

MESSAGE FROM THE PRESIDENT

Dear Members,

The nation has responded with empathy and heartfelt sorrow to the death of Robin Williams. As we all know, he was just one of the countless victims of mental illness. Although it's sad that it takes the death of a prominent public figure to increase awareness of an issue that has affected so many unknown individuals, we should all take this opportunity to celebrate what we do as advocates and keep the conversations going.

We at NAMI Syracuse are busy gearing up for Mental Illness Awareness Week, Oct 5-11th. Our fall educational conference is October 7th and aptly titled **Crucial Conversations!** As always this year's conference promises to be insightful, educational, and inspiring. Thanks to the generosity of our friends at OnCare we are able to offer scholarships to parents to attend our conference. If you or someone you know needs some financial assistance and would like to attend our conference, please let us know!

I'm thrilled to announce the release of my third advocacy novel on Sunday, October 1st. NAMI Syracuse will be sponsoring a fundraiser/book launch party at Kelley's on September 28th. I hope you can all join us for food, drink, music, and fun!

World Suicide Prevention Day is Wednesday, September 10th. On this day at 5:45pm, we are invited to participate in a **Candle Lighting Memorial** in Long Branch Park sponsored by the American Foundation for Suicide Prevention Central New York Chapter and CONTACT Community Services. (see page 9 for details)

All over the Internet are films of people doing the ALS Ice Bucket Challenge. Sheila Le Gacy has always called Robin Williams our poster boy for bipolar disorder. The incidence of ALS is 2 out of 10,000. It's estimated that 30,000 individuals have ALS in the US. The incidence of mental illness is 1 out of 4, which translates to 61.5 MILLION individuals. Other than stigma, I'm not sure why people aren't dumping buckets of ice water on their heads and donating money to help prevent slow insidious crippling of the brain. We may have lost our poster boy, but we have not lost our voice. Keep crucial conversations going!

~~Karen

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You're Invited

*Celebrate the release of NAMI Syracuse President
Karen Winters Schwartz's new mental health advocacy novel,
The Chocolate Debacle
while helping to raise money for NAMI Syracuse*

*Sunday, September 28, 2014, 2 to 5 pm
Kelley's Restaurant, 5076 Velasko Road, Syracuse, NY 13215*

*RSVP by September 21 to:
315-487-2085 or namisyracuse@namisyracuse.org
or send donation to:
NAMI Syracuse, 917 Avery Avenue, Syracuse, NY 13204*

*Suggested donation:
\$25/person, \$40/couple*

PROMISE Residential Project has recently received the benefit of the efforts of **Silverhammers**, a group of retired people who do construction projects for the benefit of local charities. The group has rebuilt the back porch at 917 Avery Avenue where we have our office and two apartments for renters with psychiatric diagnoses. PROMISE Residential Project paid for the materials, but Silverhammers' labor was donated.

At silverhammers.com you can see how the group offers free construction services in lieu of paid labor in exchange for contributions directly to a charity chosen from a list that they provide. Homeowners may find that they would want to explore using Silverhammers if they are wanting significant home improvements such as siding, deck construction, the creation of rooms in basements.

NAMI Syracuse Educational Conference

Crucial Conversations!

Tuesday, October 7, 2014, 9:00am-3:00pm

Rosamond Gifford Zoo, One Conservation Place, Syracuse

presenters

Stephen Kuusisto is an author, poet, disability advocate, and recently named director of SU Renee Crown University Honors Program. Professor Kuusisto, who has been blind since birth, is the author of **Eavesdropping: A Memoir of Blindness and Listening** and his acclaimed memoir **Planet of the Blind**, a New York Times "Notable Book of the Year." He speaks widely on diversity, disability, education, and public policy.

We're All In This Together

Dr. Abdul Ahmed is a board certified psychiatrist who serves as the clinical director of Suboxone and mental health services at Syracuse Behavioral Healthcare. For the past 10 years he has been relentless in his effort to empower his patients to fight their addiction, recover and restore their lives. His secret to success has been his ability to recognize addiction as a disease, promote mental health and wellness and his uncompromised passion for his profession.

Battling Stigma & Shared Decision Making

Dr. Rich O'Neill is a Psychologist and Associate Professor of Psychiatry and Behavioral Sciences at Upstate Medical University in Syracuse, NY. He treats adults for Anxiety, Depression, Panic Attacks and Mental Illness. He utilized both group and individual psychotherapy and is a practitioner of Systems Centered Therapy.

Caring for the Caregiver

Panel Discussion

Sheila Le Gacy, Director of Family Support & Education Center, Enable/Transitional Living Svcs.

William Dee, family member

Jennifer Hardwich, member of Syracuse Police Department's Crisis Response Team

*Local Efforts to Work with Police Department
Crisis Intervention Team*

NAMI Syracuse Educational Conference

Crucial Conversations!

