NAMI SYRACUSE

National **A**lliance on **M**ental **I**llness

Newsletter

JULY/AUGUST 2015

Meeting Schedule

NAMI Syracuse - Support & Sharing Meeting
Third Tuesday of each month
ACCESS-CNY
420 East Genesee Street, Syracuse 13202
(parking and entrance in rear of building)

NAMI Syracuse is a not-for-profit, self-help organization of active and concerned families and friends of people who suffer from serious and persistent psychiatric illnesses, most commonly schizophrenia, bipolar disorder (manic depression), and severe depression.

CARING ***SHARING***
EDUCATION ***ADVOCACY***

Events Calendar

June 29 thru August 15, 2015	**"SEE ME TOO!"** Community Folk Art Center *(see page 2 for location & hours)*
July 21, 2015	**Support & Sharing Meeting** 7:00pm - AccessCNY
August 4, 2015	**Information & Education Meeting** 7:00pm - NAMI Syracuse office Family Advocacy & Leadership *(see page 2 for details)*
August 8, 2015	NAMI Syracuse Picnic *(see page 3 for details)*
August 18, 2015	**Support & Sharing Meeting** 7:00pm - AccessCNY
September 1, 2015	**Information & Education Meeting** 7:00pm - NAMI Syracuse office (*topic to be announced)*
September 13, 2015	**NAMI Syracuse Fall Fundraiser** *(see page 7 for ways you can help)*
October 8, 2015	NAMI Syracuse Educational Conference ***Supports & Strategies for Recovery***

Contents

NAMI Syracuse, Inc., 917 Avery Avenue, Syracuse, New York 13204
phone (315) 487-2085, FAX (315) 487-2154, email namisyracuse@namisyracuse.org, web site www.namisyracuse.org
NAMI Syracuse is the local affiliate of NAMI - New York State, 1-800-950-FACT, web site www.naminys.org and
National Alliance for the Mentally Ill (NAMI), 1-800-950-NAMI, web site www.nami.org

MESSAGE FROM THE PRESIDENT

Dear fellow NAMI members,

I do believe that even the ducks are tired of the rain this summer! I also believe that better weather is on the way, and I know that - no matter what - some wonderful NAMI Syracuse activities are going to happen!

First up is the second annual **"See Me Too!"** Art & Poetry Show at the Community Folk Art Center. The official opening reception is July 8th. The exhibit will be on display through August 15th. The gallery location and hours are listed below.

An interactive educational meeting will be held on August 4th, 7:00p.m., at the NAMI Syracuse office. Judy Bliss Ridgway and Marla Byrnes will co-lead the discussion on advocating for our family member - what works and what doesn't work.

On Saturday, August 8th come join us for burgers, hotdogs, and fun at our annual picnic. See page 3 for details.

We're also very excited to be planning a big fundraiser party for this fall. The date is Sunday, September 13th! Stay tuned for details.

So, rain or shine, ducks or no ducks, I do hope you'll join NAMI Syracuse in all our activities and in actively trying to make a difference!

Best,

Karen

NAMI Syracuse 1st Tuesday of the Month Information & Education Meetings Return!

Please join us at the NAMI Syracuse office
917 Avery Ave., Syracuse, NY
Tuesday, August 4th, 7:00pm

Family Advocacy and Leadership Educational Meeting

What do you need to know to advocate for your child, youth, adult family member or yourself?

August 4th at 7:00pm, Judy Bliss Ridgway and Marla Byrnes will co-lead a discussion on advocating for our family members. We will discuss what has worked and not worked when advocating for our families. We will discuss how we can have an impact as individuals, as a group of family members and as an organization.

Let's talk about what changes in the system would benefit our families.

We can make a difference.

Pizza will be served!

For the latest happenings at NAMI Syracuse visit us on **Facebook** and LIKE our page.

Like

facebook.com/NAMISyracuse

Follow us on **twitter:**

Tweet

twitter.com/NAMI_Syracuse

"SEE ME TOO!" ART & POETRY SHOW

Please support our talented family members and families by visiting the **"See Me Too!" Art & Poetry Show** at the Community Folk Art Center, 805 East Genesee Street, Syracuse.

The exhibit is on display **June 29th thru August 15th** with a reception, Wednesday, July 8th, 3:00pm-5:00pm.

Gallery hours:
Tuesday-Friday, 10:00am - 5:00pm
Saturday, 11:00am - 5:00pm

NAMI Syracuse Annual Picnic!

Please join us

Saturday, August 8, 2015

1:00pm

at the home of Judy & Joe Ridgway

2503 West Genesee Street, Syracuse

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

Please let us know if you plan on coming:

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

Please join us in visiting and reminiscing with our long time members and meeting and greeting our newest members! Find out more about NAMI Syracuse and how you can help!

RISE IN SUICIDE BY BLACK CHILDREN SURPRISES RESEARCHERS

New York Times, Sabrina Tavernise, 5/18/15

The suicide rate among black children has nearly doubled since the early 1990s, while the rate for white children has declined. A new study has found an unusual pattern that seemed to suggest something troubling was happening among some of the nation's most vulnerable citizens.

