
MESSAGE FROM THE PRESIDENT

Dear Members,

July! It's hard to believe that the first half of 2014 is already behind us. As your new president, I've spent much of the last six months getting my sea legs. Luckily for me, I have a great crew.

What makes NAMI is its people. We've grown considerably since that early conception in 1979 when a few concerned parents got together and formed an alliance, but our hearts are all the same. Since then, definite inroads have been constructed, but there is much work still to be done: better education about mental illness in our schools and communities, continuity of care, smoother referral systems, increased number of inpatient beds and effective community based services, larger numbers of quality psychiatric providers, restructuring HIPAA laws so that families can be more involved in care, increasing the number of trained law enforcement officers, forming a justice system that is better equipped to deal with mentally ill individuals, decreasing stigma by increasing community outreach. This list is incomplete. It may seem insurmountable. But it isn't. NAMI Syracuse and its members are slowly carving the way to addressing each of these key issues.

If you are getting this newsletter then you are a part of our continuing efforts. Thank you.

Please help us reach our goals by joining us for two upcoming events. On Friday, July 25th we are doing a fundraiser at UNO Pizzeria & Grill in Liverpool. UNO is donating up to 20% of your check to NAMI Syracuse. Just grab the "Dough Rai\$er Donation Tickets" included in this newsletter and bring your family and friends to UNO! Our board members will be there with info, door prizes, and thank you's! More information can also be found on our website: www.nami-syracuse.org. I also hope to see you all at the annual NAMI Syracuse picnic on August 16th. This is always a great time with lots of food, swimming, and fun! See the details on page 3.

Together we can make a difference. Let's all work to make 2014 a year to remember!

~~Karen

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Memo to NAMI Syracuse Members

Thank you to everyone who has renewed your NAMI Syracuse membership for 2014 and welcome to our new members!

A reminder to those who haven't as yet renewed: WE NEED YOU! Please renew today! If you're not sure if your dues are current, call or e-mail the NAMI Syracuse office and we will check your membership status. Thank you!

\$35.00 Individual/Family Dues

\$ 3.00 Open Door Membership

(for those where dues present a hardship)

Save the Date! Tuesday, October 7, 2014

NAMI Syracuse Educational Conference Crucial Conversations!

9am - 3pm, Rosamond Gifford Zoo, Syracuse

~~presenters~~

Professor Stephen Kuusisto, *We're All In This Together*

Dr. Abdul Ahmed, *Shared Decision Making*

Dr. Rich O'Neill, *Caring for the Caregiver*

Sheila Le Gacy, William Dee, Jennifer Hardwich, *Local Efforts to Work with Police Department Crisis Intervention Team*

NAMI Syracuse Annual Picnic!

Saturday, August 16, 2014

1:00pm

*at the home of Judy & Joe Ridgway
2503 West Genesee Street, Syracuse*

**hot dog and hamburgers provided by NAMI
please bring dish and/or dessert to pass
beverage
bathing suit, towel, if you want to swim**



A Lovely Picnic with Friends

*Oh what a lovely day it was
The weather warm and sweet
Packed with friends we cherish
No better folks could you meet*

*We barbecued dogs on the grill
Out in the bright sunshine
Enjoying the open sky to eat
A meal that was truly fine*

*Burgers too were grilled just right
Topped with onions and stuff
Just simple tasty scrumptious food
Without a lot of unnecessary fluff*

*Deviled eggs so perfectly made
With a sprinkle of paprika on top
A delicious blend of flavors
That really truly hit the spot*

*It was a day we will remember
Good food, good friends together
Can't ask for a more relaxing time
With the gift of perfect weather!*

~by Marilyn Lott

Please let us know that you plan on coming!

**Call 487-2085 or e-mail:
namisyracuse@namisyracuse.org**



CIGARETTE SMOKING "COULD MAKE YOU PSYCHOTIC"

Experts at the Institute of Psychiatry in London are publishing research suggesting that smoking cigarettes may be a contributory cause of schizophrenia (a psychotic disorder). This startling finding includes a just published study, plus research to be published in the near future, all of which appears to suggest an association between smoking cigarettes and developing psychosis.

These new findings raise a question - could the most obvious fact about cannabis - that it is usually consumed in combination with tobacco - have been neglected in researching the link between cannabis and psychosis?

In the new study just published, 'Cigarette smoking and cannabis use are equally strongly associated with psychotic-like experiences: a cross-sectional study in 1929 young adults', smoking tobacco was found to be an equally strong predictor of frequency of psychotic experiences as monthly cannabis use.

This latest investigation from researchers at University Medical Centre Utrecht, The Netherlands, and the Institute of Psychiatry, London, was partly inspired by the well-known observation that majority (as much as 70-85%) of patients with schizophrenia smoke cigarettes.

Within academic medicine the association between cannabis use and psychotic symptoms is firmly established.

Some have argued those who begin to experience psychosis initiate using cannabis in attempts to 'self-medicate' distress, but this suggestion has been rebuffed by a host of surveys, according to Sir Robin Murray - Professor of Psychiatry at the Institute of Psychiatry in London. Sir Robin Murray is involved in forthcoming research which will further strengthen the evidence smoking cigarettes may well be a contributory cause of schizophrenia.