Tuesday, October 7, 2014 * 9:00am-3:00pm * Welch Allyn Room, Rosamond Gifford Zoo, Syracuse

Please register by Friday, October 3, 2013

<input type="checkbox"/> Professional/Provider/Non-NAMI Member	\$60.00
<input type="checkbox"/> NAMI Member	\$50.00
<input type="checkbox"/> Student/Recipient of MH Services	\$30.00
<input type="checkbox"/> Become a member of NAMI Syracuse & attend the conference	\$80.00
<input type="checkbox"/> Sorry, not able to attend; but please accept my tax deductible donation	\$ ____

NAME: _____

FROM: (Agency, NAMI, School, etc.) _____

ADDRESS: _____

PHONE: _____ E-MAIL: _____

Scholarships available to Family Members - Registration includes Continental Breakfast & Lunch - Request Vegetarian Lunch []
Mail registration form along with payment to NAMI Syracuse Inc., 917 Avery Avenue, Syracuse, NY 13204

DEPRESSION CAN BE TREATED, BUT IT TAKES COMPETENCE

by Kay Redfield Jamison

When the American artist Ralph Barton killed himself in 1931 he left behind a suicide note explaining why, in the midst of a seemingly good and full life, he had chosen to die.

"Everyone who has known me and who hears of this," he wrote, "will have a different hypothesis to offer to explain why I did it."

Most of the explanations, about problems in his life, would be completely wrong, he predicted. "I have had few real difficulties," he said, and "more than my share of affection and appreciation." Yet his work had become torture, and he had become, he felt, a cause of unhappiness to others. "I have run from wife to wife, from house to house, and from country to country, in a ridiculous effort to escape from myself," he wrote. The reason he gave for his suicide was a lifelong "melancholia" worsening into "definite symptoms of manic-depressive insanity."

Barton was correct about the reactions of others. It is often easier to account for a suicide by external causes like marital or work problems, physical illness, financial stress or trouble with the law than it is to attribute it to mental illness.

Certainly, stress is important and often interacts dangerously with depression. But the most important risk factor for suicide is mental illness, especially depression or bipolar disorder (also known as manic-depressive illness). When depression is accompanied by alcohol or drug abuse, which it commonly is, the risk of suicide increases perilously.

Suicidal depression involves a kind of pain and hopelessness that is impossible to describe - and I have tried. I teach in psychiatry and have written about my bipolar illness, but words struggle to do justice to it. How can you say what it feels like to go from being someone who loves life to wishing only to die?

Suicidal depression is a state of cold, agitated horror and relentless despair. The things that you most love in life leach away. Everything is an effort, all

day and throughout the night. There is no hope, no point, no nothing.

The burden you know yourself to be to others is intolerable. So, too, is the agitation from the mania that may simmer within a depression. There is no way out and an endless road ahead. When someone is in this state, suicide can seem a bad choice but the only one.

It has been a long time since I have known suicidal depression. I am one of millions who have been treated for depression and gotten well; I was lucky enough to have a psychiatrist well versed in using lithium and knowledgeable about my illness, and who was also an excellent psychotherapist.

This is not, unfortunately, everyone's experience. Many different professionals treat depression, including family practitioners, internists and gynecologists, as well as psychiatrists, psychologists, nurses and social workers. This results in wildly different levels of competence. Many who treat depression are not well trained in the distinction among types of depression. There is no common standard for education about diagnosis.

Distinguishing between bipolar depression and major depressive disorder, for example, can be difficult, and mistakes are common. Misdiagnosis can be lethal. Medications that work well for some forms of depression induce agitation in others. We expect well-informed treatment for cancer or heart disease; it matters no less for depression.

We know, for instance, that lithium greatly decreases the risk of suicide in patients with mood disorders like bipolar illness, yet it is too often a drug of last resort. We know, too, that medication combined with psychotherapy is generally more effective for moderate to severe depression than either treatment alone. Yet many clinicians continue to pitch their tents exclusively in either the psychopharmacology or the psychotherapy camp. And we know that many people who have suicidal depression will respond well to electroconvulsive therapy (ECT), yet prejudice against the treatment, rather than science, holds sway in many hospitals and clinical practices.

Severely depressed patients, and their family members when possible, should be

involved in discussions about suicide. Depression usually dulls the ability to think and remember, so patients should be given written information about their illness and treatment, and about symptoms of particular concern for suicide risk - like agitation, sleeplessness and impulsiveness. Once a suicidally depressed patient has recovered, it is valuable for the doctor, patient and family members to discuss what was helpful in the treatment and what should be done if the person becomes suicidal again.

People who are depressed are not always easy to be with, or to communicate with - depression, irritability and hopelessness can be contagious - so making plans when a patient is well is best. An advance directive that specifies wishes for future treatment and legal arrangements can be helpful. I have one, which specifies, for instance, that I consent to ECT if my doctor and my husband, who is also a physician, think that is the best course of treatment.

Because I teach and write about depression and bipolar illness, I am often asked what is the most important factor in treating bipolar disorder. My answer is competence. Empathy is important, but competence is essential.

I was fortunate that my psychiatrist had both. It was a long trip back to life after nearly dying from a suicide attempt, but he was with me, indeed ahead of me, every slow step of the way.

~~Kay Redfield Jamison, a professor of psychiatry at the Johns Hopkins School of Medicine, is the author of *An Unquiet Mind: A Memoir of Moods and Madness* and *Night Falls Fast: Understanding Suicide*.