Suicide among children ages 5 to 11, the age range the study measured, is rare, and researchers had to blend several years of data to get reliable results. The findings, which measured the period from 1993 to 2012, were so surprising that researchers waited for an additional year of data to check them. The trend did not change.

Suicide rates are almost always lower among blacks than among whites of any age. But the study, published in the journal **JAMA Pediatrics**, found that the rate had risen so steeply among black children - to 2.54 from 1.36 per one million children - that it was substantially above the rate among white children by the end of the period. The rate for white children fell to 0.77 per million from 1.14.

It was the first time a national study found a higher suicide rate for blacks than for whites of any age group, researchers noted.

"I was shocked, I'll be honest with you," said Jeffrey Bridge, an epidemiologist at the Research Institute at Nationwide Children's Hospital in Columbus, Ohio. "I looked at it and I thought, "Did we do the analysis correctly?" I thought we had made a mistake."

The researchers used national data based on death certificates that listed suicide as the underlying cause. In the study, they offered a few possible explanations for the difference, including that black children are more likely to be exposed to violence and traumatic stress, and that black children are more likely to experience an early onset of puberty, which can increase the risk of depression and impulsive aggression. But it was not clear whether those characteristics had changed much over the period of the study and would account for the sharp rise.

Sean Joe, a professor of social work at Washington University in St. Louis, who has studied suicide among black youth and did not take part in the new research, pointed out that suicide had long been one of the few negative health outcomes that have affected blacks less than whites.

A departure from that trend happened from the mid-1980s to the 1990s, when rising suicide rates among black teenagers narrowed the gap with white teenagers. One hypothesis was that the rate was driven up by easier access to guns; another was that there had been a cultural shift, in which young blacks were not as religiously observant as older blacks. In that thinking, religious faith had conferred a protective quality that had made older blacks less vulnerable to suicide.

"What it means to grow up young and black has changed," Professor Joe said. "Something happened that put black teens at risk."

He added, "I find the rates for children even more troubling, because they are the most vulnerable."

The finding seemed to buck other trends by race. Among adolescents of both races, for example, the rate declined over the same period, falling for blacks more than for whites, according to figures Dr. Bridge provided. The rate for black boys rose sharply. The rate for black girls also rose, but the change was not statistically significant, he said.

The way the children were dying seemed to provide some clues. Dr. Christine Moutier, chief medical officer for the American Foundation for Suicide Prevention, who read the study, pointed out that gun deaths among white boys had gone down by about half while staying about the same for black boys, signaling that gun safety education may not be reaching black communities as effectively as white ones.

Suicides by hanging, on the other hand, roughly tripled among black boys, while remaining virtually unchanged for whites.

"He uncovered something very significant in the data," she said, referring to Dr. Bridge. "Viewed over all, that age group looked like it was flat."

She said the traditionally lower rates for blacks had often been attributed to strong social networks and family support, religious faith and other cultural factors. "That makes me wonder whether there is something in those protective factors that may have shifted in the wrong direction over those two decades," she said.

CONTACT COMMUNITY SERVICES - SUMMER AND FALL SCHEDULE

Mental Health First Aid

8 hour workshop

Mental Health First Aid is a general class about mental health issues (including risk of suicide). Sign up for this 8-hour workshop and learn to manage crises, reduce stigma and practice a 5-step plan for helping someone in a mental health crisis.

Our next class is two half-day sessions: Tuesday, July 28 and Wednesday, July 29, 9 a.m. - 1:15 p.m. each day

You must attend both sessions.

Cost: $40. Space is limited to first 20 paid registrants.

To register, please call 315-251-1400 x 132

Mental Health First Aid/Youth

8-hour workshop

Mental Health First Aid/Youth covers normal adolescent development and common mental health challenges of youth, including anxiety, depression, substance use, disruptive behavior disorders (including AD/HD), nonsuicidal self-injury and eating disorders. This workshop is intended primarily for adults interacting regularly with young people (ages 12-18).

Our next class is two half-day sessions: Thursday, August 20 and Friday, August 21, 9 a.m. - 1:15 p.m. each day

You must attend both sessions.

Cost: A grant allows us to offer this training for free to any adult who interacts with Syracuse City School District youth. Space is limited.

To register, please call 315-251-1400 x 132

(continued on page 5)

Fall Volunteer Training for Contact Hotline

Attend our next free weekend training and become part of the **Contact Hotline**, a unique and rewarding volunteer experience. If you are a student at an area college, you may be able to use your Hotline experience to fulfill your field placement or service learning requirements.
Friday, September 11, 2015, 9am-5pm
Saturday, September 12, 2015, 9am-5pm
Sunday, September 13, 2015, 9am-5pm

You must attend all three days.
For more information:
call 315-251-1400 ext 112 or
email lbest@contactsyracuse.org

Other Classes

Children 1st

Children 1st is an educational program for parents involved in a custody dispute. Offered regularly, call 315-251-1400, ext. 132

Anger Management

This six-week class (90 minutes per week) helps adults learn to use anger in more constructive and healthy ways. Offered regularly, call 315-251-1400, ext. 132

Suicide Prevention Training

Help create a suicide-safer community by increasing awareness, recognizing warning signs and taking steps to keep a friend safe.

