NAMI SYRACUSE

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

Newsletter

MAY/JUNE 2016

Meeting Schedule

NAMI Syracuse - Support & Sharing Meeting
Third Tuesday of each month
AccessCNY
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

May 17, 2016	**Support & Sharing Meeting** 7:00pm - AccessCNY
May 20-21, 2016	**NAMI Syracuse Barn/Yard Sale** 2103 West Genesee St., Syracuse 8:00am-3:00pm both days
June 21, 2016	**Support & Sharing Meeting** 7:00pm - AccessCNY
June 28-Aug. 13, 2016	**"SEE ME" Art & Poetry Show** Community Folk Art Center *(see page 3 for details)*
July 1-July 18, 2016	**Nothing to Hide** Photo/Text Exhibit Hazard Branch Library 1620 W. Genesee St., Syracuse
July 19, 2016	**Support & Sharing Meeting** 7:00pm - AccessCNY
October 5, 2016	***Save the Date!*** NAMI Syracuse Educational Conference **Preparing for Tomorrow!**

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 Members:

I'd start this letter talking about the weather, but since I'm finding this to be a particularly cold and dreary spring, I'll start off by talking about what a wonderful children's conference we just had at the Rosamond Gifford Zoo. Special thanks to our Children's Conference Committee: Marla Byrnes, Judy Bliss-Ridgway and Carol Sheldon Brady for putting together such an outstanding day. Those of you who were lucky enough to attend know that the morning and early afternoon was filled with dynamic and informative speakers. Many thanks to Dr. Adrienne Allen, Dr. Bridget Hier and Regina Canuso! In the late afternoon the attendees were moved by a series of heart-wrenching and heart-warming personal stories from mothers. It was so apropos for the week before Mother's Day. Thank you April Lawrence, Kathleen Hyde, Jennifer Daly, Jenny Redmond, and Kelly Covert for your bravery and all you do to help improve the services to our children.

Congratulations to Frank Mazzotti and Spence Plavocos for receiving the 2016 Joe Gentile Memorial Award! Without the two of you, NAMI Syracuse would not be what it is! Thank you both for your many years of dedication and work in the community!

Please plan to stop by our first annual **NAMI Yard/Barn Sale** on May 20th & 21st. Judy Bliss-Ridgway has been kind enough to offer her home for this event. We'll have lots of great deals and all proceeds benefit NAMI Syracuse and all we do! ***(see page 5 for details)***

It's time to start creating brilliant artwork and writing your poetry as we're hosting the **"SEE ME" Art and Poetry Show** again this year at the Community Folk Art Center. This a wonderful venue and we're so pleased to be returning this year!

I hope all of you heeded my advice in the last newsletter and made time for yourself. Even though spring is stubborn this year, go out and plant that garden, take that walk and watch the trees bud, get out your paints and paint the cloudy sunset (then submit it to the art show!), read that good book on the patio while eating chocolate. Enjoy each and every moment in the process of living.

Karen

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

Like

facebook.com/NAMISyracuse

May is Mental Health Month

Nearly 44 million American adults, and millions of children, experience mental health conditions each year, including depression, anxiety, bipolar disorder, schizophrenia and post-traumatic stress. Although we have made progress expanding mental health coverage and elevating the conversation about mental health, too many people still do not get the help they need. Our Nation is founded on the belief that we must look out for one another - and whether it affects our family members, friends, co-workers, or those unknown to us - we do a service for each other when we reach out and help those struggling with mental health issues. This month, we renew our commitment to ridding our society of the stigma associated with mental illness, encourage those living with mental health conditions to get the help they need, and reaffirm our pledge to ensure those who need help have access to the support, acceptance, and resources they deserve.

~~from Presidential Proclamation, National Mental Health Awareness Month, 2016

Reminder...

Register your current Amazon account with NAMI Syracuse Inc. today by going to:

smile.amazon.com

and Amazon will donate 0.5% of the price of your eligible AmazonSmile purchases to NAMI Syracuse!

“SEE ME “NAMI SYRACUSE ART & POETRY SHOW

Name_____

Address_____

Phone_____ **E-mail** _____

Art Title_____

Media (i.e. oil, pastel, photo,etc.) _____

Poetry_____ May submit online to namisyracuse@namisyracuse.org

Do you want your name posted with your art work or first name only?

_____

We are not liable for loss/ damage to your property. Entry is at your own risk. This show is open to the public. Entries must stay up the entire show period. Must be 18 years old or older to enter.

Your artwork must be display ready and wired. One to two pieces per person and list priority for showing due to limited space. If all work cannot be displayed, there will be an “online” gallery.

Please drop off your art piece June 14 - June 17 10am-5pm at Community Folk Art Center, 805 East Genesee St., Syracuse, NY 13210, 315-442-2230.
YOU MUST BRING THIS FORM WITH YOU.
The show will run June 28 thru August 13th.
NAMI Syracuse will host a reception Wednesday, July 13 - 3pm-5pm.
GALLERY OPEN Tuesday-Friday 10 am-5pm and Saturday 11am-5pm
You must pick up your art work August 16-19.

“SEE ME” ART and POETRY SHOW

NAMI Syracuse is again excited to be hosting our 3rd annual art and poetry show June 28-August 13, 2016 at the Community Folk Art Center.