Of all the responses to Robin Williams' sad suicide, Kay Redfield Jamison's Op Ed essay in the NYTimes (August 15, 2014) struck me as especially wise and informed. She distinguishes between different kinds of depression - many of the recent responses to Williams' suicide lump all depression into one category. It is well known that the depression of bipolar disorder is far more difficult to treat than unipolar depression. Treating bipolar depression is a challenge that psychiatrists frequently write about. And, unfortunately, many professionals who prescribe medications to

individuals who present with depressive symptoms do not consider the possibility (and often the probability) that their patients may have underlying bipolar disorder. Consequently, patients are prescribed antidepressants without mood stabilizers and are often tipped over into mania or extreme agitation. A leading expert in the field of mood disorders commented that giving a patient with known bipolar disorder an antidepressant without the protection of a mood stabilizer amounts to malpractice. Yet my program continually hears from families about their relatives who have been given antidepressants (and/or stimulants) and who have been triggered into manic episodes. Therefore, Jamison's focus on the need for competence in the field of psychopharmacology is most welcome.

For readers unfamiliar with Kay Jamison, I recommend her fascinating book *Touched with Fire, Manic Depressive Illness and the Artistic Temperament* (The Free Press, 1993). Although individuals diagnosed with bipolar/manic depression are not always creative, there is definitely a disproportionate rate of manic-depressive illness or depressive illness among poets, composers, painters, writers and, yes, comedians. As Jamison wrote, there is a compelling association, if not an actual overlap, between two temperaments - the artistic and the manic-depressive. And many of these artists, like Robin Williams, have directly or indirectly influenced the lives of others and contributed vastly to our world.

The following are edited from articles in the Bipolar Network News, Vol. 18, Issue 1, 2014 by Sheila Le Gacy, Director of the Family Support & Education Center, TLS/Enable and member of the NAMI Syracuse Board.

NAMI members interested in reading the complete publication should contact Le Gacy.

Ketamine

Data continue to add to the already strong findings that the drug ketamine produces rapid-onset antidepressant effects. When and where ketamine should be incorporated into routine clinical

treatment of depression remains to be further clarified. A recent report in the **Bipolar Network News** suggests that ketamine produced antidepressant effects more quickly than ECT, and these effects were significantly better than baseline for the duration of the study.

Inflammatory and Metabolic Abnormalities Predict Poor Response to Antidepressants

There is mounting evidence that inflammation and metabolic problems are related to depression. A recent study in the journal **Neuropsychopharmacology** examined patients with depression to see whether levels of inflammatory markers in the blood and metabolic factors such as cholesterol, blood pressure, and waist circumference predicted whether those patients would still be diagnosable with depression two years later. People who had four or more types of inflammatory or metabolic abnormalities had almost twice the odds of having chronic depression.

One explanation is that inflammation and metabolic problems worsen and complicate a patient's depression and reduce the patient's responsiveness to traditional antidepressants. Alternative ways of treating these patients aimed at their inflammation and metabolism may be necessary.

Individual Predictors of Response to Treatment

Researcher Andrew H. Miller reported that there is tremendous heterogeneity in people's illnesses, and doctors must get better at sorting out what treatments will work for each patient, striving toward personalized therapeutic.

There are many clinical correlates or predictors of nonresponse to antidepressants used in unipolar depression. These include inflammation, obesity, stress in childhood, anxiety disorder comorbidity, substance abuse comorbidity, and medical comorbidity. How do we doctors target these clinical correlates of illness for better therapeutic effects? We are just starting to learn, and until we identify good markers for predicting illness, the best we can do is carry out carefully sequenced clinical trials of medications and therapies with different mechanisms of action.

Patients can assist their physicians by engaging in precise, preferably nightly charting of their mood, functioning, medi-

cations, life events, side effects, and other symptoms such as anxiety on a personal calendar.

A good personal response to a novel treatment or a poor response to a Federal Drug Administration-approved treatment trumps anything that is written in the research literature.

Edited from Bipolar Network News, Vol. 18, issue 4, 2014

Lithium Superior to Valproate at Preventing Manias, Depressions, and Hospitalizations

In a special symposium on bipolar disorder at the 2014 meeting of the American Psychiatric Association, researcher Mike Bauer reviewed a new meta-analysis that showed lithium not only has significant effects in preventing manias, but also depressions. Bauer concluded that lithium is under-used in the treatment of bipolar disorder, especially in the US, where lithium is prescribed less often than valproate.

He noted that lithium-related goiter and low thyroid are easily treated, and that kidney damage while taking lithium can be prevented by avoiding episode of lithium intoxication. It is easy to conclude that lithium should be used more often, especially given its positive effects against suicide and brain gray matter and hippocampal volume loss.

New Antidepressant Vortioxetine May Improve Cognition and Depression

Vortioxetine (Brintellix) is a new antidepressant that has a range of effects on serotonin receptors, making it different from SSRIs, the most common type of antidepressants, which work only on the serotonin transporter. Vortioxetine appears to be useful in patients who have previously failed to respond to antidepressants. It may be unique among antidepressants in that it appears to improve cognition.

Special Treatment Approaches Needed for Bipolar Depression

Bipolar illness affects 4.5% of the US population. Several researches reported during a symposium on Bipolar at the 2014 meeting of the American Psychiatric Association.

The newest data indicate that traditional antidepressants that are effective in unipolar depression are not effective in bipolar depression. And some patients are at increased risk of switching into mania and making a suicide attempt while taking antidepressants.

There is impressive data on the superiority of most forms of targeted psychotherapy or psychoeducation compared to treatment as usual for bipolar depression.

The main take-away messages of the speakers were: use more lithium, use more caution and fewer antidepressants in treating bipolar depression, use more combination therapy for acute illness and for maintenance, and definitely use more psychotherapy.