For information about bringing a suicide prevention training to your organization, call 315-251-1400 ext. 112 or email lbest@contactsyracuse.org.

THE PESTICIDE FACTOR

Psychiatric Times, Dee Rapposelli, 6/16/15

Pyrethroid pesticide use may be encouraging expression of an ADHD phenotype, according to researchers from the Cincinnati Children's Hospital in collaboration with researchers from Rutgers, University of Rochester, Brown University, and Simon Fraser University. To follow-up on murine and rodent studies that showed a correlation between pyrethroid exposure and ADHD symptoms that were especially pronounced in males, the researchers assessed exposure and ADHD symptomatology in a random sample of 687 US children, age 8 to 15 years.

These children were participants in the 2001-2002 National Health and Nutrition Examination Survey (NHANES), which was the only NHANES cycle that included a structured diagnostic interview regarding ADHD, pyrethroid pesticide biomarkers, and covariates (e.g., sex, household income, age, race/ethnicity, health insurance status, prenatal tobacco exposure, blood lead level, and urinary organophosphate pesticide metabolite level).

Exposure was assessed by measuring concurrent urinary levels of the pyrethroid metabolite 3phenoxybenzoic acid (3-PBA). An ADHD diagnosis was defined as either meeting DSM-IV criteria via the Diagnostic Interview Schedule for Children or a caregiver report of a past diagnosis. Multivariable logistic regression examined the link between pyrethroid exposure and ADHD, and poison regression investigated the link between exposure and ADHD symptom counts.

In all, 15% of the study population met criteria for an ADHD diagnosis. Urinary 3-PBA levels were detected in 79% of the study participants (mean, 1.14 µg/L), with the means for the 10th, 50th, and 90th percentiles being 0.07, 0.29, and 1.94 µg/L, respectively.

After adjusting for covariates, the researchers discovered that children with detectable urinary 3-PBA were twice as likely to have ADHD as those in whom 3-PBA was undetected. Higher 3-PBA levels also were associated with an increasing number of hyperactive/impulsive symptoms. In fact, hyperactive/impulsive symptom counts were 77% higher in children with detectable 3-PBA levels than in children with nondetectable levels. Whereas effect on inattentiveness was insignificant, hyperactive/impulsive symptoms increased by 50% for every 10-fold increase in 3-PBA level measured. This effect was also sex-specific.

Boys most at risk.

In correlation with animal studies, boys were far more affected than girls. Boys with detectable urinary 3-PBA were nearly 3 times more likely to have ADHD than boys in whom urinary 3-PBA was undetectable. Further, a 10-fold increase in urinary 3-PBA level was associated with a 43% increased prevalence of ADHD whereas this pattern was not seen in girls.

Pyrethroid pesticides, such as the insecticide permethrin, have been thought to be safer than organophosphates, which were banned for residential use by the US Environmental Protection Agency in 2000-2001. Pyrethroid pesticides are now the most commonly used pesticides for residential use and are increasingly being used in agriculture as well. Although additional investigation is warranted, given the findings of this study, residential and personal use of pyrethroid pesticides should be reconsidered. Clinicians serving the pediatric as well as obstetric care populations may want to inform patients and their caretakers of the health risks of pyrethroid-based pesticide/insecticide use in relation to ADHD symptomatology.
http://www.psychiatric-times.com/adhd/pesticide-factor

WHY WE NEED A PARADIGM SHIFT IN MENTAL HEALTH CARE: THE CASE FOR RECOVERY NOW!

*by Leah Harris, **Huffington Post,** 6/12/15*

Another **May is Mental Health Month** has come and gone, and it is time to build on years of awareness campaigns and move into action to promote whole health and recovery. People with serious mental health conditions are dying on average 25 years earlier than the general population, largely due to preventable physical health conditions, so why do we still focus on mental health separately from physical health? And when we know that people with serious mental health conditions face an 80 percent unemployment rate, why do we largely ignore the role of poverty, economic and social inequality, and other environmental factors in mainstream discussions about mental health?

Decades of public health research have clearly shown that access to the social determinants of health -- affordable housing, educational and vocational opportunities, and community inclusion -- are far more important to mental and physical health than access to health care alone. As one recent article explained: "For many

patients, a prescription for housing or food is the most powerful one that a physician could write, with health effects far exceeding those of most medications." Yet this wisdom does not generally guide policymaking in the U.S. Among nations in the Organization for Economic Co-operation and Development (OECD), the U.S. ranks first in health care spending, but 25th in spending on social services. Is there something wrong with our very concept of "care"?

This question is not just theoretical for me. As an adolescent, I attempted suicide several times. I found myself in the back of a police car more than once and was frequently hospitalized. At age 16, I was diagnosed with bipolar disorder. Two years later, I found myself sitting in a squalid group home, where I was told I needed to remain for life. I had no high school diploma and no job. My hopelessness and despair were all-encompassing.

I managed to get on a different path when I obtained access to safe and stable housing, education, and social support. Today, I am living life as a mother and a mental health advocate. I train human service providers in suicide prevention, recovery, trauma-informed approaches, and person-centered health care. Every day, I'm grateful that I was able to regain my life, and I want everyone to have this opportunity.

