia and later, schizoaffective disorder. I thought, well, maybe not in ninth grade, but when I was older, I used alcohol in my college years, and I thought marijuana was similar to that, so it was a rude awakening when way after the fact, I found out differently. Jim has been ill now for 20 years and even he, himself, will say that if he had known the effect that marijuana, and then it led to other drugs with him, much more serious drugs, as well, then he would have been much less apt to use it, or at least as much. He feels that he got sick earlier than he would have, worse than he would have, and maybe he could’ve even gotten away with a very mild case if he hadn’t used all those drugs. So, we’ve had a very hard time, and that’s why I wrote my book that Dr. Realmuto was kind enough to read early. Can I call you George?

George Realmuto: Mindy, yes you can.

MG: Your family experience has been similar to ours, except yours ended much more sadly. Can you tell us a little bit about your daughter.

GR: I certainly will. Mindy, thank you for this invitation, thank you for writing your book, thank you for exposing in your book the vulnerable emotions that family members experience when they have a family member, a child, an uncle, sister, daughter, brother, who had so much promise and then, it begins to evaporate. Your book does such a great job of demonstrating how elusive the beginning of that journey is down the rabbit hole of mental illness and addiction. Perhaps, at night, at 3 o'clock in the morning, we who have had family members afflicted, try to think about, if only I had recognized that sign, or if only I had done something at that point, things would have been different. It's something that we then live with the rest of our lives. It's not regret, but it's the need to try to solve a problem that our current culture, society, laws, really, have very few answers for. We can talk about the medical treatment and how that is helpful but it needs to be all of those things, and it's not. So, let me talk about my daughter. Similar to your son, she started her addiction with marijuana. This happened so long ago that the [Star Tribune](#) was doing a feature on the early use of marijuana by adolescents. At the time, it was thought to be strange and unusual. She was one of the students interviewed for that story. She had some difficulty with driving because of the use of alcohol and marijuana. But the addiction story starts with kind of dabbling, and then, experimentation, and then, recreational use, and then, addiction that causes some level of dysfunction. The functional addict is a way that people call that. And then, for some, it becomes malignant. The malignant story is they live for their addiction because the withdrawal phenomenon and the drive in their nucleus accumbens, their pleasure center, is such that nothing else really can compete with the drug. With marijuana, however, there is another little bit that we know to this story. The developing brain is influenced by marijuana and if you look at MRIs or other ways of looking at neural circuits, those that use more marijuana have brains that look much more like schizophrenia than not. And so, it is a neurotropic influence on brain development that moves one towards the symptoms of schizophrenia. It's not well-known but there is scientific evidence that demonstrates that.

MG: Both George and I were at a [NAMI Minnesota](#) annual conference last fall and for the first time, this link that George is talking about, is well enough known that there were several workshops at that conference devoted to the connection between early use of marijuana and developing schizophrenia. And they were packed sessions; I wonder if the planners even realized what a nerve they were hitting. It was hard to get a seat in those sessions. I, at the time, told George

afterwards that I wish he had been one of the presenters because he stood up and spoke to the room so eloquently about this topic.

GR: Well, in terms of presentations, I'm going to go back to your book, *Fix What You Can*. For the most part, when people talk about this, it is a moment in time that's a crisis. Your book is filled with points that were crises. My relationship with my daughter and her mental health and addiction issues often came together around a crisis; she was homeless; she didn't have money for treatment. The relationships that she had, where she was living, broke down. She was being abused. There are all these dysfunctions that follow along with the use of drugs, alcohol and are contributed to by mental illness. When I was able to read the book and see the whole story laid out, not just a crisis, but the crisis followed by the crisis, followed by the other crisis, followed by things being dropped by the system, things that the system never really considered, the lack of participation by the family and other natural supports that could have made a difference. That is the beauty of this book. The book not just talks about symptoms. I think the medical community should take some responsibility. As a child-and-adolescent psychiatrist, and someone brings a youngster to me who is having difficulty, I could go through the symptom list and make a diagnosis. And so, what is my job? To make a diagnosis and prescribe the medications that are consistent with that diagnosis. Well, there's a lot more to this story than diagnosis and treating symptoms. There's relationships, there's dysfunction, there's the necessary support to make sure somebody has a place to live, the basic requirements of human beings to exist and the decency that we need to accord them. That is a big part of this story, and that is the story that you tell and I'm glad you do it.