Early onset of illness and delay in time to first treatment are both independent predictors of a poor outcome in adulthood, indicating the need to intervene earlier and more effectively in the two-thirds of patients with bipolar disorder who have onsets in childhood and adolescence (before age 19).

There is a kindling-like process in the illness, where recurrent episodes yield more rapid relapses and episodes that begin to occur without precipitating stressors. There is increased reactivity to repeated stressors, episodes, and bouts of substance use, which all induce illness progression. Greater numbers of prior depressions are associated with cognitive dysfunction, treatment resistance, medical comorbidities, and neurobiological abnormalities. Thus, preventing the onset of new episode becomes the primary goal of treating bipolar disorder.

Prevent episodes and protect the body, the mind and the brain. Lithium, in combination with other agents and psychotherapy, is one of the best ways to do this in patients with bipolar disorder.

WHEN THE CAREGIVERS NEED HEALING

by Catherine Saint Louis, 7/28/14

“This has happened before,” she tells herself. “It’s nowhere near as bad as before, and it will pass.”

Robbie Pinter’s 21-year-old son, Nicholas, is upset again. He yells. He obsesses about something that can’t be changed. Even good news may throw him off.

So Dr. Pinter breathes deeply, as she was taught, focusing on each intake and release. She talks herself through the crisis, reminding herself that this is how

Nicholas copes with his autism and bipolar disorder.

With these simple techniques, Dr. Pinter, who teaches English at Belmont University in Nashville, blunts the stress of parenting a child with severe developmental disabilities. Dr. Pinter, who said she descends from “a long line of the most nervous women,” credits her mindfulness practice with giving her the tools to cope with whatever might come her way. “It is very powerful,” she said.

All parents endure stress, but studies show that parents of children with developmental disabilities, like autism, experience depression and anxiety far more often. Struggling to obtain crucial support services, the financial strain of paying for various therapies, the relentless worry over everything from wandering to the future - all of it can be overwhelming.

“The toll stress-wise is just enormous, and we know that we don’t do a really great job of helping parents cope with it,” said Dr. Fred R. Volkmar, the director of Child Study Center at Yale University School of Medicine.

“Having a child that has a disability, it’s all-encompassing,” he added. “You could see how people would lose themselves.”

But a study published recently in the journal **Pediatrics** offers hope. It found that just six weeks of training in simple techniques led to significant reductions in stress, depression and anxiety among these parents.

Researchers at Vanderbilt University randomly assigned 243 mothers of children with developmental disabilities, genetic syndromes or psychiatric issues to mindfulness training or “positive adult development.” At the start of the study, 85 percent of the participants reported significantly elevated stress; 48 percent said they were clinically depressed, and 41 percent reported anxiety disorders.

The first group practiced meditation, breathing exercises, and qigong practices to hone mental focus. The second received instructions on curbing negative thoughts, practicing gratitude and reclaiming an aspect of adult life. Both groups were led by specially trained mentors, themselves the parents of special-needs children.

The parents were assigned some unlikely homework: In the mindfulness

group, for instance, they were told to bring a moment-to-moment awareness to a daily activity like chopping vegetables. An assignment in the positive development group might entail taking a “guilt inventory” to assess if your guilt is healthy or counterproductive.

Part of what makes the experiment innovative is that it was targeted to adults, not their children, and it was not focused on sharpening parenting skills. Instead, parents learned ways to tackle their distress as problems arise. The idea is to stop wasting energy resisting the way life is.

The mindfulness treatment and positive adult development led to significant reductions in stress, anxiety, depression as well as improved sleep and life satisfaction among participants. But the mothers in the mindfulness group saw greater improvements in anxiety, depression and insomnia than those who receive positive adult development training. (As there was no control group, it’s hard to know how many parents might have improved on their own.)

Stress-reduction groups like these could be a cost-effective way for parents to help other parents, Dr. Volkmar said: “We could think about doing this more broadly to reduce stress and improve quality of life” - for siblings, too.

In August, manuals detailing the two strategies - mindfulness and positive adult development - will be available online for \$200 each (\$350 for both manuals) for parents of special-needs children who want to start groups.

Learning to quell distress and anxiety is especially important for parents of children with development disabilities because it’s often a lifetime caregiving commitment, said Elisabeth M. Dykens, the lead author of the Vanderbilt study.

“Other 21-year-olds move out and take jobs, but most of these children stay at home,” said Dr. Dykens, the director of the Vanderbilt Kennedy Center. “You have aging parents and aging offspring. You are each other’s for life.”

Still, just as some middle-aged caregivers of elderly parents are reluctant to shift the focus to themselves, so are some parents of special-needs children. The Lexington Center in Fulton County, N.Y., is already using the positive adult develop-

ment curriculum, after two people involved with the Vanderbilt research trained seven mentors last November. But to persuade parents to attend, the center has had to vigorously advertise, call and email.

"They are so stressed to begin with," said Nancy DeSando, the director of community supports at the center. "To get them to consider one more thing is very challenging."

Karen Pilkerton, a registered nurse and a peer mentor who led mindfulness training at Vanderbilt, said participants tended to think, "I don't have time for self-care." "By the end of the six weeks, she said, they realized, "When I fill my own cup, I have more to give." Sometimes, they didn't realize how depleted their cup was."

Indeed, one 2008 study by psychologists at Swansea University in Wales noted that high levels of parent stress reduced the effectiveness of interventions for the child.

Phil Reed, a psychologist at Swansea and author of the coming book, **Interventions for Autism**, said, "It's good that people are beginning to look at how we can help parents in and of themselves."