Cannabis contains many chemicals, some of which may have psychosis-inducing effects, while one may even have anti-psychotic properties. Research is currently underway in various phar-

maceutical laboratories isolating the active anti-psychotic ingredients in order to deploy them in treatments for psychosis.

The authors of this new study van Gastel, MacCabe, Schubart, Vreeker, Tempelaar, Kahn and Boks point out that previous research has found nicotine dependency is associated with psychotic symptoms. The more you smoked when young the more likely you are to develop psychotic symptoms later in life. Other research has independently established an association between cigarette smoking and psychosis.

The authors of this new study, just published in the journal *Psychological Medicine*, conclude it might be that individuals who are already prone to Psychotic Experiences are also more inclined to smoke cigarettes and use cannabis. They caution that heavy use of cannabis leads to additionally increased psychosis proneness. The study found that moving from monthly use of cannabis to weekly, was associated with a stronger link between cannabis and Psychotic Experiences.

To explain this startling finding, that in a large sample of young adults aged 18 to 30 years, cigarette smoking was as strongly associated as cannabis use with frequency of Psychotic Experiences, might involve a new understanding of how tobacco effects the brain.

The authors suggest that smoking profoundly effects the nervous system - which is why it's pleasurable. The chemical nerve transmitters cigarette smoking increases the levels of, including the neurotransmitter dopamine, are not just linked with feelings of reward but also psychosis. A more remote possibility, the authors suggest, is that Psychotic Experiences could be the result of nicotine withdrawal.

This most recent research was partly inspired by a study entitled 'A prospective study of smoking in young women and risk of later psychiatric hospitalization', published in the *Nordic Journal of Psychiatry*.

Researchers in Copenhagen followed 7,926 young women from 1959 to 2007, and found significant positive associations between number of cigarettes smoked and schizophrenia-like disorders, substance abuse and other non-psychotic disorders. A total of 1,301 of these women were admitted to a hospital for psychiatric reasons, and a strong positive association between number of cigarettes smoked and being

admitted for a psychiatric disorder was found.

The authors of the study, Holger Sorensen, Erik Mortensen, June Reinisch and Sarnoff Mednick conclude that as the relationships between amount of cigarettes smoked in 1959 - 61, and increased risk of psychiatric hospitalization later in life, were similar for almost all the major categories of mental illness, it's possible there is a non-specific association between smoking and mental illness.

But smoking might be even more dangerous for your mental than that, as a study published in the *American Journal of Psychiatry*, entitled 'Higher Rates of Cigarette Smoking in Male Adolescents Before the Onset of Schizophrenia: A Historical-Propective Cohort Study' suggests.

This study used the fact that each year, a random sample of male Israeli military recruits, who have been screened and found not to be suffering from major mental illness, complete a smoking questionnaire. Through the Israeli National Psychiatric Hospitalization Case Registry, 14,248 of these adolescents were followed to determine later psychiatric hospitalization.

Compared to non-smokers, adolescents who smoked 10 cigarettes/day or more were over twice as likely to be hospitalized later for schizophrenia.

The authors go on to argue that if smoking tobacco is in some way causing schizophrenia, then the reduction in incidence of schizophrenia that would be observed if no one smoked, would be very high, probably 23%.

It's possible that you need a combination of the 'wrong' genes plus the risk activity (like smoking cannabis or tobacco) in order to generate psychotic illness.

But smoking tobacco or cannabis heavily, remains an activity most doctors would warn against as bad for your physical and mental health.

If smoking cigarettes is established as a significant risk factor for future psychosis, then should cigarette packet warnings include the new threats now uncovered to your mental health? If we are not going to be legally tougher on tobacco, in order to retain consistency, does this new research mean the law should now become more liberal on cannabis?

ESSAY ABOUT MY STRUGGLE WITH DEPRESSION

by Liz Droge-Young

I do not harbor any illusions that the internet denizens are clamoring to hear my quippy quips, see my humorous gifs, or pour over my shared articles from Wired, but for anyone who is curious about the reason underlying my current absence, in the actual and e-world, I've been struggling - what an oh, so apt word - with depression.

When I say I'm struggling with depression, I don't mean "Oh, man! They stopped carrying my favorite nail polish color. I am sooooo depressed." I mean, virtually every aspect of my life has been slowly torn apart over the past two and a half months. There is no hyperbole in that statement.

I have dealt with depression on and off since Spring 2012, sometimes with grace while staring down pain and isolation, or more recently being entirely consumed by intolerable fear and desperation. Those feelings lead to panic, to surrender, and at times cause me to physically harm myself. More seriously, those feelings also temporarily convince me that all of the beautiful things I have experienced in my life, and may potentially experience in the future, are not worth the soul-wrenching loneliness and helplessness I so acutely experience. They convince me that there is only one resolution - to end my life immediately. Now is the critical time to mention: despite these frustratingly frequent impulses, I am safe. It is remarkably hard to internalize feelings of safety and love, but through incredibly open and honest communication with my immediate support network, I am no longer physically alone when these feelings hit, and as difficult as it is to emotionally grasp, I am continually plied with affection and support.

Let me tell you what this depression is not: it is not feeling down due to reduced hours of sunlight under the "gothic skies of Syracuse", as Joyce Carol Oates described our local meteorological features. It is not being overwhelmed with grad school; when I am able to love things, I love my science more than

nearly anything in this world. It is not an immature cry for attention. It is not to be solved by yoga, camomile tea, reading self-help books, or contemplating the infinite mystery of nature when standing alone in a meadow at dusk.