MG: Well, I'm really glad that you pegged into the parent piece because that, as we know, it's an evidence-based practice, people that have mental illness do better when their families are involved. One of many goals in the book was certainly to highlight and showcase the plight of the parents and how when someone is in crisis, as your daughter was, and our son thankfully isn't at the present time, but certainly has been many times and only a few of them are in the book, then, the mental health system tends to throw up their hands and toss the person back to the family. But when they're doing better or when they're in crisis and then, coming out of it, then, the family is often held at bay. You know, have you signed a release of information, are you sure you're not the problem. I think a lot of us parents feel defensive because we might get looked at askance. Maybe we did something; we already think we must've done something, and then, the mental health system reinforces that. Maybe these aren't always good parents; maybe we're part of the problem. I think that's why so many families, there are plenty of good ones and plenty of people like us that stick through thick and thin, but there's also families, really good families, too, who bow out and kind of fade away because the person, maybe not in their right mind, is not being kind to their

family, the mental health system doesn't want them to be involved, it's easier. I was an elementary teacher. So, I know. It's easier just to deal with the student. But I also know that it was a heck of a lot better for the student and for me as a teacher in the long run if there was family involvement — reinforcing at home what I was trying to teach in the classroom. So, that is a big part of the book. And, I am sure, George, you as a professional, and also as a family member can see that really well.

GR: With children and adolescents, it's expected that the family has the best interests of the child at heart. And, when you have a brain disease that prevents a person from making high-level, in-their-best-interest decisions, it would seem that the family would be a good resource for the community to discuss decisions and plans and what's next and how to support people like my daughter and your son. And yet, it seems that community care includes anybody but the family. It should be mandatory that at the time of a hospitalization, those crossroads that occur, that are so significant, that people who are interested, and should be supportive, could come to a meeting, should be asked to come to a meeting. Now, if the adult who has mental illness or addiction doesn't want them there, there could be a discussion about that and maybe they would have to leave. But to be invited in the first place, I think, creates an environment for the affected person, that, we're asking these people to come because they love you, they want to support you, and they have been supportive of you in the past. The problem is the word "enabling." And that word is like a hammer that hits the parents over the head. You're enabling them, they should be able to make these decisions, and if they make mistakes, they will learn from their mistakes. Excuse me, they have a brain disorder; they do not learn the way other people learn. If you're talking about a healthy person, you should not enable them. If you're talking about someone with brain disease, the word enabling needs to be redefined so that it says this is supportive; here are the things that you can do that are supportive: paying for treatment, making plans for shelter, helping somebody through the maze of forms and bureaucratic requirements to get a job. These things are difficult for people with brain disease.

MG: This is music to my ears to hear you say this because this is exactly what I think. Our family tried [Al-Anon](#). We were recommended by more than one person in the mental health system. Try Al-Anon. Even though Jim is not an alcoholic; it's other drugs that he abuses. And we went, and yes, it was focused on alcohol, but not totally. The topic of mental illness did not come up. It was all about exactly as you're saying George, not enabling, learning when you can sit back, take care of yourself, don't let yourself get sucked in. That part was helpful in the sense that yes, we weren't taking very good care of ourselves. But, I had to block out everything they were saying if they thought I was going to leave someone with schizophrenia, brain dysfunction, and just let him fend for himself

on the street. I didn't think he would make it, and it didn't seem right. My husband and I, I think we lasted four meetings, maybe. And we just decided that was not for us.