Janet Shouse, a mother of three including a son on the autism spectrum, led positive adult development groups for the study. One lesson entailed parents allowing themselves to grieve for the dreams they'd once had for their child - but then to limit the time they dwell on that loss.

Another lesson Mrs. Shouse had to learn herself: how to redirect anxiety into positive action.

She spent years panicking that she wasn't doing enough to get her son Evan, now 18, to learn to talk by age 5, or 7, or 10. (She had been told if he didn't converse by a certain age, he never would, but the deadline kept changing).

The first and last time he asked for food, he wanted an apple. She was thrilled.

"It wasn't until that apple incident, I finally realized, if he's not able to communicate more adequately, I'm O.K. with that," Mrs. Shouse said. "It was such a huge relief that I wasn't striving to

do all this therapy and to make every moment a teaching moment."

During the sessions Mrs. Shouse led, she tried to help other mothers understand it's O.K. to "enjoy their kids as kids" and to not make "all moments edifying."

In retrospect, Dr. Pinter said, it's easy to see how stressed she'd become caring for Nicholas, who just got a job at a church farmer's market on Sundays. She ground her teeth and chewed ice. At restaurants, she used to crinkle paper straw covers compulsively, but not when her son was at camp. "When we picked him up, I'd start back up again," she said.

Practicing mindfulness has helped her live more in the moment. "So many people think it's just out there or I can do it on my own or all I need is more money, she said. They don't know how much it can help."

AN ANTI-VIOLENCE HEALTH PLAN

Mad in America, Mark Ragins, 7/22/14

It seems almost every week now that we hear of a mass murder/shooting in the media. By now the pattern is too familiar to be as frightening as it once was: An isolated young man, with some ongoing mental illness that isn't being actively treated, is resentful of his world, buys guns and a lot of ammunition, and kills people until someone kills him. The response has also become reflexive: Guns should be made less available, especially to people with mental illnesses, and potentially dangerous people should be treated for their mental illnesses - involuntarily if necessary - so they can live safely in our community. Yet, nothing much changes, outraging the next set of victim's families and communities.

I would like to propose a different long-term, proactive strategy on the mental health side of the problem.

From a mental health point of view these young men, have two relevant characteristics - their mental illness and their social isolation. We've focused much more attention on their illnesses than on their social isolation. I believe this is because we have a lot more faith in doctors, medications, and treatment than we have faith in relationships and community. Never mind that these people seem to have a variety of con-

ditions (though it's hard to make diagnosis on dead people from media reports). Often they seem psychotic, probably from schizophrenia. Sometimes they seem socially impaired from childhood, even dramatically so, perhaps with some variant of autism. Occasionally PTSD seems to be part of the problem. Even though they all seem to have very longstanding problems, we seem to have the belief that if only someone would have gotten them some treatment, especially into a hospital, their tragedy could've been averted.

There are plenty of expert psychiatrists willing to tell the media about how effective our treatments are - if only we'd be given the power to force more people to receive them. It's unclear if that's actually true. Some of these young men have received treatment, and seem to mostly have been antagonized by it and further isolated and stigmatized in the process. Don't get me wrong: treatment, including medications, can be a very powerful tool to achieve recovery, but it will never be "the answer."

Psychiatrists don't publicly share that our treatments mostly only work when we can engage the person in their own treatment and recovery, when they collaborate in the hard work of recovery, and that recovery needs to be an ongoing effort. (When was the last commercial you saw that said, "If your antidepressant isn't working, maybe you need to be more involved in your recovery"?) Maybe mental health workers need to do better at engaging people and collaborating with them and working on goals they think are important.

One of the main reasons we're reluctant to share our limitations is that we don't want society demanding that more and more people with mental illnesses, who are uncooperative, be locked up indefinitely in mental hospitals again. Despite some vocal counter examples, most mental health professionals have neither the stomach nor the budget for locking up lots of people. The main reason we're locking up more people in jails instead of hospitals isn't because anyone thinks it's better for them; it's because most judges were prosecutors and they don't have any budgetary constraints on them. They have society's permission to be extravagantly coercive. Psychiatrists

don't have that permission and we're not likely to ever have it again. The judges don't get blamed for overcrowded, budget busting, inhumane prisons. Psychiatrists did get blamed for overcrowded, budget busting, inhumane hospitals.

What if instead of heading down this dead end again, we focus on the "socially isolated" part of the equation? Could we find ways together focused not as much on how to help get people into treatment, but how to help get them into life? (Notice before we start down this road, that most of the recommended treatments further isolate, shame, and stigmatize the person. For example, colleges are busy hiring psychiatrists so they'll know which students to get rid of to "make sure no one gets hurt.")

Here's my five step plan for reducing social isolation:

1. Outreach

Our mental health systems say we're too overwhelmed with the people showing up to our programs every day to go out and look for more people in trouble. Therefore, we only allocate resources to share the burden with police of responding to dangerous situations. (Note that many people think this is a legal requirement - "We can only do something if they're dangerous to themselves or others." I don't think any state has a law against involuntary outreach, wellness checks, or listening to concerned families.)

There are a number of ways of being alerted to who might be in trouble and isolated. Usually their family knows. We could answer the phone when they call and actually go out and meet their family member. We could use data bases (for example, people withdrawing from college, signing up for unemployment, cancelled weddings, evictions, bankruptcy, loan defaults, jail releases, even gun purchases) to reach out and offer human contact. We could have "social isolation" outreach teams instead of "call the police."