Consumers and family members, 18 years old or older may submit one-two art pieces or poems.

Art work must be display ready.

Deadline for submission of art or poetry is June 14-June 17.

Please see entry form above for details.

Reception to be held on Wednesday, July 13th, 3-5pm, 805 East Genesee St. Community Folk Art Center with live music, poetry readings, and Karen Winters Schwartz book signing.

If you are interested in contributing to the reception on July 13th with desserts/soda/munchies or if you have any questions, please call the NAMI Syracuse office, 487-2085.

Please support our talented family members and families.

PEERING IN: A LOOK AT MENTAL HEALTH PEER PROVIDERS AND HOW THEY HELP PEOPLE RECOVER

by Emily Grosman, HuffPost, 3/1/2016

Kids seem to have a sixth sense. At least that was my experience of them while teaching middle school about a decade ago. There I was, working hard, while also vigilantly trying to hide the fact that I had spent the previous decade in and out of treatment for bipolar II disorder. Yet, somehow, my students kept on coming to me with their mental health struggles. Could they somehow sense that I was more than just sympathetic -- that my empathy was that of a person who had experienced similar?

I will never clearly know the answer to this question -- but one thing did become clear: I had to help these kids, and not just in the traditional way that a teacher is allowed to help--the old guidance counselor referral -- but REALLY help. I remember my tenure year of teaching, when I sat down with another member of the staff at the school and told this person that I was resigning.

"Are you out of your mind?" my colleague said. "You have a stable job WITH a pension, and the economy is terrible. How could you give that up?"

My answer was simple: I needed to follow my heart-and my heart was with those kids - kids like me who could become anything they wanted if they were treated for their mental health struggles early. I knew this first-hand because I had lived it. After being in the psychiatric hospital at least 13 times during my college career, I had graduated, gone to Columbia University to get a master's in education, and started my journey in recovery teaching the students that I loved.

Yet, because I had a huge loan out from my second degree, I couldn't afford to go back to school again for mental health, so I found an alternative: Peer Specialist training. It turned out that NJ had a program that trained people who were living in recovery from mental illness to provide mental health services to others. The concept was that a person with "lived experience" of mental illness and recovery could really help others to get well.

After the training, I went on to work as a peer specialist in community mental health centers, where I worked alongside social workers, psychiatrists, supported employment specialists, and others helping people to get well. I loved (and still love) the work. I even "hung a shingle" and began my own peer specialist practice, which still exists (shameless plug). And then, I got into training other mental health professionals and peers on how to implement services that really put the client and their recovery first (also known as Recovery-Oriented, Person-Centered services), which I still do also.

So, why do I believe in peer services so much? Well, first, I have seen first-hand how we can provide people with mental illness hope. No one can show a person that they can recover from mental illness like a person who's been there. Second, peers know HOW to recover. Don't get me wrong, recovery looks different for each person, but there are common themes and threads that run across every recovery story. We didn't learn from a textbook how to help people recover. We learned how to help people by recovering ourselves. We've walked the walk, tried all different types of treatments, and we have seen first-hand what is effective. Third, we can be your biggest advocates. We know what the mental health system can be like: how at its worst it can be shaming, stigmatizing, and take away people's freedom. We know this because we've lived through it. And, we don't want you to live through the same pain. So, we'll fight for you like no one else.

I believe that recovery is possible. Not just for me, but for EVERYONE. Does this mean that everyone recovers? No, because not everyone is taught the skills to recover. Also, once a person learns the skills, they have to choose to use them. My peer specialist colleagues and I can give you a flashlight so that you can see your way out of the darkness of mental illness. You make the choice about whether or not to turn the flashlight on. I can tell you, that life can be absolutely beautiful in the light of recovery. Won't you join me here?

Family Tapestry

'Heroes of Hope' Annual Walk

Family Tapestry is a grassroots not-for-profit organization that assists families who have children with mental health challenges. Our mission is to join families together to find strength and support from each other in their times of need. We work to empower them to become strong advocates for themselves and their families. Your donation and/or support will help us with this mission.

Family Tapestry Inc.
118 Grandy Dr
Liverpool, NY 13088
Phone (315) 559-2174
familytapestryinc@gmail.com

SATURDAY, MAY 21, 2016
Burnet Park-Skating Rink Area
Registration: 9:00am to 9:45am
Walk: 10:00 am-1:00pm
RAIN OR SHINE
Suggested Donation per Walker:
$25.00 includes T-Shirt
16 year olds and under
must be accompanied by an adult

The Family Tapestry Board Thanks You!

Keeping young minds and their families woven together!

Hutchings Psychiatric Center
Family & Community
Education Schedule

June 14, 2016 10:00am-12:00 noon

The Ontrack Model: Early Intervention for Psychosis

Presenters:
Rachel Cowen, LCSW-Program Mgr.
Julie Aspenleiter, Psychologist
Hutchings Psychiatric Center

Free and open to the public. Room 102, 545 Cedar St., Syr., NY. To register call, 426-6873 or 426-6870.

LETTER TO THE EDITOR: CONTACT HOTLINE IS HERE TO LISTEN, PREVENT SUICIDE

by Pat Leone, Executive Director, Contact Community Services

Citing a report by the Federal Centers for Disease Control and Prevention, The Post Standard and media outlets from around the country reported last week that the nation's suicide rate is at its highest level in 30 years. *(see page 9 of this newsletter for article)*

Unfortunately, that's not news to us.