GR: Yeah, well that model, there are some good things about that model, there are a number of other people in that group who are going through the same thing. And you hear their story, and you say, my goodness, that's my story, too. I hear you struggle with how to interact, what kind of a relationship you can maintain with an adult child who gets so angry that you haven't given them money so that they can buy their drug. That's a significant part of your book, the amount of money that is required to maintain a cocaine habit. It's just unbelievable. And if you don't pay that bill, what is the dealer going to do to you? It's incredibly scary. That is a well-done part of the book. But the Al-Anon model is from the '30s. At the time, we didn't understand what craving was, what part of the brain was affected by these drugs. And the tools that we had were, if you have a relationship with a sponsor, every time you have this need to take a drug, call your sponsor, and because that relationship is an important one to you, maybe it will deter you from using the drug. That was it. The model was developed at that time with that as the only tool. We've come a long way from that, but the Al-Anon, [Nar-Anon model](#) continues to use some antiquated ideas. For adolescents, the imposition of "turn your life over to God," for many, doesn't make any sense at all. They are invincible. They're not going to turn anything over to anybody.

MR: No, and at different times, when we were looking — Jim was sent to various treatment programs — and there was one model that he really liked, that didn't involve the 12 steps, but at one time, when he was being encouraged to take the 12 steps, he himself thought he might be God or the devil or maybe both. And so, that really was not a model that he could relate to at all. Well, I would like to pick your brain, George, about some of the things about — you started a little bit with what marijuana can do with the brain. Being a child psychiatrist, could you give us a roadmap of exactly what happens to the brain when young people are developing mental illness or maybe aren't even going to develop it but then, they start using drugs. I know I didn't know about that, as I said, when our children were teenagers.

GR: There is a physical pain and emotional pain and the pain of mental illness, being beset with thoughts, ideas, voices, visual hallucinations. These are not fun things, this is painful. And it all goes through the same circuit in the brain, whether it's physical pain or mental anguish or emotional pain. The thalamus is involved and the limbic system is involved, and the amygdala is involved, such that, you're in a car accident or you're raped, or you're shot at and it's traumatizing every time you hear the sound that's similar to a gunshot. Your stress hormones and the stress response system kicks in. Rape is when you're in

the presence of someone who is acting bossy, aggressive, controlling, the same stress response system kicks in. And so, that is another part of the pathway to the use of drugs and alcohol and other things that affect the amygdala because the amygdala is like the volume on the radio. And once it gets turned up by these traumatic experiences or by mental illness or by other circumstances like toxins, it's very difficult to turn it back down. You have to reset your system so that you're in vigilance, you're attuned to the environment, trying to protect yourself from this stress response system going into overdrive. There's a common pathway here around which the pain of that system, the fear of that system overtaking you and making you feel overwhelmed, there's a couple of solutions; [CBT](#), some new treatments that affect, that can be delivered through electronic stimulation.

MG: Could you tell everybody what CBT stands for?

GR: Cognitive behavioral therapy.

MG: Yes, yes.

GR: Where you work very hard — and there's a lot to it — to use your brain to think about other ways and other solutions other than the one that is right before you. Like, this voice telling me I'm God, and so, if I'm God, then, I ought to be able to do this, this and this. OK. There's another part of your brain that could add a different perspective to that. I know it's going to be very hard to think about a different perspective, but with practice, you can do it. And that's why it's a skill. And you come away from CBT with a skill that offers you alternatives to the pathway that's usually taken in your brain.

MG: Our son has actually had that, and he has really benefited from it. He thinks it's a lot of work, that he can't just trust his perceptions or trust that he heard what my husband or I or any of his friends might have said. He has to do that work to think, is that plausible? Would my mother really say she hated me and wanted me to die. He knows I wouldn't say that. He thought he heard me say that, so he has to stop and think, no, she wouldn't say that. So, then, he can discard that. So, he considers it a lot of work, but, it actually has helped him. Because he does do that work when he's doing well and then, he can move and separate out what is real and what is not.