2. Engagement

Depending on how the outreach went, we could triage people who are actually socially isolated and at risk into a variety of paths of engagement. Some would require mental health professionals, but

not all. Programs like Emotional CPR, Mental Health First Aid, and What a Difference a Friend Makes train the general public to engage people with mental illnesses. Peer outreach workers, who are in recovery from mental health conditions themselves can do outreach. Sometimes the most pressing need might be for some other specific non-mental illness social engagement - unemployment benefits and a job developer, an educational counselor, a financial counselor, meals-on-wheels, clergy, etc. If we worked together we could form a sizeable engagement team.

3. Inclusion

These young men have been socially excluded for a reason. They have serious problems. They've all experienced far more rejection and bullying than acceptance and inclusion during their lives. We live in a community that is not accepting and inclusive of people with mental illnesses in the same way we are with physical illnesses. For them to be included, individuals, whether mental health professionals or not, will have to be part of a "counterculture of acceptance." Examples of disability-based inclusion programs are: Compeer, Cornell's practices of reintegrating students after mental health crisis, 12 step programs, impaired physician programs, Yolo county and other NAMI programs, Project Return self help clubs, etc. Probably more important, however, would be non-disability based inclusion. (The movie "Lars and the Real Girl" is a great example, so are "midnight basketball" and Big Brother/Big Sister programs.) The engagement worker would have to be willing to include these people in other parts of their lives and in other roles besides disabled person receiving help.

4. Protection

Risk factors for dangerousness are only predictive in the absence of protective factors (when they're predictive at all). Common protective factors include having an income, having a reasonably secure place to live (an actual "home" is best), having a family (it doesn't have to be a "perfect family"), having other adults in life (romantic partners are probably the most impactful), having a role besides "outcast" or "mentally ill", and having some active spiritual faith and connection. Think of how few protective factors these mass murderers

had. Once we've engaged with people we can work with them on building protective factors. Mental health professionals can be one of their protective factors, but we shouldn't be all they have.

5. Strengths-Based Growth

Every person, even mass murderers with mental illnesses and social isolation, has strengths, talents, and personal gifts. We can help people reclaim and develop their strengths and enrich all of us. (A social worker once told me that her job is to "help people remember what made their heart sing and find a way for them to do it again.") The difference between a contributing, valuable person and a frustrated mass murderer may be more in their opportunities, how they look at themselves, and how we react to them, than in their diagnoses. And that's a difference worth making.

There's good news and bad news in this strategy.

The good news is that even if we can't identify the needle in the haystack to find that rare socially isolated, armed, mentally ill person who will actually commit murder, those people accidentally included in this strategy are likely to be benefited anyway (unlike the likely inadvertent consequences of being locked up, involuntarily medicated, terrified, and traumatized). We'd likely prevent some suicides with this strategy too.

The bad news (besides the problem that I can't think of a clever acronym for these five steps) is that all of us have to get involved. We have to be a community that cares about each other. We can't just put all the responsibility on the mental health system (no matter how well funded, which it rarely is) to keep us safe. We can't say that's someone else's kids or "No one is that crazy in my family. . . or my neighborhood, or school, or work, or church." We're in this together. We can't just change the channel and see what else is on tonight. It's not happening to someone else. It's happening to all of us.

FAMILY AND COMMUNITY
EDUCATION SCHEDULE
HUTCHINGS PSYCHIATRIC CENTER
September 2014 - November 2014

All classes are *free* and *open to the public*, and held in the H.P.C. Education and Training Building, at 545 Cedar Street, Syracuse, N.Y. Paid parking is nearby. To register for classes please call the Education and Training Department at 315-426-6872. Please register at least 1 week in advance.

9/09/14 - 10am to 12 noon

Following a Wellness Plan - How to help yourself or those you care about - Information for Individuals, Families and Friends

Presenter:

Aaron Tussing, LCSW-R
HPC Social Worker

10/14/14 - 10am to 12 noon

Living with Borderline Personality Disorder - Information for Individuals, Families and Friends

Presenters:

Pam Fortino, LCSW-R
Bob Switalski, LMSW
HPC Social Workers

11/18/14 - 10am to 12 noon

Dual Diagnosis - Working with the Developmentally Disabled Who have Serious Mental Illness - Information for Individuals, Families and Friends

Presenter:

Dr. Lisa Harrel-Delamater
HPC Licensed Psychologist

*Check with your family member's inpatient and outpatient therapist for information regarding supports groups available on the units and at the clinics.

You are cordially invited to the

World Suicide Prevention Day Candle Lighting Memorial Long Branch Park, Liverpool, NY, September 10, 2014 at 5:45pm

The American Foundation for Suicide Prevention Central New York Chapter and Contact Community Services, Inc. will hold a candle lighting memorial on Wednesday, September 10th in observance of World Suicide Prevention Day.

We will gather to:

Remember our loved ones who have died by suicide

Support survivors and people with lived experience

Bring awareness to our community about suicide prevention

The candle lighting memorial in observance of World Suicide Prevention Day will start at 5:45 pm. We will be meeting in the West Shore Trail parking lot on Long Branch Road. At 6:00 pm we will proceed to the pavilion and dock area on the West Shore Trail. Once we arrive at the dock we will pass out candles and have a couple of poems read out loud. We will then light our candles and share a few moments of silence in memory of those we have lost to suicide. We will provide candles, but if you wish to bring your own, please feel free to do so.

