



NAMI SYRACUSE

National Alliance on Mental Illness

Newsletter

JANUARY/FEBRUARY 2012

Meeting Schedule

NAMI Syracuse - Support & Sharing Meeting

Third Tuesday of each month, 7pm, **Transitional Living Services,**

420 East Genesee Street, Syracuse

Madison County - Support & Sharing Meeting

Third Tuesday of each month, 6pm, Oneida Library, 220 Broad Street, Oneida

NAMI Syracuse - Information & Education Meeting

Quarterly Meetings to be announced

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

January 17, 2012	Support & Sharing Meeting Syracuse - 7:00pm Madison County - 6:00pm
February 21, 2012	Support & Sharing Meeting Syracuse - 7:00pm Madison County - <i>no meeting</i>
March 20, 2012	Support & Sharing Meeting Syracuse - 7:00pm Madison County - <i>no meeting</i>
April 17, 2012	Support & Sharing Meeting Syracuse - 7:00pm Madison County - 6:00pm

Reminder: *The Depression and Bipolar Support Alliance, CNY Support Group, a self-help, peer-to-peer support group run by and for people with a diagnosis of depression and bipolar disorder, meets every Tuesday, 6:30 - 8:00pm at Transitional Living Services, 420 East Genesee Street.*

Contents

Message from The President	2
Active Minds: Changing the Conversation about Mental Health	3
NAMI Syracuse Elects New Board Members	3
Severe Mental Disorders Highly Prevalent In Jails, Prisons	4
Meditation Can "Turn Off" Regions of the Brain	4
Finding Purpose After Living with Delusion	5
NY's Chance for Better Mental Health Care	7
Non-Adherence Common in Schizophrenia Patients	8
Eat Feel-Good Foods	8
"A Bitter Cold Night" - Personally Speaking	9
Elder Suicide: A Public Health Challenge of the Elder Boom	9
Mental Crisis and Weapons Spell Trouble	10
Family Members as Partners with the Treatment Team	11
2012 Hutchings Psychiatric Center Family and Community Education Schedule	11
Off-label Antipsychotic Use Helpful for Generalized Anxiety and OCD	11

MESSAGE FROM THE PRESIDENT

Dear Members:

What's with this weather? I hear so many people being grateful that there is no snow and it's been so often unseasonably warm for Syracuse weather; but, I worry about not having water in the summer.

I hope everyone had great holidays according to their traditions. I know that it can become a very stressful time of year; and, families with a member with mental health issues enjoying the holidays often depends on how well that person is handling the stress.

NAMI Syracuse is planning a conference this spring about mental health issues in children. Andrew Gerber, MD, PhD, Child and Adolescent Psychiatrist from Columbia University Medical Center, New York Psychiatric Institute will be our keynote speaker for the conference on May 16, 2012. Joe and I participated in Dr. Gerber's session at the NAMI NYS conference last November, and were impressed by his knowledge, and commitment to his work. I am very excited that we are taking steps to bring more education and support to the families, teachers, and care providers working with these special needs children.

In fact, I should add the general public to the above list. I believe that educating *all people* is the most effective way to stomp out the stigma related to mental illness. Recently, I was quite surprised to hear Rick Santorum (one of the Republican candidates running for the office of President this year), at one point while talking about his wife and children, he looked down from the camera, became red faced as he mentioned his child who has "mental issues". Families should not have to deal with such shame and the stigma of mental illness.

Respectfully,
Judy

Save the Date: Wednesday, May 16, 2012

To celebrate May is Mental Health Month and to honor the memory of Joe Gentile, NAMI Syracuse is planning an educational conference focusing on childrens issues.

Our Children's Mental Health

Rosamond Gifford Zoo
Wednesday, May 16th
9:00am-3:00pm
\$35.00 (includes lunch)

More about the conference in next newsletter!

Presenters:

Dr. Kevin Antshel
Dr. James Demer
Dr. Andrew Gerber
and more....

NAMI Syracuse Officers

Judy Bliss-Ridgway.....President
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Help us update our files! To keep you better informed of our services, meetings and events, please send your email address to: namisyracuse@namisyracuse.org or call 315-487-2085.