GR: Yeah, I'm glad. That's a nice, practical description of how it works. So, there are talk therapies like that, there's the antipsychotic medications, the new ones, that have some level of effectiveness. There's one or two that have come out in the past year that purport to not only affect the positive symptoms like hallucinations but the negative symptoms. Your book talks about Jim's lack of interest, lack of motivation, just sitting there and not being able to get going. So, there's one or

two new medications that supposedly have improved that symptom. But that gets us back to the supports that are necessary because motivating people usually happens or can happen in a relationship. When someone knows someone else really well, they can say things like, “You know, you can sit there all day or we can go out and watch the Twins beat the Red Sox. Or the Yankees, which would be better.” That gets them out of the house, otherwise, that becomes their whole life; they just sit there and progress in thinking about these negative ideas and these unrealistic ideas.

MG: That’s one of the things that bothers me about the mental health system. Families are much more apt to do that. And as we’ve already said yet, families aren’t always welcome within the mental health system. But there are case managers, very well-meaning social workers, nurses, doctors, people that work through [\[Community Access for Disability Inclusion\] \(CADI\)](#) waivers to help with things. But often, they are coming to check on medication, see if the apartment is clean, see if there’s too many symptoms, see if he’s making his appointments, getting his paperwork in, helping him with his voluminous amounts of paperwork. But the idea of anybody ensuring that he has friends or gets out of his apartment, and goes to coffee shops, takes walks, those are things that, by and large, are left to families, which is part of the tragedy then, of not involving them. Our son actually, with very little poking, will get up and be so happy if he actually got out in the sunshine and took a walk on a park trail or something. But he just wouldn’t do it himself. Nobody else in the mental health system to speak of — they suggest it — but they don’t actually say, “Come on, I’ll go with you. Let’s go right now.” Because, they don’t have time.

GR: Yes, Mindy, and so, that should be part of a community care plan where the kind of social, recreational supports are made available. Social workers are busy and yes, they are doing their job, which is, manage the paperwork and things like that, find another apartment if necessary, connect the funding to the client. But the real business of living a life is not that. The real business of living a life is the enjoyment of the contacts you have with people who you feel good about being with. That’s a life. Where is that in the plan?

MG: Exactly. And what role do you think illicit drugs play in people’s lives who have mental illnesses who aren’t having those kinds of experiences, so they aren’t feeling happy in those ways. Is there a correlation between drug use and having a life that’s not satisfying?

GR: Absolutely. And here’s how I think it works. People with mental illness become marginalized. So, their access to healthy people decreases; they get narrower and narrower in number of people who are willing to put up with their unusual ideas, their rants and their difficult behaviors. One of the things that

connects them is: Let's use drugs together. It's a party. We're at a party, and so, we're using drugs together. And there are people there who now accept me because I'm using drugs with them. So, that substitutes for real relationships. And your book does a good job of describing situations like that for Jim. And that happened to my daughter. She left Minnesota, went to another state, affiliated with people who were using drugs, and that became her life. And those relationships, they're not real relationships. Those are relationships that connect people only around the use of drugs. When the drugs are not there, they're not friends anymore.

MG: That's exactly what happened with my son. He had a girlfriend who I write about in the book. And once they got into court as a result of all their drug use and some other illegal activities and were told not to use drugs anymore, she mostly kept on doing so. And Jim didn't. And once he stopped, their relationship fell apart. He was able to see that it wasn't a good relationship and broke up with her and thankfully, still is not with her, but that was totally all their relationship was — was using drugs as fast and furiously as they could get them and get the money any way they could to continue using drugs. So, I'm sorry to hear that your daughter had those same experiences.

GR: But Mindy, your book is not talking about one person. It's like every person, every Jim, every Kathleen. It's the same story. It's not just Jim's story. When people read this book, they'll know, this is what happened to my child. This is what happened to my family member. It's the same story. It's not that unique, I'm sorry to say.

MG: Yeah, I'm really sorry to say that, too. I've read other books, and I've found a lot of commonalities. And that was my hope with this book. I did hear the current head of psychiatry at the University of Minnesota say if you've heard one story about a person with mental illness, you've heard one story. I think that's true in a very tight definition, but I think it's more, as you said, there's so many commonalities that we can totally take one person's story and relate it to ours in so many ways. And that was part of my purpose, too, in writing the book.