This is the third annual candle lighting memorial held by AFSP CNY, which helps to raise awareness about suicide prevention and mental health issues. The World Health Organization reports that approximately one million people worldwide die by suicide each year. This corresponds to one death by suicide every 40 seconds. The number of lives lost each year through suicide exceeds the number of deaths due to homicide and war combined.

If you can not attend our candle lighting memorial, you can still participate at home. At 8:00 pm, people from around the world will be lighting a candle near a window in memory of those lost to suicide.

For more information about this event, please contact:

Sarah Vroman, American Foundation for Suicide Prevention, CNY Chapter Chair

e-mail: talklistensave@aim.com

or

Laurie Best, Contact Community Services, Inc.,

e-mail: lbest@contactsyracuse.org

Walk to Prevent Suicide

2014 Out of Darkness Community Walks

REGISTER & DONATE TODAY www.afsp.org/walk

Saturday, October 11, 2014

Long Branch Park

Long Branch Park, Liverpool, NY

Registration - Check-in 10:00-11:30am

Walk - 11:30am - 2:00pm

Hamburgers, Hot Dogs & Drinks available for purchase

Rain or Shine

**NAMI SYRACUSE BOARD
MEMBER RECEIVES 2014
CONNIE LIEBER RESEARCH
AWARD FROM NAMI NYS**

NAMI-NYS is delighted to announce that **Stephan Glatt, Ph.D.**, has been chosen to receive the 2014 NAMI-NYS Connie Lieber Research Award. The recipient of this award is someone who has shown outstanding excellence in mental health research and this year Connie (Founder of NARSAD/Brain & Behavior Research Foundation), in consultation with Dr. Sho Tin Chen, has chosen Dr. Glatt to receive this prestigious award.

Dr. Glatt is the Director of the Psychiatric Genetic Epidemiology & Neurobiology Laboratory (PsychGENe Lab) at SUNY Upstate Medical University in Syracuse.

This award honors Dr. Glatt's work on candidate-gene and genome-wide association, expression, and functional studies of schizophrenia, post-traumatic stress disorder, bipolar disorder, autism spectrum disorders, attention-deficit/hyperactivity disorder, heroin dependence, and other psychiatric and substance use disorders. The ultimate objective of his research is to identify the causes of these illnesses, and to find biomarkers that will facilitate earlier identification, intervention, and prevention.

Dr. Glatt has been awarded two Young Investigator Awards, an Independent Investigator Award, and the Sidney R. Baer, Jr. Prize for Schizophrenia Research from NARSAD: The Brain and Behavior Research Foundation. He is also the Principal Investigator on two Research Project grants from the National Institute of Mental Health. Dr. Glatt is also a co-investigator or consultant on numerous grants from the National Institutes of Health which are focused on identifying the nature and causes of mental disorders.

The award will be presented to Dr. Glatt on Friday evening November 14th at the NAMI NYS Education Conference. Dr. Glatt will give the evening's featured presentation following his receiving the award.

**MENTAL ILLNESS AWARENESS
WEEK, OCTOBER 5 -7, 2014**

In 1990, the U.S. Congress established the first full week of October as Mental Illness Awareness Week (MIAW) in recognition of NAMI's efforts to raise mental illness awareness. Since then, mental health advocates across the country have joined with others in their communities to sponsor activities, large or small, for public education about mental illness.

MIAW coincides with the National Day of Prayer for Mental Illness Recovery and Understanding (Oct. 8) and National Depression Screening Day (Oct. 10).

Why is MIAW important?

Each year millions of Americans face the reality of living with a mental health condition. During the first full week of October, NAMI and participants across the country are bringing awareness to mental illness. Each year we fight stigma, provide support, educate the public and advocate for equal care. Each year, the movement grows stronger.

We believe that these issues are important to address year round, but highlighting these issues during Mental Illness Awareness Week provides a time for people to come together and display the passion and strength of those working to improve the lives of the tens of millions of Americans affected by mental illness.

**GET INVOLVED TODAY!
DONATE - SPEAK OUT - ADVOCATE**

"An idea is like a play. It needs a good producer and a good promoter even if it is a masterpiece. Otherwise the play may never open; or it may open but, for a lack of an audience, close after a week. Similarly, an idea will not move from the fringes to the mainstream simply because it is good; it must be skillfully marketed before it will actually shift people's perceptions and behavior."

~David Bornstein, How to Change the World: Social Entrepreneurs and the Power of New Ideas

**PRIMARY CARE PHYSICIANS
TRAINING INADEQUATE IN
MENTAL HEALTH**

"Primary Care clinicians are not fully trained to diagnose or treat mental health problems, yet people with these conditions typically are seen in primary care more than any other setting," so says the U.S. Department of Health and Human Services in an issue of **Research Activities**, a publication of the Agency for Healthcare Research and Quality (AHRQ). The practice of under qualified physicians diagnosing and treating people without integrating mental health professionals into the process, is resulting in depression and other mental health problems being misdiagnosed or inadequately treated and inappropriate psychotropic drugs being prescribed with little follow-up.

The article goes on to say that the "training in mental health for primary care physicians is very superficial and not very deep-and they don't know what to do if anything goes wrong." There are presently barriers to integration of mental health in the primary care setting, such as reimbursement problems and a fragmented workforce. Research is showing, however, that wherever a team approach is utilized, costs go down and patients get better.