To help promote a paradigm shift in mental health care, I've been part of starting a new, nonpartisan public awareness campaign called **Recovery Now!** This campaign seeks to educate all Americans about the kinds of services and policies that promote real recovery and whole health for people affected by mental health conditions. Here are a few key messages of the **Recovery Now!** campaign.

Recovery is possible for all.

The vast majority of people living with mental health conditions, even people diagnosed with serious mental illness, can enjoy a high quality of life in the community with access to the right kinds of services and supports. Dr. Richard Warner, clinical professor of psychiatry at the University of Colorado, noted: "It emerges that one of the most robust findings about schizophrenia is that a substantial proportion of those who present with the illness will recover completely or with good functional capacity." A slew of other studies have found similar results.

An argument used against recovery is that there are some who can't or won't voluntarily seek treatment or services. Yet there are plenty of evidence-based ways to reach people, such as motivational interviewing, or employing peer-to-peer support or community health workers to do homeless outreach or to engage with persons with complex mental and physical health needs. But these kinds of strategies are vastly underutilized.

We must advocate for recovery-oriented policies.

Hope is essential for recovery. But hope is not enough. Too many people are still unable to access the kinds of services and supports that would help them to recover. In particular, people of color are overrepresented in our jails and prisons, and are underrepresented in community-based mental health and social services.

A prime example is in Chicago, where newly re-elected Mayor Rahm Emanuel closed six community mental health clinics in the most economically disadvantaged parts of the city, which has resulted in an increase in persons with mental health conditions being incarcerated in the Cook County Jail for low-level, nonviolent offenses related to their disabilities. While the recent appointment of a psychologist to head the jail is a step in a better direction, how will this appointment impact upon the lack of availability of community-based services in Chicago for people who desperately need them?

Yet Mayor Emanuel is not unique in his choices. Community-based services have been slashed in many state and local budgets. Any short-term "savings" accomplished by such cuts will always be offset by the devastating long-term human and economic costs that result when we deny quality services and supports to the people who are most vulnerable.

Mental health legislation has been introduced in the House and is expected in the Senate. All legislation should be evaluated through a recovery lens and should clearly address the social determinants of health. Policy should seek to end deadly cycles of poverty, homelessness and incarceration in ways that are culturally appropriate, rehabilitative rather than punitive, and community-based. We can't talk about more hospital beds without talking about supportive housing and other programs that will actually help people to stay out of the hospital and out of prison. We need legislation that tackles disparities in access to education and employment, and funds proven programs that prevent crisis and recidivism.

We need sound policies that promote recovery for all Americans affected by mental health conditions. We don't have the luxury of continuing to get this wrong. Too many individuals, families, and systems are in crisis, and it doesn't have to be this way. We need recovery, and we need it now.

*~~Leah Harris is a mother, storyteller, mental health advocate, and coordinator of the **Recovery Now!** campaign.*

REPORT ON MANDATORY TREATMENT TOUTS SAVINGS IN TAXPAYER OUTLAYS

Arlington, VA, February 18, 2015

A new report commissioned by the Treatment Advocacy Center suggests there are substantial savings in government spending associated with court-ordered treatment for people with serious mental illness who are stuck in the "revolving door" of repeated incarceration, emergency department visits and hospital stays, the Washington Post reports.

Opponents of mandated treatment, also known as assisted outpatient treatment (AOT), argue that the practice violates individual rights. Doris Fuller, executive director of the Advocacy Center, said court-ordered outpatient care is "an effective treatment option that saves lives."

According to the new report, the practice also saves taxpayer dollars. The report listed net savings of 47 percent in New York City, 50 percent in five outlying New York counties, and 50 percent in Summit County, Ohio.

The advocacy center said that when individuals stayed in treatment - keeping medical appointments, filling prescriptions and otherwise using mental health services - the costs "were more than offset by the reduction of other public investments such as hospitalization and incarceration."

NAMI Syracuse Educational Conference

Supports and Strategies for Recovery

Thursday, October 8, 2015, 9:00am-3:00pm, Empire Room, NYS Fairgrounds, Syracuse

presenters

Erik Lilly, SHRM-CP, PHR, Employee Representative, Wegman's Food Markets

Laila Keysor, SHRM-SCP, SPHR, Employee Representative, Wegman's Food Markets

Recently released: *Publix Super Markets and Wegmans Food Markets are the first-ever recipients of the Ruderman Family Foundation's Best in Business Awards for their hiring practices, training and support for individuals with disabilities. "Not only are they providing the path to full inclusion for people with disabilities, but they are gaining loyal, dedicated employees who change the environment of their workplaces, so all employees feel good about their places of employment," Ruderman Family Foundation President Jay Ruderman said.*

Jacqueline Colello, Artist, shares her story of struggle, strength and hope.

Kirsten Hubel, Director of the Sunrise Peer Recovery Center

Nathan Baird, Peer Specialist

Sunny Aslam MD, considers himself a recovery-oriented psychiatrist and will speak on negotiating with your psychiatrist when returning to school or work.