GR: And the way the mental health system of care deals with individuals is everybody's story, too. Now, the uniqueness of every individual needs to be respected, highlighted, and that's why you need family members who know the uniqueness of their family member. They are not generic people, but their story is a generic story.

MG: Exactly, exactly. So, drugs provide artificial friendships, artificial lives. Are there any treatments that you would care to talk about or highlight that work best for people that have both mental illness and chemical dependency. They

generally say half the people with mental illness have a chemical dependency, and vice versa. And if you count mental illnesses that aren't terribly serious like the kinds that our children have and many other people have, it's probably much higher than that in the correlation. Is there any treatment that really works and how long has it been in coming?

GR: Well, let's start at the very beginning. There's prevention. I had the opportunity to get in with other members of the faculty at the university, a number of grants to prevent adverse outcomes. One of the trajectories that leads to drug use and mental illness is early onset behavioral difficulties. The kid in first, second and third grade who ends up in EBD class, special education because of behavior, not because of learning problems, those kids are at high risk for adverse outcomes, like getting involved in the juvenile justice system or the criminal justice system, using drugs, leaving school prematurely. And there's a lot of environmental issues and genetic issues but there are things that prevention programs can do to allow those kids to have skills so that they can connect with prosocial peers and not get marginalized so that the only peers they have are those that have negative behaviors and so, they start modeling each other's negative behavior. And where is that going to go? We had a project called [Early Risers](#), and there are a number of these that have been developed and sponsored by the federal government. Some of those elements are in our school at this point, social, emotional supports and education. Mindy, remember when we went to: Schools should be only about reading, writing and arithmetic?

MG: I remember those days.

GR: Very basic [ideas] about school and all of the other things were supposed to be managed or somewhere else. Well, if a kid is in school for eight hours, you can't just absent those social emotional skills that are —

MG: No kidding —

GR: — necessary to live your life.

MG: — that's for sure.

GR: So, prevention, it's good to start there. Let's see. Other things that are useful are supports for parents because it's very confusing to have a child who has behaviors that are not typical; how do you manage them, how do you think about them, what's developmental, what's atypical? And I think marriage and family therapists can be very effective in helping parents understand where a kid is at. I remember so vividly a 2-year-old boy after a rain running out and jumping in a puddle. And one parent was getting all over the kid about making a mess and

getting wet and the other parent was very supportive; like, this is what a 2-year-old does, they want to see what a puddle does. I could imagine later in the day those two parents argued about what was the right thing to do?

MG: I'm sure they did.

GR: Yes, and how many parents are experts in child development to know that was such a need for that child to jump in that water.

MG: Yes.

GR: So, I think adding a developmental flavor to family therapy is a very good approach.

MG: I know I would've loved to know more about what is normal teenage behavior. When Jim was getting sick — as I said, he started using drugs in ninth grade — we began to finally tumble to the fact that he was using drugs. But mental illness never caught our attention or came up even though my grandmother who I write about in the book had schizophrenia. She didn't use drugs, I never knew her when she was a teenager. What is normal behavior versus what is teenage behavior with drugs, and then, to pile on top of that, what is teenage behavior with drugs and with budding mental illness? I think that's just too much for any parent to be able to separate.

GR: Yeah, it's not easy for a professional. I mean, in adolescence, the brain is being reworked, there's new connections. The behaviors, as a consequence, are pretty unusual. Why you said something that yesterday was accepted but today, you get snapped at. What's that about? Unfortunately, the teenager doesn't have a better perspective than anybody else about why that happened. It's just: "You were irritating me." "But I only said this." "But that was irritating." "Why is that irritating?" "Why are you asking me so many questions?"