For the newest happenings at NAMI Syracuse visit us on Facebook and LIKE our page!

NAMI Standards of Excellence

For several years, National NAMI leaders and members have been working together to craft "mutually agreed upon standards of operation." In September 2011, in keeping with the **Standards of Excellence** and based on input from the members, the NAMI Board of Directors established NAMI's standardized dues at \$35.00 to take effect in July 2012. More about the NAMI **Standards of Excellence** to follow in next newsletter.

ACTIVE MINDS: CHANGING THE CONVERSATION ABOUT MENTAL HEALTH

by Mark Katz, Ph.D.

The stigma associated with mental health issues can be far more painful to bear than the challenges themselves. For college students who are affected by mental health challenges, the rapidly growing network of campus-based, student-led chapters of Active Minds can help. Based in Washington, DC, this nonprofit organization works to remove the negative perceptions about mental illness at colleges and universities throughout the United States.

By using the student voice, Active Minds aims to “change the conversation about mental health.” Mental illness is frequently misunderstood, not only by college students with symptoms but by a significant percentage of the general population as well. Stigma decreases as understanding grows, and college students who are suffering in silence become far more willing to seek the help they need. Some students with learning or attention difficulties experience co-occurring mental disorders, and for this reason, the Active Minds mission will resonate for a number of students with ADHD. A sampling of the organization's national and campus-based programs can be found on ActiveMinds.org.

Send Silence Packing, an Active Minds campaign designed to increase awareness of student suicide, is among the organization's signature programs. Roughly 1,100 college students take their lives each year, according to program director Sara Abelson, MPH. The campaign presents a public awareness display of 1,100 individual backpacks, many donated by parents grieving the loss of their child to suicide. Each backpack tells a person's story. The collection travels from campus to campus around the country, reaching tens of thousands of students. They put a face and a personal story to a suicide, so that others not simply treat it as a statistic. Students who are at risk learn about resources that can help. “It's very important that students themselves are educated and empow-

ered,” says Abelson. “Research shows that sixty-seven percent of young people who do choose to disclose suicidal thoughts disclose them first to their friends.” Active Minds also reaches out to parents and family members, many of whom participate in campus-based activities designed to increase awareness.

For college students, the days and weeks leading up to final exams can be a particularly stressful time. So, each year during the spring semester, Active Minds chapters sponsor National Stress Out Day activities designed to help students learn ways to manage stress and reduce anxiety. The program is conducted in collaboration with the Anxiety Disorders Association (ADAA), with support from OCD Chicago and the National Suicide Prevention Lifeline (NSPL).

More than a hundred chapters conduct special campus-based events to combat stigma during Mental Health Awareness Week. Their mantra: “Stigma is shame. Shame causes silence. Silence hurts us all.”

Chapters also reach out to local high schools, helping the younger teens become more aware of different mental illnesses and symptoms. They spread the message that there's no longer any reason to suffer in silence. While the vast majority of chapters are located on college campuses, a few now also exist on high-school campuses.

Active Minds is the brainchild of Alison Malmon, who started the organization in 2001, following the tragic loss of her older brother to suicide. Her only sibling, he had been experiencing serious symptoms for several years prior to his death, yet spent much of that time suffering in silence. Malmon created Active Minds so that no one suffering with mental health challenges ever has to reach the point of feeling hopeless. Among her goals is spreading awareness that help is available and that people with mental health challenges can lead meaningful and productive lives.

Students whose symptoms go back many years likely have also endured the stigma associated with these symptoms for many years. This was clearly illustrated in the findings from the National Stigma Study-Children (NSS-C), the first large-scale national survey of public beliefs and attitudes regarding children's mental health, including beliefs and attitudes

about ADHD. Nearly half of the respondents believed that children diagnosed with and receiving services for a mental health condition would experience immediate and lasting social ramifications (including rejection in school and later in life). More than two-thirds had negative views on psychiatric medications.

For college students who have endured this double burden for many years, Active Minds could not have come along at a better time. Readers interested in learning more about the organization are encouraged to visit ActiveMinds.org. Facebook groups are also available for those wishing to engage in more immediate dialogue.