At Contact Community Services in East Syracuse, we operate the Contact Hotline and serve as a National Suicide Prevention Lifeline center for local and national calls. From April 1-25, we received about 1,500 crisis-related calls and 475 of those calls said they were thinking about killing themselves. And more that 70 of those 475 callers were serious enough that we had to send help to keep them safe.

This past weekend, we received calls from around the country from a man who was about to jump from a bridge; a woman whose son had killed himself and she wanted to do the same; and a man who had just tried to asphyxiate himself. Locally, we received three calls from parents who were worried that their children were going to kill themselves.

We want to remind you that we've been answering the Contact Hotline since 1971 and we're here to help with free and confidential crisis and suicide prevention counseling, training and information. The Contact Hotline number is 315-251-0600 (877-400-8740 if you live in Cayuga County). For all of the services we provide, please visit: **contactsyracuse.org** and click on "crisis and suicide prevention."

*~~reprinted from **The Post Standard**, Syracuse, NY*

NAMI Syracuse Barn/Yard Sale

Friday, May 20th, 8am - 3pm
Saturday, May 21st, 8am - 3pm
2503 West Genesee Street, Syracuse
~~all proceeds to benefit NAMI Syracuse~~

Please stop by and support NAMI Syracuse!

Shining the Spotlight on Mental Health Awareness Month

The Krebs, the restored landmark restaurant in Skaneateles, that donates a share of its earnings to charity, will host another in a series of celebrity bartender events to benefit local causes.

This month **The Krebs,** 53 W. Genesee St., Skaneateles is supporting **Mental Health Awareness Month** on **Thursday May 19th from 5:30p.m.-7:30pm**

Celebrity bartenders for the evening include Ed Sayles, former Artistic Director for the Merry-Go-Round Playhouse in Auburn and now Consultant for ARC of Onondaga, and others. Our own Board Member, Sherie Ramsgard will also be helping the celebrities pour drinks while educating the crowd on Mental Health.

Proceeds/tips made for the evening will benefit NAMI Syracuse!

NOTHING TO HIDE - MENTAL ILLNESS IN THE FAMILY PHOTO/TEXT EXHIBIT

Hazard Branch Library, 1620 West Genesee Street, Syracuse 13204 will display our **Nothing to Hide** photo/text exhibit July 1 through July 18, 2016.

Nothing to Hide provides people coping with mental illness and their families an opportunity to come out of the shadows and into the public eye. The compelling stories of children, siblings, parents, grandparents and extended family members demonstrate strength, courage, integrity, and accomplishment in the face of adversity and stigma.

Created by Family Diversity Projects, Inc. a non-profit organization based in Amherst, Massachusetts, this powerful and moving exhibit has been purchased by NAMI Syracuse and **is available for loaning to mental health centers, hospitals, high schools, colleges, universities, corporations, libraries and faith houses** in an effort to help dispel harmful stereotypes, myths and misconceptions about mental illness. **Nothing to Hide** consists of photographs by Gigi Kaeser and text from interviews conducted by Jean Beard and Peggy Gillespie with individuals and their families whose lives have been affected by schizophrenia, bipolar disorder, obsessive compulsive disorder, major depression, and other serious brain disorders.

If you are interested in displaying this exhibit at your location or would like more information, please contact the NAMI Syracuse office, 315-487-2085 or namisyracuse@namisyracuse.org

NOW THAT SPRING IS HERE, GET OUT AND WALK!

Getting out for a walk has well-documented benefits for your mood. Here's a quick spin through the positive effects for the body too:

Managing Weight. Walking helps control food cravings and promotes weight loss. University of Pittsburgh researchers found that overweight people who walked briskly for 30 to 60 minutes a day shed pounds even if they didn't change any other lifestyle habits. Another study of overweight individuals, published in the journal PLOS One in March 2015, found that walking briskly for 15 minutes reduced their urge to consume chocolate treats even after three days of chocolate deprivation.

Preventing Chronic Illness. Walking has been shown to maintain blood sugar levels, lower blood pressure, and reduce the risk of diabetes, heart attack and stroke. In fact, two large, long-term studies out of Harvard University suggest that walking for just 20 minutes a day can cut the risk of having a heart attack by 30 percent. People who have been sedentary before beginning a walking program see the biggest gains.

Sleeping Better. The National Sleep Foundation highlights the connection between regular exercise and a good night's rest. Although people who get vigorous exercise on a regular basis report getting the best sleep, Brazilian researchers found that a single session of walking made it easier for people with chronic insomnia to fall asleep and stay asleep.

FOR POLICE, A PLAYBOOK FOR CONFLICTS INVOLVING MENTAL ILLNESS

by Erica Goode, April 25, 2016

In response to high-profile shootings of people with mental illness, police departments around the country are turning to crisis intervention training.

PORTLAND, Ore. - The 911 caller had reported a man with a samurai sword, lunging at people on the waterfront.

It was evening, and when the police arrived, they saw the man pacing the beach and called to him. He responded by throwing a rock at the embankment where they stood.