Sherie Ramsgard, Owner/Psychiatric Nurse Practitioner at Whole Mental Wellness will discuss stress management and self-care.

Save the Date! Brochures will be available soon!

NAMI Syracuse Planning New Fall Fundraiser!

SAVE THIS DATE! Sunday, September 13, 2015, 4:00pm - 7:00pm

Dr. Paula Zebrowski and Pam Fortino have offered their beautiful home in Phoenix, NY to NAMI Syracuse to raise money for our organization. We are planning an extravaganza for early fall.

catering by Marie Mahar
music by Bob Switalski & Ensemble
silent auction will include:
Karen Winters Schwartz and her husband are donating a week at their home in Belize,
August Cornell is donating jewelry from his import business, and much more to bid on!

We need your help!

*We look to **all our members** to help solicit items for our silent auction to raise much needed money for our advocacy work.*
*We will need **volunteers** to help set up the day before and the day of the event and clean up.*
*We will need **volunteers** to direct parking and **volunteers** at the registration table.*
***Volunteers** will be needed to handle the silent auction.*
*We will need **everyone** to solicit items for the auction. And, we will need **everyone's help** to sell tickets and buy tickets!*
If you are interested in helping with this fundraiser, please call the NAMI Syracuse office, 487-2085.

NAMI Syracuse members will be mailed an invitation and be sure to watch our website as more details become finalized!

PET THERAPY IS A NEARLY COST-FREE ANXIETY REDUCER ON COLLEGE CAMPUSES

Forbes, Jill Castellano, 7/6/15

This May, hundreds of Caldwell University students filled the Newman Center Courtyard to try out bracelet beading, massage therapy, dancing, crafts and a host of other activities to serve as stress relievers before final exams. One of the most popular activities was furrier than the rest of them: dog therapy.

As stressed students tax colleges' conventional mental health resources, universities have been conjuring up new ways to reduce stress and anxiety. Since 2005, the use of therapy dogs on college campuses has gone from nonexistent to the norm-one of the main reasons, proponents of the program say, is because of the low cost.

Anxiety and depression are on the rise among college students. More than 11% of college students have been diagnosed or treated for anxiety in the past year, and more than 10% reported being diagnosed or treated for depression, according to the National Alliance on Mental Illness. Over half of college students feel overwhelming anxiety that strain their academic abilities, according to a recent report from the American College Health Association.

"Maybe years ago, having these events wouldn't have been as needed, but because of increased stress levels, now they are," says Robin Davenport, Director of Counseling Services at Caldwell.

Most university pet therapy programs are entirely free for students and practically free for universities. The dog handlers are most often volunteers who bring their own pet-therapy certified dogs to campus for special events and receive no pay. Costs for the handlers themselves only amount to parking fees and registration fees for training their dogs.

Universities also don't take the burden for any incidents with the dog that happen on campus, like a dog biting a student. The two largest therapy dog training schools, Pet Partners and Therapy Dogs International, offer liability insurance covering up to $1 million for any incident with a trained dog.

From the start of pet therapy on college campuses, the cost of liability was a concern. When Kent State University researcher Kathy Adamle approached the school's administration in 2005 about starting a pet therapy program, she says, the university turned her down.

"I thought they were going to kill me. This was unheard of, to do something like this at a state university," Adamle says. "They said, "What if one of the students gets sick, what if a dog destroys something?" It took them a long time to understand we're not going to take a dog off someone's couch."

A year later, Adamle finally convinced Kent State to launch the program, she says. Once the first pet therapy programs introduced to a U.S. college, starting with five dogs in 2005, Dogs on Campus now has 26 dogs and has conducted over 100,000 visits.

Sometimes, pet therapy programs even help provide for other university services. For the 10-year anniversary of Kent State's program this year, those who participated in dog therapy were asked to donate nonperishable goods or gift cards to the university Women's Center that could be given to students in transition or crisis.

"How can you really turn this down when you are carrying no liability and the program is free for everyone involved?" Adamle says. Since launching the program 10 years ago, she has received calls from hundreds of universities asking how they can implement similar programs on their own campuses.

Campus pet therapy has spread like wildfire, with success that has gone far beyond what many schools predicted. When Tufts University held its first Tufts Paws for People event, the school expected about 20 students to show up-over 200 did.

Dogs can increase levels of oxytocin in humans, a hormone that reduces anxiety and blood pressure, studies show. People become less frightened and more secure when they pet dogs. But whether dog therapy programs can have an impact on one's overall mental health is still unclear.

"Anything we can do to de-stigmatize mental health is important, so taking a holistic approach to treatment makes sense," says assistant professor at Tufts University Megan Mueller, who has conducted her own research on the benefits of pet therapy. "As we learn more about how human-animal interaction can reduce stress and anxiety, we think this might be a really interesting cost-effective method of helping students' mental health."

The biggest pet therapy cost for a university is time. Julian Aiken, a librarian at Yale Law School, made headlines in 2011 when he started bringing his certified dog Monty to the library, who can be "checked out" like a library book for meetings with small groups who want to interact with him.