It is an imbalance of neurotransmitters. It is a horrid gene by environment interaction. It is clinical depression. Above all else: it is real. It is unendingly frustrating that these feelings all come from me. From my head. The enemy resides entirely within; I conjured these feelings and am now made to constantly struggle with them.

In a cruel twist of fate, depression is shockingly common, yet although the stigma of mental illness continues to lessen, depression is also strongly isolating. I didn't realize that friends and even immediate family members had suffered from situational (i.e., life is bad) or clinical (i.e., I am bad) depression until I began, ever so slowly, to reach out. I avoided seeking help for myriad reasons: remarkably strong denial that depression was a serious and potentially life-threatening condition, the unfounded notion that I could manage all problems myself, and not least of all, a fear of the perceived stigma accompanying a diagnosis of depression. If this is ever you: you are not alone and I can confidently surmise that remarkably successful people in your chosen field have also dealt with and overcome depression. In talking to people about their experiences with depression, one of the biggest regrets I hear is that it took so long to ask for help, as well as the initial and sometimes pervading reluctance to communicate this perceived weakness to loved ones. As I continue this journey to disassemble old, injurious habits, and reassemble a sustainable way of relating to myself and my life, I feel these regrets too. In a large part, pervading silence is why I write this note.

I am by no means "better", but some days it seems possible that "better" exists. Until then, I try to listen to myself and what I really need. I work on saying no. I seek love and support even though it invariably leaks through me as though I were made of mesh. I struggle with just being and letting time pass. Letting neurotransmitter levels stabilize with the aid of next-generation antidepressants. Letting therapy help me

see how I can live in my own skin. I voraciously consume zombie movies, television shows, and video games (I have a pretty robust zombie / depression metaphor that helps me get through the less-sensical days). I make jokes about suicide and depression - both because I feel I've earned the right and also because I think I would explode if I couldn't laugh. I create entirely inappropriate ornaments, frost inappropriate cookies, and rebelliously draw on my arms to counter impulses of self destruction. I play with the arbitrariness of social norms when I'm feeling well and try my damndest to Just. Stay. Still. in my worst moments.

It would be a lie to say I have faith that I will make it through this, but I have an amazing support system that trusts that I will. And on the good days, that's enough.

Syracuse VA Behavioral Health Family Support & Education

Providing the best care is a priority at the Syracuse VA. To do this we deliver evidence-based programs and collaborate with local and national partners to deliver best practices within the field. These family programs include: The NAMI Family to Family Program, NAMI Home Front Program, SAFE Family Program, Military Child Education Coalition, collaboration project for parenting support, and evidence-based couple's and family therapy.

NAMI Home Front is a free 6 week consecutive Family Support & Education Group run in collaboration with the National Alliance on Mental Illness (NAMI Syracuse), for family members of Veterans living with mental health issues and concerns. This class will focus on Veteran culture and the "new normal".

Class begins August 20th, 6-8:30pm at the Syracuse VA Behavioral Health Outpatient Center, 620 Erie Boulevard West, Syracuse, 13204

For this class or more information on any of the other programs, call **Ann Canastra, Local Recovery Coordinator at 315-425-4400x52717.**

FROM SELF-CARE TO COLLECTIVE CARING

Mad in America, Leah Harris, 6/16/14

As a trauma survivor growing up in various adolescent mental health systems, I was taught that my current coping skills (self-injury, suicidal behavior, illicit drug use) were unacceptable, but not given any ideas as to what to replace them with. No one seemed to want to know much about the early childhood traumas that were driving these behaviors. Instead, I collected an assortment of diagnoses. I was told that I would be forever dependent on mediated relationships with professionals, and an ever-changing combination of pills. The message was that my troubles were chemical in nature and largely beyond my control.

It took many years for me to overthrow that painful legacy, and come to learn that I could take responsibility for my own well-being. After escaping from the mental health system at 25, I attempted to “prove my worth” through overwork and nonstop activism to change the system. In my late twenties, I was headed for a heavy dose of burnout. I couldn’t get out of bed. I was wracked with physical pain and I was deeply depressed. I felt myself heading into a crisis. Overwork was no longer working.

For some reason, I picked up an audiobook by Thich Nhat Hanh called **Creating True Peace**. That was what got me on a path of mindfulness. I toned down my activist work, and threw myself into wellness instead - signing up for every retreat and every class. I was on a mission to heal myself, reading every book I could find about meditation and holistic health. I signed up for acupuncture, because thankfully I had insurance and it would cover it. I took my acupuncturist’s advice and changed my diet to be in accordance with my blood type. I was doing all my wellness practices. And I sometimes felt guilty and self-indulgent for needing so very much care just to function.

Then I had a baby, and soon thereafter became a single parent. I tried my best to keep up with my wellness practices, but they went out the window when I was

faced with the demands of raising a baby all alone, as well as being on the verge of losing my house. Self care became a luxury that I could in no way afford. I was exhorted to “meditate for 5 minutes,” but even that felt out of my reach. I had no family nearby to help, and my friends were all themselves single parents just struggling to get through each day. Again, crisis loomed.