They shouted to him from a sheriff's boat; he threw another rock. They told him to drop the sword; he said he would kill them. He started to leave the beach, and after warning him, they shot him in the leg with a beanbag gun. He turned back, still carrying the four-foot blade.

In another city - or in Portland itself not that long ago - the next step would almost certainly have been a direct confrontation and, had the man not put down the weapon, the use of lethal force.

But the Portland Police Bureau, prodded in part by the 2012 findings of a Justice Department investigation, has spent years putting in place an intensive training program and protocols for how officers deal with people with mental illness.

At a time when police behavior is under intense scrutiny - a series of fatal shootings by police officers have focused national attention on issues of race and mental illness - Portland's approach has served as a model for other law enforcement agencies around the country.

And on that Sunday last summer, the police here chose a different course. At 2:30 a.m., after spending hours trying to engage the man, the officers decided to "disengage," and they withdrew, leaving the man on the beach. A search at daylight found no signs of him.

People with mental illnesses are overrepresented among civilians involved in police shootings: Twenty-five percent or more of people fatally shot by the police have had a mental disorder, according to various analyses.

In Chicago, for example, police officers killed a 19-year-old mentally ill man, Quintonio LeGrier, in December after the police said he had come at them with a baseball bat. In Denver, Paul Castaway, 35, who had a history of mental illness, was fatally shot by the police last year after they said he moved "dangerously close" to them, holding a knife to his own throat. Similar encounters have occurred in Albuquerque, Dallas, Indianapolis and other cities.

In response to public outcry, many police departments have, like Portland, turned to more training for their officers, in many cases adopting some version of a model pioneered in Memphis almost three decades ago and known as crisis intervention team training, or C.I.T.

Studies have found that the training can alter the way officers view people with mental illness. And the approach, which teaches officers ways to defuse potentially violent encounters before force becomes necessary, is useful for officers facing any volatile situation, even if a mental health crisis is not involved, law enforcement experts say.

Whether the training leads to less use of force by officers, however, is still an open question: The findings of studies have been mixed, although one study to be published later this year suggests that Portland's program, which is based on C.I.T., is having an effect. And training alone is not enough, experts say. For the approach to be effective, it needs the full backing of a police department's leadership, continual checks on its effectiveness, and collaboration with the mental health community.

"The training is great, but it's not magic," said Laura Usher, coordinator of crisis intervention team training for the National Alliance on Mental Illness. "The thing that actually transforms the way the system works is when everyone gets together."

The decision by the Portland police to leave the sword-wielding man on the beach was controversial within the department. Some officers argued that more should have been done: What if the man had injured or killed someone? Others countered that it was late and that the secluded area was deserted. The man had committed no crime. And a confrontation could easily have ended with him or the officers being harmed.

But the discussion itself, some officers said, was a sign of change. "Ten years ago, we would have been more proactive in dealing with him at the start," said Officer Brad Yakots, a specialist in mental health issues who was called to the scene. "It's a new way of looking at it."

As in other cities, change in Portland began with a fatal encounter: On Sept. 17, 2006, James Chasse Jr., 42, a singer in a local band who had schizophrenia, died after a confrontation with police officers.

Mr. Chasse's death outraged the public. The Police Bureau, in response, revised policies and required all its officers to complete 40 hours of crisis intervention training.

But after more troubling instances involving the mentally ill, a Justice Department investigation concluded in 2012 that the Police Bureau had shown "a pattern or practice of unnecessary or unreasonable force during interactions with people who have or are perceived to have mental illness."

This time, the Police Bureau's leadership responded far more aggressively. In addition to the mandatory training for the entire force, a group of about 100 patrol officers signed up for 40 extra hours of instruction to handle more complex calls involving mental illness or drug and alcohol addiction.

Teams of officers were paired with mental health clinicians to follow up on cases. New protocols were put in place. And the police connected with housing and mental health organizations to help further.

"It's really about a culture shift," said Lt. Tashia Hager, who heads the unit that coordinates the department's mental health response.

She noted that in cases like that of the man with the sword, "there's a potential negative outcome regardless of the decision we make."

In the past, she said, officers were taught, "If you do this, I'm going to do that." Now they are encouraged to question whether "that" is really necessary.

Officers need to be educated about mental illness, many criminal justice experts say, because cutbacks in financing for mental health services have put them on the front lines of dealing with many people who have psychiatric disorders.

Jails around the country have filled with mentally ill inmates who, unable to obtain treatment in the community, are arrested time and again for minor offenses like disorderly conduct and petty theft. Police officers have been forced to play dual roles as law enforcers and psychiatric social workers.

"We are working in the backdrop of a fractured mental health system that has gotten worse and worse," said Portland's police chief, Lawrence O'Dea III.

Yet many police officers know little about mental disorders, and what they do know is often shaped by stigma. Bizarre behavior is often interpreted as a prelude to violence. And routine police actions aimed at control - placing a hand on a person's shoulder, for example - can backfire with someone with a severe mental illness.

"Instead of being calming, it can trigger them to either pull away or resist," said Matthew Epperson, an assistant professor of social work at the University of Chicago. The officers, in turn, can misinterpret such responses as resistance or an attempt to flee, he added.

In the crisis training, officers learn about psychiatric medications, role play various scenarios, and have opportunities to interact with people who have a mental illness when they are not in crisis.