"It's cheap in terms of money, but not in terms of my time. I'm paid by the hour, and some of that I'm clearly spending with the dog," he says. Now 15 years old, Monty has retired, but Aiken is training his year-old Jack Russel Pippa to fill Monty's shoes. For Aiken, the time he puts into the program is worth it.

"I've been delighted with this program. I think anything we can do to stop student stress is good," he says. "Dogs give uncomplicated love."

Staying On Track

How YOU Play an Important Role!

Mental health recovery is an ongoing process, not a single outcome. Each person's recovery experience is unique.

By making a personalized, inclusive plan for managing a mental health condition, a person has the best chance of living a meaningful life.

DUAL DIAGNOSIS - RECOVERY FROM SUBSTANCE ABUSE

Melvin G. McInnis, MD, FRCPsych

A "dual diagnosis" means having two disorders diagnosed at the same time. It could be any two diagnoses, but typically it refers to the co-occurrence of a mental illness along with a substance abuse problem.

Sometimes people with bipolar disorder may use alcohol or drugs to help cover up or mask symptoms. For racing thoughts due to mania, an alcoholic drink may slow things down. For intense sadness or hopelessness because of depression, a drug may help one feel happy or hopeful for a period of time. This "self-medication" may *appear* to help, but after the temporary effects of the alcohol or drugs wear off, one's symptoms are often worse than ever.

Why is alcohol abuse so prevalent in people with bipolar?

Alcohol is among the most frequently used and abused substances in our culture, and people with bipolar disorder, like the average person, often engage in social drinking. Many are able to limit themselves to one or two drinks with friends, but more than half of individuals with bipolar develop major problems with alcohol.

The exaggerated use of alcohol most often occurs during hypomanic and manic states. Many use alcohol as a method of tempering mania; others drink to attempt to sustain euphoria; some report that during manic episodes, they associate alcohol with power and prestige. The common thread is that there is limited insight into the nature and extent of problems caused and/or exacerbated by alcohol abuse.

Surprisingly, drinking during the depressed state of bipolar disorder is less common - but when it does occur, it may be a harbinger of a more serious problem with alcohol.

What about drug abuse?

As with alcohol, people with bipolar may turn to drugs in an attempt to "self-medicate" due to anxiety, depression, or mania, or to "even out" mood swings. There are many readily available substances to "take the edge off," marijuana being one popular choice. Again, while it can seem to help in the short term, within a few hours drug use can cause serious problems with fluctuating moods and negative thoughts.

Individuals with bipolar disorder are more likely to develop a drug addiction after casual use, and they find it much harder to quit. In addition, drug use increases an already high suicide rate among people who have bipolar.

What are some effective paths for recovery?

The treatment of people with co-occurring substance abuse and bipolar disorder is more complicated than the treatment of either condition alone. The good news is, there are many paths to recovery!

In the past, conventional wisdom held that people with a dual diagnosis had to be "clean and sober" before psychiatric treatment could succeed. Today, however, we recognize the importance of treating bipolar disorder *along with* substance abuse. This integrated approach can encompass a number of different strategies, such as some combination of one-on-one psychotherapy with a mental health professional, counseling, and holistic therapy. There are numerous programs and therapeutic centers across the country that specifically address dual diagnosis.

Self-help programs, such as Alcoholics Anonymous (aa.org) and Narcotics Anonymous (na.org), for people with substance abuse issues and/or their loved ones are offered in most communities, at no charge, by nonprofit groups whose mission is to connect people and their families with information and resources to help them recover.

Support from loved ones is crucial to any successful wellness management plan. It is helpful to have honest conversations with family and friends regarding the availability and use of alcohol or drugs, and to develop strategies to manage personal and social situations where substances may be present.

There is no one tried-and-true formula that works for every dual diagnosis situation; still, recovery is absolutely possible.

*~~from **bp magazine**, Spring 2015*

LATEST INFORMATION FROM THE BIPOLAR NETWORK NEWS (VOL. 19, ISSUE 3, 2015)

Edited by Sheila Le Gacy, Director of the Family Support & Education Center, AccessCNY (formerly Transitional Living Services)

MEGA-3 FATTY ACIDS IMPROVE MOOD IN YOUTH WITH BIPOLAR DEPRESSION

Children who have a parent with bipolar disorder are at risk for bipolar illness, but it may first present as depression. Treating these children with antidepressants has the risk of bringing on manic episodes. Researchers are looking for treatment options for youth at risk for bipolar disorder.

A recent study adds to the literature on the positive effects of 1-2 grams of omega-3 fatty acids in depression. Given the safety of omega-3 fatty acids and the ambiguous effects of antidepressants in bipolar depression, omega-3 fatty acids would appear to be a good alternative, especially since the FDA-approved atypical antipsychotics (quetiapine and lurasidone) are not approved for bipolar depression in people under 18.

ANTIPSYCHOTICS THAT WORKED FOR A FIRST EPISODE MAY NOT WORK AS WELL FOR A SECOND EPISODE

In new research, patients in their first schizophrenic episode who reached remission in response to one of two antipsychotic medications (risperidone or olanzapine) and relapsed due to medication non-adherence were re-treated with the same medication regimen that had brought about remission. Reinitiating the same treatment was not as successful in bringing about remission of the patients' second psychotic episodes.