Overall, integrated health care seems better for everyone.

An integrated approach seems the best way.

**STIGMA AND SERIOUS MENTAL
ILLNESS. WHAT IS THE
RELATIONSHIP?**

August 26, 2015

Stigma is one of the most important problems encountered by individuals with severe psychiatric disease, lowering self-esteem, contributing to disrupted relationships and negatively impacting the ability to socialize, obtain housing and become employed.

And it's getting worse, recent studies report.

The Treatment Advocacy Center's backgrounder, "What is the main cause of stigma against individuals with serious

mental illness?" updated in March 2014, explores three topics:

1. Increased stigma against individuals with mental illness
2. The association of violence and stigma
3. How stigma can be decreased

According to the background, it is "self-evident that stigma will not be decreased until we decrease violent behavior committed by mentally ill persons, and this can only be done by ensuring that they receive treatment."

Stigma is one of the most important problems encountered by individuals with severe psychiatric disorders. It lowers self-esteem, contributes to disrupted family relationships, and adversely affects the ability to socialize, obtain housing, and become employed. In December 1999, the Surgeon General's Report on Mental Health called stigma "powerful and pervasive," and the Secretary of Health and Human Services added: "Fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover."

Recent studies have demonstrated that stigma against people with mental illnesses has increased over the past half century and is still increasing. Multiple studies have also shown that the major cause of this stigma is the perception that some individuals with mental illnesses are dangerous. Given this fact, it seems self-evident that stigma will not be decreased until we decrease violent behavior committed by mentally ill persons, and this can only be done by ensuring that they receive treatment.

Thus, campaigns to decrease stigma by simply trying to educate people will not work. The current situation finds an average commuter riding a bus to work, facing an anti-stigma poster proclaiming that "mentally ill persons make good neighbors," and simultaneously reading a newspaper detailing the most recent violent act committed by a mentally ill person.

In 2010, Pescosolido et al. assessed stigma against mentally ill persons using a 2006 survey that had been done simi-

larly to a survey in 1996. They reported that stigma had increased during that 11-year period and that "significantly more respondents in the 2006 survey than the 1996 survey reported an unwillingness to have someone with schizophrenia as a neighbor. . . . Our most striking finding is that stigma among the American public appears to be surprisingly fixed, even in the face of anticipated advances in public knowledge."

Previously, these same researchers had compared the public perception of stigma in 1996 compared to a similar survey carried out in 1950. They reported that, despite an increased understanding of the causes of mental illness in 1996, stigma had increased. This finding was also reflected in the 1999 Surgeon General's report on mental health: "Stigma in some ways intensified over the past 40 years even though understanding improved."

A 2012 national survey of 1797 Americans assessed the effects of a news story about "a mass shooting by a person with a history of serious mental illness" on the attitude of the public. The news story significantly increased negative attitudes to and stigma against mentally ill persons. The authors concluded that such stories "appear to play a critical role in influencing negative attitudes towards persons with serious mental illness and support for gun control policies."

In 2008, a Harris poll reported that a majority of the public believes that violent behavior is a symptom of schizophrenia, and "roughly one in four Americans say they would feel uncomfortable around adults who have been treated for schizophrenia."

In 1999, a man with schizophrenia killed two people in a library in Salt Lake City. According to a newspaper account, within hours Valley Mental Health began getting calls from frightened clients. "Clients were just sobbing," said Connie Hines, public relations director for Valley Mental Health. They were afraid, she said, that the public would want to retaliate against them and that whatever progress had been made in the de-stigmatization of mental health had been set back years by the shooting.

In 1999, a study reported that 61 percent of adults believed that an individual with schizophrenia was "very likely" (13 per-

cent) or "somewhat likely" (48 percent) to do "something violent to others."

In 1996, a study of American university students reported that reading a newspaper article reporting a violent crime committed by a mental patient led to increased "negative attitudes toward people with mental illness."

In 1995, a study in Germany reported that, following two attempts on the lives of prominent politicians by mentally ill individuals in 1990, "there occurred a marked increase in social distance towards the mentally ill among the German public." Although this social distance slowly decreased over the following two years, "it had not yet completely returned to its initial level by the end of 1992."

A 1994 survey of Utah residents reported that 38 percent agreed that "people with mental illness are more dangerous than the rest of society."

A 1993 survey reported that more than half of people agreed with the statement that "those with mental disorders are more likely to commit acts of violence."

The major effort to decrease stigma against individuals with mental illness has been through public service announcements, such as film star Glenn Close talking about her mentally ill sister. There is no evidence that such efforts have any effect in decreasing stigma.

Since violent behavior by individuals with untreated severe mental illness is the main cause of stigma, it is unlikely that stigma will be decreased until the violent episodes are decreased. This was noted as early as 1981 by Dr. Henry Steadman who observed: "Recent research data on contemporary populations of ex-mental patients supports these public fears [of dangerousness] to an extent rarely acknowledged by mental health professionals. It is [therefore] futile and inappropriate to badger the news and entertainment media with appeals to help destigmatize the mentally ill."

This has been noted by many others in the intervening years. For example, in 2012 former APA President Steven Sharfstein noted that negative attitudes toward persons with serious mental illness are unlikely to decline "as long as there are untreated, delusional, disheveled, threatening homeless individuals on our streets and in high-profile media examples of violence."

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.)