MG: Yeah, very, very hard. In the adult system, I don't think it's figured out yet. Because, it seems like there's very few places that Jim could go — he's now, as I said, doing well, we thank the Lord for that — even the last time he was needing to go to treatment after a stay in the psych ward for his mental illness and chemical use, there are very few places it seems that treat both. They often want the mental illness taken care of first, and then, they'll deal with the chemical dependency or vice versa. Why do you think that is?

GR: Well, these two forms of brain disease grew up in different places. Those silos never got connected. The federal government made an effort to connect them and wanted places that were delivering mental health care to also have care

for chemical health problems. The worlds are so different. The chemical health orientation is: Why are you doing this, confrontation. And as the person is describing their addictive behaviors, people are jumping all over them, to tell them, “You’re making all of these mistakes, and you’re not being realistic about your chemical health issues.” The mental health system came from: “Let’s understand this, let’s talk about this, tell me about your feelings.” It’s not confrontive, so from the very beginning, you have two different models of care. One thinks about a medical model and medications, and the other one thinks about confrontation and tough love. It’s one of those, just buck up, be a man, tough love. They don’t mix. It’s oil and water. It doesn’t mix very well. Now, the chemical health group, like with [Hazelden](#), has come a long way, much more consistent with what we understand about the brain. But other systems haven’t changed very much even if the federal government has said you need to both of these things at the same time. Because the level of comorbidity is so high for these; people with addiction have mental illness, and people with mental illness will develop addiction at a very high rate. So, it’s not two silos. These are behaviors and for some of these behaviors, we’re very critical and judgmental. For other behaviors, if somebody is crying and they’re depressed, we’re so sympathetic to that person. Well, that’s a brain disease, and it has certain kinds of behavioral characteristics and why we want to be so kind to one and so nasty to another — I think we need a cultural rethinking of how we behave towards people. One other thing, before I forget, when you were talking about Jim going from hospital to a treatment center, it reminds me of the fact that when you say that we have a mental health system of care, what we really have is a set of procedures. When you finish this, the procedure is, you go there. When you finish that, the procedure is, you go there. It’s a set of procedures. To say it’s a system and use the word “care,” it’s a bureaucratic system of transitions around which people are funneled from one place to another.

MG: Yes, and in my book, as you know, one time that happened to Jim for 19 months. This place, then, that place, then, that place, then, that place. It was hard to keep up with where he even was. Because all those places tend to be three months or less, 90 days. It’s all connected to how they’re funded. And once the funding is done, it doesn’t matter what stage the person is in, in terms of their mental health or their chemical dependency; they need to be moved on to somewhere else where nobody knows them, either. It’s really not a good system.

GR: You’re exactly right, procedures around transition. You say this so clearly. Why can’t we just see what they need and give them what they need? It’s so obvious.

MG: I know it. Now, that leads into another sticky wicket question that we’ve had a lot of trouble with, with Jim at different times when he’s not doing well

especially, or every Jim as you say, what do we do about people who don't agree to be helped? If they have brain dysfunction, there's nothing the matter with me, I don't have a mental illness, I can handle my substances that I'm using and I'm not going to cooperate and you can't make me. What do we do about that? Obviously, there's civil commitment for the very, very high level people that are dangerous to themselves or others. But what about everybody else if they won't agree to be helped?

GR: Mindy, you're defining the use of the commitment act only when it bothers other people. When, I'm upset because this person is bothering me, he is a danger to me, or he appears to be a danger to himself; and that's going to be really messy so, let's not have that. But it's the same brain disease at the lesser level of bother as well. They're not making these good decisions. I don't understand why I can't just go to a judge and say, "My daughter has been diagnosed with such-and-such; she's having these behaviors and she's refusing to do things in her best interest. I may not know exactly what her best interest is, but I know it better than anyone else. Why don't you empower me to make these decisions for her? Because this is what will happen, because it happened the last time: The things that happened in their apartment caused them to be kicked out of their apartment and to become homeless. She's not going to be homeless now but she will, eventually. Can we do something now before it's danger to self and others?" I don't understand why I can't just say, "It's brain disease, stupid."