These data are consistent with the research of J.A. Lieberman and colleagues fifteen years ago, which showed that response to antipsychotic treatment is poorer in successive episodes of psychosis. The findings are also consistent with the idea of episode sensitization in mood disorders, developed by Robert Post. Episode sensitization refers to the case in which greater numbers of prior depressions or

manias are associated with faster relapse and a greater degree of treatment resistance.

The data raise major doubts about the common practice of quitting medications to see if remission can be maintained without them. There are dozens of studies in patients with schizophrenia showing that continuous treatment is more effective than intermittent treatment.

KETAMINE SHOWN EFFECTIVE FOR BIPOLAR AND UNIPOLAR DEPRESSION

Ketamine, an anesthetic sometimes used intravenously in the treatment of depression, can bring about rapid onset of antidepressant effects. A new meta-analysis presented at a recent conference showed that Ketamine's maximum antidepressant effects occur within one day of administration, and its effects remain significant (compared to control conditions) one week following infusion. There was a trend for better response in patients with bipolar disorder than with unipolar disorder.

(Families interested in seeing the original articles these edits are based on should contact Sheila Le Gacy at AccessCNY, 315-218-1614.)

ACCEPTANCE: PATH TO EMPOWERMENT

Deborah Serani, Psy.D

Why do I need to "accept" my depression?

When you accept the reality of your depression, it doesn't mean that you're giving in to it. Nor does it imply that you're hopeless. In the psychological sense, acceptance is seeing an experience for what it truly is.

Accepting you depression allows you to realistically recognize how the illness touches your life - to understand what you *can* and *can't* change. With this increased self-awareness, you can learn to adjust your expectations, shift goals when necessary, and adapt to adversity better.

Acceptance is a deeply textured set of emotions where you concede, compromise, and yield for the sake of finding a healthy way of living. New ways of thinking and feeling arise because you're no longer stuck on the impossible - "I wish I didn't have depression" - but instead can focus on what's possible to achieve within the parameters granted to you.

I know the power of acceptance from my own experience. My journey from diagnosis to recovery was filled with denial, anger, sadness and regret - as well as bargaining with myself and others as I tried to escape the bleak cloud of my illness. I tried to fight the fact of my depression by ignoring it (not going to talk therapy sessions, skipping medication) or minimizing its impact (dismissing the importance of good sleep and a healthy diet).

Reaching acceptance wasn't an "aha" moment for me. It was a fusion of many experiences that slowly filled me with insight and awareness - and ultimately taught me that I was fighting my depression in unproductive ways. When I finally accepted my limits, I was empowered to realize where my strengths could take me. I couldn't change the fact that I have depression, but I could live in a meaningful way in spite of it.

Once I accept my depression, then what?

Empowerment emerges alongside acceptance. Empowerment is the process by which you gain a healthy control over your life by finding ways to feel confident and strong despite having depression.

Empowerment is not a one-stop destination. Your sense of agency, of feeling in charge, will continue to grow and deepen as you learn more about yourself and your illness. (The more you educate yourself on the science about depression, the better you will understand your symptoms and how to work around them.)

CREATE A NEW NORMAL. When you accept the limits of your illness, you can develop a new set of expectations and goals based on what you can realistically accomplish. This leads to a life filled with meaningful experiences rather than frustration.

STRIVE FOR BALANCE. This often involves making sure you do all the healthy things that help you manage depression and increase well-being (sleep well, eat well, exercise, take your meds, get to therapy), as well as acquiring techniques to shake off the bad moments or bad days that inevitably come along.

REQUEST RESECT. Empowerment includes asking others to respect you and your illness. This can be done by challenging stigma, clarifying myths about mental illness, or just standing up for yourself and your needs.

MAKE CONNECTIONS. Share time with like-minded people who make you feel good, whether in a peer support group, a yoga class, your faith community, or some other setting.

CHEER YOURSELF ON. Collecting inspiring quotes and motivational photos is a wonderful way to keep your inner self strong. Leave them around the house, post them at your work station or tag them on your computer screensaver.

*~~from **esperanza**, Spring 2015*

INFORM YOURSELF ABOUT MEDICAL MARIJUANA

by Sheila Le Gacy, AccessCNY

In the next newsletter I will review several articles dealing with marijuana research. Many families report that their relatives are self medicating with marijuana for their anxiety. In some cases young people are truly addicted to marijuana and experience paranoia and other destructive symptoms. Smoking marijuana has led to relapse and impedes recovery. It is certainly not something I would recommend to individuals with major psychiatric disorders. However, we are getting reports that in some situations anxiety appears to be helped by marijuana. This is confusing for families.

As the use of marijuana for medical purposes is now legal in 23 states, including New York, it is important for us to become informed about the positive and negative aspects of medical cannabis.

I recommend going on line to **Mercola.com** and read the article *"Marijuana Research Supports Its Safety and Benefits."* This is a general overview that might help you understand why many young people who are addicted to marijuana are harming their recovery. You will benefit from the important information that some properties of marijuana are psychoactive, (making the user high) whereas others are not. It is the marijuana that is most psychoactive, that with high **THC** which has diminished medicinal value and an increased likelihood of producing adverse effects.