The officers are told, among other things, to use distance and time to try to defuse potentially violent encounters.

About 2,700 law enforcement agencies around the country use some form of the approach, said Ms. Usher, of the mental illness alliance, and that number is growing as more departments have come under pressure to change police behavior.

In January, responding to a series of high-profile shootings across the country, a group of law-enforcement leaders urged departments to adopt higher standards for the use of force than those set down by the Supreme Court, and to adopt methods to defuse volatile situations and avoid violence.

Some departments require crisis training for all their officers. But Maj. Sam Cochran, who coordinated the first crisis intervention program in Memphis and now consults with other departments, said he believed the training worked best when departments trained a smaller group of volunteers who then took the lead on police calls involving mental health issues.

"There's all kinds of specialization in law enforcement," Major Cochran said. "We've got bomb technicians, narcotics, robbery. I want all the officers present at a scene to understand that this C.I.T. officer is the leader. That represents clarity, and responsibility brings about a level of accountability."

In a draft report released this month, outside monitors concluded that the Police Bureau in Portland still had more to do, including keeping better track of how many police contacts involved mental health issues.

But the bureau, the monitors said, had made "substantial progress" in improving the way they dealt with the mentally ill.

And the study of the Portland police that is to be published later this year found that the use of force by officers had decreased by 65.4 percent from 2008 to 2014, as measured in quarterly reports. The researchers attributed the drop in large part to increased training and oversight in recent years, although the study did not specifically look at interactions with the mentally ill.

Police shootings, the researchers found, had also dropped, averaging three a year from 2007 to 2014, compared with eight a year from 2002 to 2005. And allegations of excessive force by citizens declined by 74.2 percent from 2004 to 2014, a decrease that Tim Prenzler, an adjunct professor of criminology at Griffith University in Australia and the lead author of the study, called "a remarkable achievement." The research will appear in Journal of Criminological Research, Policy and Practice.

Officer Yakots, who has been on the force for nine years, said he thought that the department's efforts to shift course had been largely successful. But he added: "Do things fall through the cracks? Yeah, it's not perfect. A lot of times we have limited resources."

It was a Monday night in late February when he and his partner, Officer Michael Hastings, were making the rounds of makeshift homeless camps and downtown street corners, listening for radio calls that might require their presence.

An adolescent girl was on an overpass, threatening to jump. A college student had called his mother in another city and told her he was going to kill himself. A 38-year-old woman was standing outside a mental health treatment center demanding to be taken to the hospital because, she said, "I am suicidal and homicidal."

Officer Hastings said that before the department changed its approach, the attitude was "enforce, enforce, enforce, arrest, arrest, arrest." But taking people to an emergency room or putting them in jail did nothing. "These people, they're out within four hours most of the time," he said.

At least in Portland, Officer Hastings said, most police officers had accepted that part of their job was now dealing with mental illness and helping to find longer-term solutions.

"We've realized that it is what it is," he said, "and we're the ones that are going to be responding to that."

6 TOTALLY AWFUL LIES THAT MENTAL ILLNESS TOLD ME

by Sam Dylan Finch, 3/11/16

For a long time, I believed that my mental illness was my own doing.

Back when I was dealing with a depressive episode, one of my partners told me, "Sam, you have to remember that not everything you think is true."

Simple, but it was a real revelation for me. Sometimes with bipolar disorder, it's incredibly hard to distinguish between your own voice and the fears, trauma, and outright lies that run on a loop in the back of your head.

I liken my experiences with mental illness to being in line at a grocery store: I've placed everything on the belt and, while the cashier is ringing everything up, some snot-nosed jerk is placing random items on the belt when I'm not looking.

Suddenly, I've got stuff I didn't even want and I'm the one paying for it.

Mental illness has a sneaky way of selling us lies. Before we know it, we're leaving the metaphorical grocery store with 10 pounds of dog food for a dog we don't even have. We've got heaps of cashews and a nut allergy.

In other words, someone pulled one over on us.

Not to be outdone, I've compiled this list of some of the worst lies mental illness has ever told me. Because while it might be in my cart, I'm sure as hell not buying it.

1. You just aren't an ambitious person.

For the longest time, as I struggled under the weight of my depression, I watched my friends and peers excel in their passions and/or careers. I was amazed with how driven they were, and wondered how they seemed to have it all.

Then I looked at myself, floundering. And I thought, "I'm just not driven like they are. I'm not ambitious. It's not who I am."

What I wish had occurred to me then was that when you're struggling with mental illness, every bit of your resources goes towards your own survival.

Not getting a byline in The New York Times, not mastering a second language, not getting a graduate degree or whatever impressive thing I thought I "should" be doing. Because staying alive? That was my priority. My only priority.

As I began to get the help I needed, I was able to start setting goals for myself and enjoying the pursuit of those goals. As it turns out, my "ambition" or work ethic wasn't the problem - it was a psychiatric disability.

2. This is the way things will always be.

I can only speak for myself in this instance - I won't assume to know anyone else's situation. But when mental illness tells me that I somehow have the ability to know the future and that the future is entirely dismal, I've learned to be a little more skeptical.

The reality is that I know nothing about the future with any certainty. That is not a psychic ability I possess, no matter how my depression might make me feel.