I instinctively knew that what I needed was not another self-care practice, but another person. I reached out to a friend, who also happens to be a gifted healer. She came right over to my house and asked me what I needed in that moment. It was such a relief, to have some practical help, someone in my corner. I fell into the comfort of her supportive presence. She helped me to tend to my immediate needs for sleep and help with childcare, and I was able to move past the crushing emotional distress into a place of being able to function again, parent my kid, and hang on to our home.

Today, the “balance” that we are all supposed to achieve still eludes me. I believe we can and should all find a unique mix of tools to care for ourselves, but I can’t, in good conscience, retreat into a “wellness bubble.” I can’t meditate or chant away the stories of oppression in mental health systems that people email to me every day. I have come to realize that the best form of self-care for me is to engage, not to retreat. I fit in meditation where I can, and wellness practices where I can. But I don’t feel at all guilty any more for consistently falling short in my personal wellness or taking less than stellar care of myself.

“The importance of prioritizing reciprocal care becomes even clearer when we understand that our stresses and traumas are a common plight and not individual pathologies. As human animals, we are living in environments that cause emotional and physiological incoherence. While we may not be able to eradicate the systems that imprison us immediately, we stand a far better chance if we don’t get tricked into thinking our struggles or the solutions to them are individual. The more ways we find to act in honesty with each other, whether in sorrow or in excitement, the stronger and more resilient we become-individually and collectively.”

Self as Other: Reflections on Self-Care

The problem with both the illness and the wellness paradigms are that they are deeply rooted in individualism. That the disease is rooted in the individual, and the individual is the one who needs to figure out how to function in society. While all along the status quo changes little.

In America, illness and wellness are almost always depoliticized and decontextualized. Depression ceases to be an understandable reaction to our dehumanizing way of life, and instead becomes a brain disease. People of privilege feel guilty for being depressed when they “have it all,” but miss the point that regardless of privilege, none of us are immune to the distress caused by our increasingly isolated and self-centered modes of being. None of us are immune to violence, abuse, and crushing hopelessness. This is why people who were said to have “had it all” still kill themselves in alarming numbers.

In society, we have a dichotomized response to distress. Suck it up and adjust to what is, or be put somewhere where you will be made to adjust. It is possible to be so focused on individual wellness that we forget the equally important need to work for collective wellness and social justice. In an ideal world, we are taking care of ourselves, one other, and working collectively to change the way things are. The Buddha himself was a social justice activist; he didn’t see any distinction between individual evolution and social change. Today, what most interests me much more than myself is changing the nature of our culture. Focusing on a vision for social change gives me energy and hope to go on.

I have been thinking about alternative conceptions of what it means to care. These would be based on seeing that we as individuals are inextricably connected with the whole. The “burden of healing” would be spread around, rather than placed squarely on each of our individual shoulders. This supposition would prioritize “co-caring” for and with one another, while simultaneously trying to change the dehumanizing aspects of our world. We would see that we are all much more alike than we are different: all wearing masks, all trying so desperately hard to hide our vulnerability and soldier on.

For several years, I have been part of a single moms’ support network. This has

nothing to do with “mental health,” (though many of the moms have struggled with deep distress at times) and everything to do with reciprocal care. We do everything from sharing words of encouragement in tough times; to sharing childcare; to having clothing swaps; to providing information and community resources; to having community pot-lucks; to bringing meals during illness or tragedy; to lending suits for job interviews; to organizing Moms’ Nights Out (MNOs) so we can let off some steam without the kids around. Levels of activity rise and fall according to the collective need. All are welcome. We are a family of sorts, created out of necessity. This costs no money, and it’s a huge benefit for us all.

These kinds of support networks could be beneficial for other groups as well. Students could form them on campuses to help with the stresses of campus life. Teachers could form them to deal with the challenges of being educators. Neighbors could form them in their neighborhoods to provide practical support and address community needs. All it takes is a few people who want to break down the isolation, loneliness, and overwhelm they see all around them. I know there are many pockets of communities like this scattered around the country, but we are in need so much more.

I want people everywhere to have access to the kind of support that doesn’t require a diagnosis or insurance or an appointment. I believe if we knew how much power we, everyday people, had to care with each other, many of these oppressive systems we have set up to care for us, would crumble. We wouldn’t have to resort to them anymore, because we would have what we need, close to home.

For too long we as a society have outsourced “care,” and it hasn’t worked all that well. Everyone admits the systems are broken. It’s time to re-imagine what care means in an uncaring world. Our current way of life is not sustainable. It’s up to us to make a different kind of world real.

HUTCHINGS PSYCHIATRIC CENTER EARLY INTERVENTION PROGRAM

Adolescence and young adulthood are periods of hope and optimism. They also mark the beginning of transition from dependence on the family to independent adulthood. Coping with a new psychotic illness while navigating into adulthood can be distressing often leading to despair and hopelessness. However, this phase of life also brings a resilience that provides a unique opportunity to intervene and minimize the consequence of psychotic illness.

Vision: To provide hope, stability and recovery for those afflicted with psychosis.

Mission: To address the unique needs of teens and young adults with psychosis through early intervention to reduce disability, improve functioning and facilitate recovery, thereby allowing one’s full potential to be realized.

Goals:

1. Early recognition followed by age and developmentally appropriate interventions.
2. Intensive treatment to assist individuals in resuming a developmentally appropriate and meaningful life path.
3. Holistic approach encompassing important areas for young adults, including social needs, education and vocational training.