The part of the plant that is being used for certain medical conditions is high in **cannabidols (CBD)** and this substance does not make the user high.

Much of the research on the helpful aspects of medical marijuana focuses on cannabidols. The Mercola article describes the research findings in a very clear manner. I will review other articles for the next NAMI Syracuse newsletter. If you cannot access this article on line, please contact me and I will send you a hard copy.

SUPPORTIVE FAMILY TRAINING COMPLETES SPRING CLASSES

by Sheila Le Gacy, Access CNY

Pat Hetrick and I have recently completed another three month course in **Supportive Family Training.** Most of the participants (parents, siblings, spouses, and adult children of individuals diagnosed with serious psychiatric disorders) have joined NAMI Syracuse.

The classes have proven to be an excellent entry to our advocacy organization. Since we are currently building our waiting list for the Fall course, which will begin in October, if any readers of this newsletter have people they would like to refer to the class this is a good time to have them contact us. Another way NAMI members might want to encourage people who are in need of support is to accompany them to the 3rd Tuesday evening of each month support group that Pat and I facilitate. This group is a comfortable way for new families to learn about community supports for themselves and their diagnosed relatives.

Remember that the **Graduate Group**, which meets on the 4th Tuesday of every month, is open to any individuals who have completed **Supportive Family Training**. Also, anyone who has taken NAMI's **Family to Family** class is also welcome to attend the Graduate Group. We focus a lot on problem solving but many people come for the ongoing support and opportunity to be with other families who "get it."

Contact Sheila or Pat at Access CNY (478-4151), for more information.

Attention Graduates of Supportive Family Training: Please return any books you have borrowed. And, if you have books you would like to donate to our program, we would be most grateful!

OF ALL U.S. POLICE SHOOTINGS, ONE-QUARTER REPORTEDLY INVOLVE THE MENTALLY ILL

NPR News, 7/4/15

At least 125 people with signs of mental illness have died in police encounters in the U.S. so far this year, according to the latest accounting from the **Washington Post.**

Recently, the **Post** published a database with information on every fatal shooting by a police officer in the line of duty in the U.S. And they took the extra step of identifying - when they could - details about the mental health of the deceased.

In evaluating the role that mental or emotional crisis played in police fatalities, investigative reporter **Kimberly Kindy** says that the **Post** attempted to be cautious as the paper compiled this data.

"Unless the families identified the deceased as somebody who was mentally ill or the police department identified them as mentally ill, we did not - even if it may on the surface of things [have] appeared as if they might be," she tells NPR's Eric Westervelt. "So it's a conservative number - but even with it being conservative, it was a quarter of the killings."

Interview Highlights

On the ways the police fatalities involving the mentally ill differ from the rest

What we're really talking about is a population where the traditional tactics that a police officer is trained to use [are] the very opposite of what they should be doing. It doesn't work very well with somebody who's in a mental health crisis, or who has a serious mental illness, for you to get in their face, yell for them to throw down a weapon. Much of the time - as one of the experts I spoke to said - there's a lot of white noise in their head, so [police officers] need to not move in and take control of the situation like you would with a criminal.

They need to give a lot of space, slow things down, speak calmly and not try to immediately control the situation. That tends to escalate things and create a volatile situation instead of de-escalating things so you can safely bring a mentally ill person into custody or, you know, take them to the hospital, which is many times [why] family or friends are calling and asking for that kind of assistance - transportation to a mental health facility.

On why there aren't broader efforts from police departments to train officers how to deal with the mentally ill

Much of the resistance is they're being asked to do something that's completely counterintuitive: you know, backing off a situation, not taking control of it. It really requires a complete shift in culture, in the way they view policing, and so it's a learning curve. And what tends to happen is that police departments start to do this type of training, like you're seeing in the LAPD [Los Angeles Police Department], when they've had a number of high-profile cases that have gone wildly wrong and there's been some community protests.

But what we found was that just about half of the police departments in the nation have this type of training.

On one story in particular that lingers with her

There are so many of [these stories]; one in particular, though, is Lavall Hall, a schizophrenic young man. His mother called for help because he went outside in the really chilly, cold air. He was out there in his underwear swinging a broomstick. The police show up, and within minutes, he's gunned down. And the mother said, "I wish I would've never called them." It's just heartbreaking because, case after case, you're talking about family members and friends who call for help, and the person ends up dead. ...

What's also heartbreaking is I think the police officers - their lives are changed forever when they take the life of somebody like this. They deserve a chance at knowing how to handle these situations and many of them are not given that chance by being given the proper training.

SEND YOUR MEMBERSHIP TO NAMI Syracuse TODAY

_____Individual Membership ($35.00)

_____Open Door Membership ($3.00 for Indivduals on a limited income)

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

Name: _____

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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**

Reminder:

If you are receiving this newsletter but are not a member, please consider joining NAMI.

If you are a member, please check to be sure your dues are up to date.

Please join or renew today.

There is strength in numbers!

The NAMI Syracuse Support & Sharing Meeting facilitated by Sheila Le Gacy is held on the 3rd Tuesday of each month at 7:00pm at ACCESS-CNY, 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.)