I remember where I was just a few years ago, desperately suicidal and lost, feeling that there was nothing ahead of me that was worth holding on for.

And then I look at where I am now, doing meaningful work and surrounded by a beautiful community that cares for me, and I can't believe how wrong I was about my future.

I said that my future was empty. I believed that with everything in my being. But it couldn't be more full, more vibrant, more fulfilling.

3. You are unlovable.

I have stayed in relationships that hurt me on every conceivable level because I honestly believed that I was unlovable. I thought that any person who loved me in spite of my illness was some kind of heroic savior to whom I owed my life.

I couldn't have been more wrong.

The truth is that we all have endured some kind of trauma. We all bring "baggage" to a relationship - some more than others - because we have all lived, we've all been hurt, we've all been broken.

Those experiences are not flaws that make us unworthy of love - they are experiences that have shaped who we are. And the people who truly love us for us will know that mental illness is not a character flaw, but a struggle that makes us so very human.

The folks who can't understand that aren't proof that we're unworthy. It simply means that they aren't ready to be a part of our journey.

4. You will only be happy if you "get rid of" your illness.

I used to think that I would only be happy if I came as close to being "neurotypical" as possible. I thought that I needed to be cured to live a whole, fulfilling life

What I've learned is that recovery is not about eliminating my mental illness.

For me, it's been coexisting with it, adapting in the face of its challenges, and understanding how to ride the waves as they come.

My recovery has been about turning down the volume so that it's no longer earshatteringly loud and senseless. Recovery is taking the unbearable sounds and quieting them into music.

5. Your struggles are all your fault.

For a long time, I believed that my mental illness was my own doing.

I believed that if I had chosen differently, the outcome would have somehow been better - maybe I wouldn't be bipolar, anxious, agoraphobic, messy, broken.

It's harder to be honest and say, "It's a complex combination of biological, sociological, and psychological factors that I will probably never understand in my lifetime."

It's harder to accept that some trauma may be inevitable or out of our control.

It's harder to accept that society conditions us to feel like we are at fault for our own illness.

But it starts with realizing that regardless of how we arrived where we are, we can begin to practice compassion - compassion for ourselves, compassion for what we've been through, compassion for all the difficult choices we made to survive.

And I've found that, in the end, choosing compassion has done more for me in my recovery than self-blame and self-deprecation ever have.

6. You won't live past age 18.

Or 19- 20- 21- 22-23- 24...

And yet, my birthday rolls around every year, and I spend a good portion of my day in tears because I can't believe that I'm still here.

Not only am I grateful that I'm here, but I'm grateful for the person I've become - someone who wouldn't be who he is without the struggle it took to get here.

By no means has this been an easy road. And some days - when my anxiety is so raw that I can't leave my apartment, or when I'm wide awake at three in the morning, convinced that I'm total human garbage - I really wish that the journey had been easier rather than longer.

But I can honestly say that of any lie mental illness has ever whispered into my ear, this is the one that I'm most grateful to be wrong about.

US SUICIDE RATE SURGES TO A 30-YEAR HIGH

by Sabrina Tavernise, April 22, 2016

Suicide in the United States has surged to the highest levels in nearly 30 years, a federal data analysis has found, with increases in every age group except older adults. The rise was particularly steep for women. It was also substantial among middle-aged Americans, sending a signal of deep anguish from a group whose suicide rates had been stable or falling since the 1950s.

The suicide rate for middle-aged women, ages 45 to 64, jumped by 63 percent over the period of the study, while it rose by 43 percent for men in that age range, the sharpest increase for males of any age. The overall suicide rate rose by 24 percent from 1999 to 2014, according to the National Center for Health Statistics, which recently released the study.

The increases were so widespread that they lifted the nation's suicide rate to 13 per 100,000 people, the highest since 1986. The rate rose by 2 percent a year starting in 2006, double the annual rise in the earlier period of the study. In all, 42,773 people died from suicide in 2014, compared with 29,199 in 1999.

"It's really stunning to see such a large increase in suicide rates affecting virtually every age group," said Katherine Hempstead, senior adviser for health care at the Robert Wood Johnson Foundation, who has identified a link between suicides in middle age and rising rates of distress about jobs and personal finances.

Researchers also found an alarming increase among girls 10 to 14, whose suicide rate, while still very low, had tripled. The number of girls who killed themselves rose to 150 in 2014 from 50 in 1999. "This one certainly jumped out," said Sally Curtin, a statistician at the center and an author of the report.

American Indians had the sharpest rise of all racial and ethnic groups, with rates rising by 89 percent for women and 38 percent for men. White middle-aged women had an increase of 80 percent.

The rate declined for just one racial group: black men. And it declined for only one age group: men and women over 75.

From 1999 to 2014, suicide rates in the United States rose among most age groups. Men and women from 45 to 64 had a sharp increase. Rates fell among those age 75 and older.

The data analysis provided fresh evidence of suffering among white Americans. Recent research has highlighted the plight of less educated whites, showing surges in deaths from drug overdoses, suicides, liver disease and alcohol poisoning, particularly among those with a high school education or less. The new report did not break down suicide rates by education, but researchers who reviewed the analysis said the patterns in age and race were consistent with that recent research and painted a picture of desperation for many in American society.