Target Population: Individuals between the ages of 15-30 and within the first year of onset of psychosis.

Treatment Activities:

1. Actively engage the individual and family.
2. Ensure continuity in treatment providers/team to facilitate healthy trusting relationships.
3. Shared Decision-Making (SDM) with the individual taking active role in recovery.
4. Intensive treatment that could include the following:

- Cognitive Behavior Therapy
- Cognitive Remediation
- Integrated Substance Abuse Treatment

- Medication Management
 - Educational and Vocational Support through individual and group processes
 - Recovery Coaching and Skills Training
 - Peer Support through individual mentoring and groups
 - Family support and education.
5. 24-hour access to support.
 6. Opportunities to participate in new research.

For more information please contact Team Leader, Julie Aspenleiter, Psy.D at 315-426-7704.

“SEE ME!” Art & Poetry Show

For those of you who weren’t able to attend the reception, there’s still an opportunity to view the NAMI Syracuse Art Show, “SEE ME!”

The gallery is closed during the month of July; but, will re-open August 1st.

Poetry, paintings and photography will be on display from August 1st through August 15th.

**Community Folk Art Center
805 East Genesee Street
Syracuse, NY 13210
(315)422-2230**

**Gallery hours:
Tuesday-Friday, 10am-5pm
Saturday, 11am - 5pm**

A great opportunity to support our talented family members and families.

Many thanks to Community Folk Art Center for their support and donation of their beautiful space for this event.

HOPE IS A HEALER

by Jerry Malugeon

Some of the world's pre-eminent health care facilities and research centers have been studying the science of hope for some years now. The results of these studies have been extraordinarily encouraging. Simply stated, there is mounting evidence that hope promotes healing and recovery in a number of ways. Here are just a few of them:

Hope strengthens our courage to face our circumstances.

It inspires confidence and sustains us.

We develop positive expectations.

Our life satisfaction increases.

It centers our focus on our progress (rather than on complete success).

When hope is viewed with genuine feelings and a belief that healing is occurring, then, the studies reveal, it becomes an authentic tool of recovery that can produce benefits such as these:

Less anxiety and depression.

Healthier choices.

Improved self-control.

More closely followed physician and treatment recommendations.

More adaptive and effective problem solving.

Increased positive relationships.

Greater self-support while needing less assistance.

To prevent someone with a brain illness from slipping into the danger of losing his or her future, dedicated and committed companions, family members or caregivers can help their loved ones stay hopeful. By cooperatively working together, they and their loved ones should always understand, remember and support these principles:

A hopeful attitude makes a large and significant difference.

Hope is as necessary as any treatment.

Positive, healing expectations are important triggers that release helpful natural brain chemicals that promote healing.

Hope is based in science. Hopeful, positive people get better faster, recover more, and relapse less.

With hope, your loved one can have control over his or her illness, and their illness need never have control over them.

OMEGA 3 FISH OIL HELPS REDUCE INFLAMMATION INVOLVED WITH HEART DISEASE AND MENTAL ILLNESS AS WELL AS OTHER ILLNESSES

More and more evidence is showing that long-chain omega-3 fatty acids, found in cold-water fish can be beneficial in reducing the risk of heart disease by reducing inflammation. The same can be said for people with inflammation of the brain or any other part of the body. For example, young people who started taking fish oil before being diagnosed with schizophrenia show less brain damage. Omega-3 supplementation also helps reduce the risk of suicide in bipolar disorder. (Both of these examples were recently reported in NAMI Syracuse newsletters.)

The best explanation for the mechanisms involved with inflammation can be heard in a Ted Talk by Dr. Stephen Ilardi titled **Depression is a Disease of Civilization**. (1) (His speech can be "Googled" on the internet.) He states that inflammation of the brain and other parts of the body can cause damage that can lead to diabetes, atherosclerosis, allergies, obesity, cancer and especially depression.

Our industrialized modern world has led to isolation and increased stress. One important factor is our radically changed environment especially over the last 200 years. As a species, we have evolved as hunter-gatherers over the last 1.8 million years which represents greater than 99% of our existence. Some genetic selection has occurred over the last 10-12,000 years, but there has been only about 8 generations in the recent past 200 years. This has not been enough time to adapt to modern industrialized life.

Over the last several hundred years humans have become increasingly dependent on grains for the vast majority of our diet, which includes grain feed meat. These grains, including the processed fast foods, contain mostly omega-6 fatty acids which are inflammatory.

Omega-3 fatty acids are also essential and are especially beneficial as anti-inflammatory. The problem is that

humans evolved as hunter-gathers where the ratio of omega-6 to omega-3 was in balance at a ratio of 1:1 or 2:1. Today the ratio is closer to 17:1 in favor of inflammation.

Dr. Ilardi recommends supplementing with omega-3 fish oil to increase our ability to reduce inflammation and thus reduce depression. The anti-depressant dose he suggests is between 1,000-2,000 mg/day with a concentration of EPA/DHA omega-3's.