MG: That's what we feel like saying to people, I can tell you that. Well, I'm a big proponent, advocate of assisted outpatient treatment. All of us, like you and me and so many others who are parents of children who have such struggles in life know that that is the right thing to do and we know that there's the other side, where patients rights groups argue for people to have the right to choose. But to me, I see it so clearly. They're not talking about someone as ill as our children. The idea that we want someone to have the right to die because of their substance abuse, or through some other suicide attempt, or to, in the case of our son, as you know, to jump off a building and break his back, those are things that can be prevented. And it seems like if we would stop and think carefully about the people who need help, there would be more talking about assisted outpatient treatment. Instead, most elected officials, and I know this well, having been one, don't want to run afoul of the [American Civil Liberties Union](#) or groups like that, that do so much good in so many areas but are so wrong about this one.

GR: I see it a little differently. They hide their nihilism about effective intervention behind the term, they have their right; they have the right to do bad things to themselves? Why is our society at the point of saying, they have the right to do bad things to themselves? Should I be respectful? Yes, should you be respectful? Yes. Do I believe in the dignity of a human being? Yes, and that's why,

I think, I need to intervene rather than throw up my hands and say, they have the right to do that. That's nihilism; that's not intervention.

MG: Well, you'll get no argument from me. We've had a wonderful conversation and we've covered so many things, and I'm so very honored and pleased, George, that you have spent all this time discussing these important issues of mental illness and substance abuse with me. And talking about our children and the scores of people that they represent and their families like us. I just want to close, I always like to end if I'm ever talking about mental illness, on a more hopeful note. So, if you had anything you'd more you'd like to add, feel free to add it in here now, but the closing question that I'd like us to discuss is, is there hope for the mental health system and especially those who also have substance issues that we're talking about today. What can we hang onto to think things are going to better?

GR: I've got things to say about that, too. I want to say, thank you for inviting me to do this, I didn't realize this would happen, but it was cathartic; it was healing. To be able to talk to you, Mindy, about these things in this personal way, I'm just so thankful for this opportunity. I am hopeful. Young people are seeing the world very differently than we are. [Black Lives Matter](#) may be all about systemic racism, but it's about a lot of other things that are like that. The way that addicts are treated is horrendous, is horrible, is inhumane. Letting people live on the street because they have mental illness is inhumane. I think young people are saying this is not right, we have to be respectful, we cannot allow people to be treated badly, everybody; we're all human beings; human beings matter. I think there's a cultural revolution going on that I hope also touches mental illness and chemical illness. When you talk to young people, they seem to have it right. That is my biggest hope. I'm old. I'm leaving this planet in the hands of some people who are advocates and just have a belief in the human race that, for many older people, they have entrenched themselves in ideas that are not helpful. That's my biggest hope.

MG: Well, I can piggyback on that and say me, too. Because writing my whole book was cathartic for me. I didn't think it would be when I started writing. I was just joining a writing group at [The Loft \[Literary Center\]](#) and I actually didn't write about mental illness for the first couple of turns I had. But once I started, I could see that was the story I was meant to write and it was very cathartic. And my hope for the future is the same as yours. And that's the young people. I have a granddaughter who is 16 years old, and she and her friends freely discuss mental illness. One of her friends that she's known since they were toddlers was struggling with depression or some sort of illness — I never caught the diagnoses — but he was missing a lot of school. He's a brilliant kid but he wasn't doing his homework and doing well. She kind of helped him through it; his mother found

him a psychiatrist. He had the support not only of his mental health staff and his family — he had the support of his friends, which, I don't think happened even when 20 years ago when Jim was getting sick. I know it didn't happen, and it's happening today. So, I think that's the hope for the future, too, the young people. So, on that note, I think it's a good spot to end unless you have any parting words, George.

GR: Yes, thank you very much, Mindy. Thank you for writing this book. Should we have put this book on every legislator's lap?

MG: I think we should.

GR: I agree.

MG: Thank you so much, and I look forward to talking with you again in the future. You're such a star of a psychiatrist and a person and a friend, so thank you.

GR: Thank you. Bye, bye.

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