"This is part of the larger emerging pattern of evidence of the links between poverty, hopelessness and health," said Robert D. Putnam, a professor of public policy at Harvard and the author of "Our Kids," an investigation of new class divisions in America.

The rise in suicide rates has happened slowly over many years. Federal health researchers said they chose 1999 as the start of the period they studied because it was a low point in the national suicide rate and they wanted to cover the full period of its recent sustained rise.

The federal health agency's last major report on suicide, released in 2013, noted a sharp increase in suicide among 35- to 64-year-olds. But the rates have risen even more since then - up by 7 percent for the entire population since 2010, the end of the last study period - and federal researchers said they issued the new report to draw attention to the issue.

Policy makers say efforts to prevent suicide across the country are spotty. While some hospitals and health systems screen for suicidal thinking and operate good treatment programs, many do not.

"We have more and more effective treatments, but we have to figure out how to bake them into health care systems so they are used more automatically," said Dr. Jane Pearson, chairwoman of the National Institute of Mental Health's Suicide Research Consortium, which oversees the National Institutes of Health funding for suicide prevention research. "We've got bits and pieces, but we haven't really put them all together yet."

She noted that while N.I.H. funding for suicide prevention projects had been relatively flat - rising to $25 million in 2016 from $22 million in 2012 - it was a small fraction of funding for research of mental illnesses, including mood disorders like depression.

The new federal analysis noted that the methods of suicide were changing. About one in four suicides in 2014 involved suffocation, which includes hanging and strangulation, compared with fewer than one in five in 1999. Suffocation deaths are harder to prevent because nearly anyone has access to the means, Ms. Hempstead said. Death from guns fell for both men and women. Guns went from being involved in 37 percent of female suicides to 31 percent, and from 62 percent to 55 percent for men.

The question of what has driven the increases is unresolved, leaving experts to muse on the reasons.

Julie Phillips, a professor of sociology at Rutgers who has studied suicide among middle-aged Americans, said social changes could be raising the risks. Marriage rates have declined, particularly among less educated Americans, while divorce rates have risen, leading to increased social isolation, she said. She calculated that in 2005, unmarried middle-aged men were 3.5 times more likely than married men to die from suicide, and their female counterparts were as much as 2.8 times more likely to kill themselves. The divorce rate has doubled for middle-aged

and older adults since the 1990s, she said.

Disappointed expectations of social and economic well-being among less educated white men from the baby-boom generation may also be playing a role, she said. They grew up in an era that valued "masculinity and self-reliance" - characteristics that could get in the way of asking for help.

"It appears this group isn't seeking help but rather turning to self-destructive means of dealing with their despair," Professor Phillips said.

Another possible explanation: an economy that has eaten away at the prospects of families on the lower rungs of the income ladder.

Dr. Alex Crosby, an epidemiologist at the Centers for Disease Control and Prevention, said he had studied the association between economic downturns and suicide going back to the 1920s and found that suicide was highest when the economy was weak. One of the highest rates in the country's modern history, he said, was in 1932, during the Great Depression, when the rate was 22.1 per 100,000, about 70 percent higher than in 2014.

"There was a consistent pattern," he said, which held for all ages between 25 and 64. "When the economy got worse, suicides went up, and when it got better, they went down."

But other experts pointed out that the unemployment rate had been declining in the latter period of the study, and questioned how important the economy was to suicide.

The gap in suicide rates for men and women has narrowed because women's rates are increasing faster than men's. But men still kill themselves at a rate 3.6 times that of women. Though suicide rates for older adults fell over the period of the study, men over 75 still have the highest suicide rate of any age group - 38.8 per 100,000 in 2014, compared with just four per 100,000 for their female counterparts.

THE COMPANION'S DILEMMA

If we were to ask companions and family members of loved ones diagnosed with mental illnesses "what are the most difficult challenges you regularly face?" non-compliance of treatment by their loved one might be at the top of many lists. Whether family members encounter occasional resistance to sensible and appropriate choices or are regularly confronted by defiant refusal to cooperate in any element of treatment, the results are very much the same: stress-filled worry eventually followed by unshakable, up-all-night concern over the whereabouts, safety and present condition of someone they deeply and truly love.

Fear is an unsettling, foreboding visitor. For companions of a loved one with an untreated mood disorder, fear can:

rob us of peace of mind

force unbearable worry on all members of the family

result in sleepless nights filled with guilty thoughts of "what did we do (or fail to do) that caused things to get so bad?"

fill everyone with paralyzing anxiety.

Persons with mental illness are already at risk of any number of challenges. Whether these challenges can be effectively controlled, specialists advise us, depends on the disease being consistently and adequately treated. So when we support a loved one with a mental illness that has been accurately diagnosed and he or she provided with an appropriate treatment program to follow, the family may well expect:

recurring problems to become less frequent as well as less severe

when issues do reoccur, symptoms will prove easier to resolve

the prospect for longer lasting recovery in the future will become more favorable

relapse may be avoided altogether.

When we are trying to help a loved one with a mental illness that is not accurately diagnosed and there is no adequate treatment program developed or being followed:

symptoms will be more evident and occur more frequently

symptoms often become even more intense and increasingly difficult to control

stability takes longer to achieve, if it ever does

ongoing untreated illnesses, tragically, all too often become life-threatening.