Dr. Steven Masley in his recent book entitled **The 30-Day Heart Tune-Up** (2) recommends taking 600 to 1,200 mg of EPA and DHA omega-3 fish oils to lower the inflammation marker hs-CPR by up to 40%. He also warns to get high-quality fish oil since there are no adequate standards in the USA. Better standards are held in Europe including products from Norway. Be sure there is no rancid taste to the fish oil. Liquids can't hide the spoiled taste, but the capsules can be tested by piercing and tasting one capsule. Return any rancid bottle back to the store. Dr. Masley also has alternately suggested choosing seafood including eating sardines 4 or 5 times a week for the omega-3's and a good protein meal as well.

Studies have shown that societies that depend primarily on fish for their diets have much less bipolar disorder than the rest of the world. All this information points to the inflammatory processes to be key or at least contributing to brain, heart and other illnesses. Dr. Ilardi also adds other lifestyle changes that help combat depression including getting sunlight, outdoor exercise, healthy sleep, anti-ruminative activity and maintaining social connection. This is all good advice for recovery and maintaining a balanced life.

(1)Dr. Stephen Ilardi **Depression is a Disease of Civilization**, a Ted x talk (x= independently organized), May 23, 2013.

(2)Dr. Steven Masley, **The 30-Day Heart Tune-Up**, c-2014. pp. 105, 200-207.

~~Review submitted by NAMI Syracuse member, Susan Hutko

**ON THE FRONT LINES OF
MENTAL HEALTH: "IF YOU'RE
MENTALLY ILL IN AMERICA,
YOU ARE **** OUTTA LUCK"**

*The Guardian, Ruth Spencer and
Amanda Holpuch, May 30, 2014*

As part of the Guardian's ongoing investigation into American mental health care, we asked you to help us illustrate the effects of the lack of access to mental health treatment. We received an overwhelming response.

We're publishing five stories that show the personal and material cost that the families and friends of the mentally ill must take on when caring for a loved one.

'My mother texts me every day to make sure I'm still alive'

I'm a junior at ASU studying Film-making and Fine Art, and I'm living with Bipolar Disorder Type Two Rapid Cycling. I see a psychiatrist and psychotherapist on a weekly basis; these appointments are an indispensable part of my treatment. My medications are constantly being adjusted to find a balance, and psychotherapy brings me awareness of the patterns of my illness. Medication and professionals, however, make up only half the arsenal to combat my illness. My family and friends are my greatest allies. They revitalize me from the eerie brokenness of depression, and effectively keep me grounded in the electric-fury of hypomania.

I've been diagnosed and seeing healthcare professionals for over 18 months now. My father is a police officer and receives great healthcare benefits. I'm still on his insurance plan and he covers the co-payments of the doctor's visits.

The monthly cost of seeing both of my doctors once a week, is about \$400. Additionally medication costs about \$30 a month. That's nearly \$8,000 for 18 months. Plus, \$350 for a 10-day hospital stay after a suicide attempt.

Before I was diagnosed or received any sort of treatment I was dysfunctional, indifferent towards my future, suicidal, self-destructive, self-medicating, perpetually moody, agitated, and I increasingly isolated myself from soci-

ety. Medical treatment provided me the capacity to counter my illness, my family and friends became the excuse I constantly told myself to keep fighting the affliction. I'm very convinced that I wouldn't be alive today if it wasn't for others looking out for me and showing kindness.

I try not to think of myself as a burden on other people, although I'm sure it's true to an extent.

I've cost my parents a small fortune, and I've seen it affect them financially. They've had to change their lifestyle, to take care of me, to be there for me. My mother texts me every day to make sure I'm still alive.

I'm not cured, mine isn't a story of transcendence. I don't believe I'll ever break out of my mental prison. I don't even know how many more years of life I have left, but I can say that I wasn't forgotten or ignored, my life was recognized by others as having enough value to at least try and fight.

John, Phoenix, Arizona

'When my daughter killed herself, I died too'

My daughter had been diagnosed with clinical depression as early as eight years old. Living in San Diego, we had access to outstanding healthcare. We took her regularly to therapists as she was on my excellent health insurance plan. Her depression, with medication, was manageable.

She did well in school, even though we had a number of problems with her moodiness. She went on to college, graduated, and no longer qualified for my health plan. She got a temp job as a teacher for a year, then was out of work.

I started paying for her doctor's visits and medication. After spending over \$40,000 dollars that I'd borrowed from my IRA, I was tapped out.

She had to rely on our county's public mental health care to get the treatment and meds she needed.

There are some excellent and well-meaning people that work for counties in mental health, but they are so overburdened and burnt out they can only do so much.

At the age of 33, my daughter committed suicide. I died too.

I was unable to continue working. I wanted to work till I was 75, but retired at 72 because I simply couldn't do it anymore. I worked for the Army Corps of Engineers

and found myself just sitting and staring at a computer screen all day and accomplishing little. That was five years ago, and my nightmares are now just beginning to subside and I can function reasonably well now.

Jim, Houston, Texas

'It was a miracle when we found my brother a place to live'

If you would have told me 25 years ago that my family and I would still be caring for my brother, I wouldn't have believed you. He suffers from schizophrenia and has wreaked havoc on our family emotionally, physically and financially.

When we found him Section 8 housing in San Rafael 12 years ago, it was a miracle and only happened because we knew somebody who knew somebody.

This year, the Non Smoking Ordinance rendered him homeless. The man who drafted this legislation told me he 'just didn't think about' how the law would impact the mentally and physically disabled people who simply are unable to quit.