A serious mental health condition that remains untreated is commonly due to the patient preventing her or his own recovery. In such situations what, if anything, can family members or companions do about it? How does one overcome such resistance? How is that accomplished?

~by Jerry Malugeon

The CNY Chapter of the American Foundation for Suicide Prevention invites you to

BAND TOGETHER
For Suicide Prevention

Saturday, May 21st, 2-6pm
Sharkey's
7240 Oswego Rd., Liverpool
performances by:
Driftwater The Lightkeepers
$15 in advance - $20 at the door
Purchase tickets by visiting
afsp.org/centralny or 315-664-0346

All proceeds benefit American Foundation for Suicide Prevention.

In Memoriam

NAMI Syracuse offers our sympathy and prayers to Ardis Egan whose son, **Donald** passed away on January 28, 2016.

We also offer our condolences to the family of **Rosemary Caldwell** who passed away on February 22, 2016. Rosemary had been a loyal and faithful member of NAMI since 1986.

We thank Ardis and Christine Spinelli and Lawrence Caldwell for designating donations in their loved one's memory be sent to NAMI Syracuse.

Rest in Peace
Donald & Rosemary

WHAT IS THE REAL MEANING OF "PSYCHOTIC?"

from HealthyPlace.com

What is the Real Meaning of "Psychotic?"

He's psychotic. You're delusional. I must be hallucinating. Terms related to psychosis are common and thrown around as casual slang. But do people fully understand the meaning of psychosis and its related terminology? What does psychotic really mean? Psychotic is a term that doesn't describe people at all. It describes a class of disorders which include schizophrenia and schizoaffective disorder. A mental illness can be a psychotic disorder, but a man or a woman experiences psychosis.

Psychosis refers to a break with reality. A person's mind begins to play tricks on him, and he can't tell the difference between what is real and what his mind is experiencing as real. The tricks happen in the form of hallucinations and/or delusions. Hallucinations involve the senses; something deep within a person's brain tells her that one or a combination of the senses (sight, sound, smell, touch, taste) is sending signals that the person experiences as real. Delusions are similar, but they involve thoughts and beliefs rather than senses. When a person experiences psychosis, he/she can't differentiate the tricks in the brain from the real world. The hallucinations and delusions of psychosis, the actual experiences rather than the cliched expressions, can be confusing and frightening.

HYPOMANIA BY DEFINITION

*from **bp magazine**, Spring 2016*

The mood state of hypomania can be found all along the bipolar spectrum. A hypomanic episode paired with one or more lifetime episodes of depression leads to a bipolar II diagnosis. Bipolar I is diagnosed based on the presence of mania, but hypomania and depression typically form part of the package.

Hypomania is often seen as "mania lite" because both have the same checklist of symptoms. With hypomania, the symptoms don't last as long and don't interfere significantly with work or school, relationships or "usual pursuits." However, impulsivity, overspending, risky behaviors, and relationship stress can leave calamity in hypomania's wake.

Hypomania may be an "edge state" into or out of mania, and often foreshadows a subsequent drop into depression.

If symptoms last more than seven days, include any psychotic features, or result in hospitalization, you've officially entered a manic episode. Watch for:

- decreased need for sleep
- uncharacteristic feelings of restlessness or lots of energy
- feelings of extreme and intense happiness (euphoria)
- increased distractibility, irritability and aggression
- more talkative, talking faster than usual
- swarming ideas, racing thoughts
- increased activity, such as taking on new projects and socializing more
- inflated self-esteem or overestimating one's importance (grandiosity)
- poor judgment and risky behavior, such as chancy financial decisions and sexual promiscuity.

YOU & YOUR PSYCHIATRIST - MAXIMIZING RESULTS

*from **bp magazine**, Spring 2016*

Your psychiatrist isn't a miracle worker. You have some responsibilities in making the most of your partnership, too. In his article "New Models of Psychiatrist-Patient Relationships," Kevin Turnquist, MD lists:

Behavior That Make Your Treatment Less Effective:

- Wanting to chat instead of talking about important things that need to be covered.
- Saving the most important topics for the end of the appointment, when there isn't enough time to discuss them.
- Not providing enough information to find effective solutions to complex problems.
- Asking for advice, then neglecting to follow it. Also, not taking medications as prescribed.

He also has advice on:

Assessing How Your Treatment Is Going:

- Whenever you take a psychiatric medication, know what it is supposed to do. Define the target symptoms that it is supposed to affect.
- Be as honest as possible about your medication compliance. If you're not truthful, the doctor may conclude that you need more medication than is currently prescribed.
- If it is hard for you to tell if your symptoms are getting better (and this is pretty common), enlist the assistance of people you trust.
- Realize that recovery from severe mental illnesses is usually a lengthy process and will look different for everyone.

Hope Connections

Hope Connections is a peer recovery coaching for people affected by substance use and/or in search of mental wellness.

Mission Statement: We are a community of "Peers" promoting integration through transformative teamwork that empowers, advocates, and mutually supports people by inspiring hope through choice and opportunity within Onondaga County.

- **Call Hope Connections, 315-362-7629**
- Participate in a brief needs interview.
- Develop a plan to co-explore people, places, and spaces in the community.
- Embark on your journey to connect with your passion.
- Unlock your potential and energize your livelihood!

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: _____

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**

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.)