The people who owned and managed the housing were so compassionate and tolerant toward him, and tried in vain to get him to stop smoking on the premises before he was kicked out. But he really didn't belong there. He belongs in institutionalized housing and care.

Now, we are housing him in a warehouse, trying to care for him. Families should not have to provide psychiatric care for their loved ones. It just doesn't work. I am trying to scrape together a loan to buy him a place so that he can't get kicked out again.

A person suffering from untreated schizophrenia simply does not have the capability to make decisions on their own to benefit them. I firmly believe in compassionate but forced medication followed by care.

People don't have a clue of the horror you have to go through to care for a loved one struggling with mental illness. I can't really talk to people about it because they just don't understand. Basically, if you are mentally ill in America, you are **** outta luck.

Robert, Bay Area, CA

'In a nation with a better mental health care system, I might have been relieved by the knowledge that my brother was being cared for, rather than the fact that he is dead'

My family was briefly involved in caregiving for my brother, before he tragically ended his own life. After he died, I read his journal and learned he was living a nightmare: convinced he was in hell, that we were demonic forces out to get him, and also suffering from visions of self-grandeur.

In his early twenties, he began exhibiting symptoms of schizophrenia and bipolar disorder, which exacerbated rapidly and aggressively. To our great distress, there was little we could do. John (not his real name) was paranoid and distrustful, and resistant to any form of contact from us.

In 2010, the police found John living in an airport. My mother was able to convince him to come home with her, and our family was reunited for Christmas, which would be our last together.

It was heartbreaking to witness him in such a state of misery and to not be able to help him. On Christmas Eve, in a fit of rage, John threatened to kill himself if my parents did not give him money for a plane ticket, we had the great relief of hearing the words that we knew could get him forcibly institutionalized. We called the police and were able to have him brought to the hospital by ambulance.

My brother was released from the hospital after 10 days, which is not even enough time for a proper medication schedule to take effect. A mere month and a half after he was released from the hospital, he turned up at a San Francisco hospital, where he checked himself in and was found to be dehydrated. He was given some sort of treatment and promptly released. From the hospital, he headed directly to the Golden Gate bridge, which he jumped off.

Only because of John's hospital visit, from which he was still wearing a wristband, were authorities able to identify his body.

While I would give anything to have my brother back, it is terrifying to imagine many more years of the stress we

experienced that Christmas, trying to constantly chase John down and keep him alive. He was suffering horribly during that last year; life was torturous for him, and his inability to care for himself made everything even more painful. When he was alive, every minute of every day I wondered, "Where is he now? Is he in pain? Is he scared? Is he hungry or thirsty? Is he safe?" I worried about the long-term cost - financial and emotional - to my family to keep him alive. I am no longer plagued by those questions. In a nation with a better mental health care system, I might have been relieved by the knowledge that he was being cared for, rather than the knowledge that he is dead.

Amy, Chicago, Illinois

'I have given up my own business and we have been through bankruptcy'

I am the caregiver for a mentally ill daughter with severe OCD, PTSD, and depression. I am daily support for checking her moods, administering her medications, and driving her to appointments. I am the first line to call emergency services in crisis, or to take her to the emergency room at the hospital.

She has been ill for 10 years. She is a college graduate who had been holding down a job and living independently. Our experience with the mental health system is that it is uneven and inconsistent with support and providers. There is a lack of agreement as to her best treatment and what local services exist.

I left my job so I could provide 24/7 support for the last decade. I have had to give up my own business and we have been through bankruptcy. Some local services for "adult daycare" have come available in just the last year where I can get some breaks.

Conservatively we have been out \$80,000 a year in my lost earnings and \$60,000 in hers. Treatment and medication costs for her run approximately \$2,000 monthly.

I have some elements of depression in my own life due to the massive shift in family lifestyle and goals. There has been tremendous strain on our marriage, and we have lost some friends who did not understand what we were going through. My career is dead-ended and now all I have waiting for me is eventual retirement.

Our daughter lives with us so there is constant tension in the home. Vacations have been non-existent for years now. We live very frugally.

It is very peculiar that there is still tremendous social stigma connected to mental health disorders and their treatment. Even though great strides have been made in understanding brain disease, there is still a persistent element in society that does not believe mental illness exists and that people just need to "snap out of it." It is viewed as some sort of moral failure, as opposed to a brain that has a distinct disease process going on that can be identified and treated. Thank God for NAMI and the work they do educating the public and supporting families.

Rob, Gresham, Oregon



"Once my loved one accepted the diagnosis, healing began for the entire family, but it took too long. It took years. Can't we, as a nation, begin to speed up that process? We need a national campaign to destigmatize mental illness, especially one targeted toward African Americans. The message must go on billboards and in radio and TV public service announcements. It must be preached from pulpits and discussed in community forums. It's not shameful to have a mental illness. Get treatment. Recovery is possible."

--Bebe Moore Campbell, 2005

Bebe Moore Campbell was an accomplished author, advocate, co-founder of NAMI Urban Los Angeles and national spokesperson, who passed away in November 2006.

She received NAMI's 2003 Outstanding Media Award for Literature. Campbell advocated for mental health education and support among individuals of diverse communities.

In May 2008 the US House of Representatives proclaimed July as **Bebe Moore Campbell National Minority Mental Health Awareness Month**.

UNDERSTANDING WHAT HIPAA MEANS FOR MENTAL ILLNESS

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that helps protect the privacy of individual health information. For individuals living with mental illness, this law is important, because it helps protect confidential mental health treatment records.

Over the years, however, there have been many misunderstandings about the type and range of information that mental health treatment providers are allowed to share with others. This often resulted in situations where family and friends of a person living with mental illness were unable to communicate with healthcare providers, often to the detriment of a loved one.

The federal Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) has enforcement authority over HIPAA. On Feb. 21, 2014, OCR released guidance clarifying how and when healthcare providers may share an individual's mental health treatment information with others. Open communication between a mental health provider and family members or friends of a person living with mental illness can help make sure that the individual receives the best treatment and care possible. Below is a set of questions and answers to make sure you know what HIPAA means for you.

Can healthcare providers share mental health treatment information to family members and friends of a person living with mental illness?

Yes, healthcare providers may share information about treatment with a person's family or friends if the person with mental illness does not object.

Are health care providers required to obtain a signed informed consent release before sharing information with family and friends?

No, citing the integral role that family and friend's play in a patient's health care, OCR's guidance states that providers may ask for permission to share relevant information, may tell the person that they intend to discuss information and give him or her the chance to object, or may infer from the circumstances, using

professional judgment, that the person does not object. For example, if a person receiving treatment invites a family member and friend to be present in a treatment situation, the provider may assume that the person does not object to disclosure of information.

What happens if the person living with mental illness objects to information sharing?

If the person receiving treatment is an adult, objects to the release of information, and is deemed capable of making healthcare decisions by the healthcare provider, then the healthcare provider may not share information with family or friends. If the healthcare provider determines that a person does not have the capacity to make healthcare decisions, then the provider may choose to share information with family, friends, or other individuals involved in the person's care if the provider believes it is in the person's best interest. A court order is not required for a determination that a person lacks capacity. Discretion lies with the treatment provider, based on professional judgment.

How much information can the healthcare provider share with a person's family members or friends?

Healthcare providers should exercise professional judgment and disclose only the information that is necessary or directly related to the family member or friend's involvement in care. Psychotherapy notes - notes that are written by a provider during counseling sessions detailing specific conversations - are treated differently than other healthcare information because they may contain especially private or sensitive information. In most instances, a provider must have a patient's permission before sharing information contained in psychotherapy notes.

May family members or friends communicate with a healthcare provider if they are worried about a person's health or wellbeing?

Yes, family members or friends may share information that they believe might be relevant or helpful to a treatment provider. Healthcare providers are not required to disclose this communication to the individual receiving treatment.

Can healthcare providers share information with parents or guardians of children?

Generally speaking, yes, a healthcare provider may share treatment information with a parent, guardian, or an individual acting as a personal representative for a child.

At what age is a child considered an adult for the purposes of healthcare decisions?

Generally, age 18, but HIPAA defers to state law if a state has a different standard.

Are there any other restrictions on how and when a healthcare provider may share information with parents or guardians?

HIPAA establishes a floor for the privacy of health information. State laws that are more protective of privacy supersede HIPAA. State laws vary and it is important to become familiar with the laws in your state.

In addition, there are some federal laws that may have additional restrictions on sharing treatment information with parents or guardians. For example, the federal confidentiality statute that applies to federally-funded drug and alcohol treatment programs has standards that are stricter than HIPAA.

Can healthcare providers share protected mental health information with law enforcement officials?

Yes, in certain circumstances, particularly if the person living with mental illness poses a danger to self or others, then healthcare providers may disclose necessary information.

The mental health community in New York State lost a leader and visionary with the passing of **Muriel Shepherd** on May 11th. She was one of the most dedicated mental health advocates you could ever encounter. Muriel was the founding president of NAMI-NYS and worked tirelessly to improve the lives of people with psychiatric disabilities. She is a mental health icon, having pushed for improved treatment and community services for over 30 years. As a shining example of grass-roots advocacy, Muriel literally started NAMI-NYS at meetings around her kitchen table. She will be missed, and will always be remembered and respected as a leader in mental health.

SEND YOUR MEMBERSHIP TO NAMI Syracuse TODAY

____ Individual/Family Membership (\$35.00)

____ Open Door Membership (\$3.00 for Individuals on a limited income)

Donation (\$_____) In Memory/Honor (\$_____) Name: _____

Name: _____

Address: _____

Tel. #: _____ e-mail address: _____

What are the benefits of NAMI membership?

- Membership at all three levels of the organization: NAMI National, NAMI-NYS & NAMI Syracuse
- Eligibility to vote in all NAMI elections
- A subscription to The Advocate, NAMI national's quarterly magazine, as well as access to optional subscriptions to specialty newsletters and information at the national, state and local levels
- Discounts on publications, promotional items, and registration at NAMI's annual convention, state and local conferences
- Access to exclusive members-only material on NAMI National's website

The NAMI Syracuse Support & Sharing Meeting facilitated by Sheila Le Gacy and Vanessa Watts is held on the 3rd Tuesday of each month at 7:00pm at Transitional Living Services, 420 East Genesee Street, Syracuse.

(Between South Townsend St. and South State St., next to the Onondaga County Sheriff's Department. Parking and entrance in the rear of the building.)