NAMI SYRACUSE ELECTS NEW BOARD MEMBERS

Congratulations to the newly elected NAMI Syracuse Board Members:

**Lori Bachman-Oot
Dr. Stephen Glatt
Katherine Spottek**

Also, congratulations to current Board Members voted on for their second two year term:

**Marla Byrnes
Ann Canastra**

Thank you to those members completing their term on the Board:

**Ardis Egan
Judy Flint
Kristin Neagle**



SEVERE MENTAL DISORDERS HIGHLY PREVALENT IN JAILS, PRISONS

by Neil Osterweil, *Clinical Psychiatry
News Digital Network*

U.S. correctional institutions are estimated to be housing 1 million men and women with serious mental illnesses such as schizophrenia or a major affective disorder, investigators reported at the annual meeting of the American Academy of Psychiatry and the Law.

The estimated prevalence of serious mental disorders among U.S. inmates ranges from 7% to 16%. Men with mental illness are four times more likely to be incarcerated than the general population, and women with mental illness have an eightfold higher risk, reported Georgia Stathopoulou, Ph.D., and her colleagues from Massachusetts General Hospital and Harvard Medical School, both in Boston.

“The prevalence of serious mental health issues is higher among incarcerated individuals than in the general population, and is associated with specific sociodemographic characteristics like male gender, younger age, and non-white race. Severe psychopathology is also associated with higher recidivism and more serious criminal offenses,” they wrote in a poster presentation.

The investigators reviewed the medical literature and U.S. Department of Justice statistics to get a handle on the size of the problem.

They found that about 804,000 people with severe mental disorders are jailed annually, and that 72% of both men and women with serious mental illness who are in jail had a co-occurring substance use disorder.

The high rates of substance use and abuse is one of the primary factors contributing to the high incarceration rate of the mentally ill, they said. Other factors, they said, are:

“The prevalence of serious mental health issues is higher among incarcerated individuals than in the general population.”

- Insufficient community resources.
- A national drug policy that emphasizes interdiction over treatment.

- Delays in release from prisons and jails to the community.

- Insufficient inmate access to evidence-based mental health therapies.

- Insufficient planning for reentry of mental health inmates into the community.

Jail inmates with mental health disorders are twice as likely as inmates without mental illness to have been homeless in the year before their arrest (13% vs. 6%), 3 times more likely to report a history of sexual or physical abuse (24% vs. 8%), and twice as likely to have lived in a foster home or institution when they were growing up, the authors found.

Specific criminal actions associated with mental disorder diagnoses include higher rates of assault among inmates with bipolar disorder, and higher assault, homicide, and drug possession rates among those with schizophrenia or nonschizophrenic psychosis.

The investigators cited a retrospective study of more than 79,000 Texas inmates, which found that inmates with bipolar disorder were more than 3 times more likely than inmates without psychiatric disorders to be incarcerated 4 or more times during a 6-year period.

Inmates with major depressive disorder, schizophrenia, and nonschizophrenic psychotic disorders also were significantly more likely to be imprisoned repeatedly, compared with the general prison population.

In all, 89% of the state public and private adult correctional facilities provide some type of mental health services to inmates. Of this group, 51% provide around-the-clock services, 71% offer therapy or counseling from trained mental health professionals, and 73% dispense psychotropic drugs.

“We need new treatments, and these treatments have to be evidence based. These treatments have to address both public safety and the clinical needs of inmates,” Dr. Stathopoulou said in an interview.

The authors did not disclose a funding source for the study. Dr. Stathopoulou reported that she had no relevant conflicts of interest.

MEDITATION CAN “TURN OFF” REGIONS OF THE BRAIN

Brain imaging shows experienced meditators can prevent their minds from wondering. **HealthDay News** 11/22/11

A new study finds that people skilled at meditation seem able to turn off areas of the brain associated with daydreaming and psychiatric disorders such as autism and schizophrenia.

Learning more about how meditation works could help advance research into a number of diseases, according to lead author Dr. Judson Brewer, an assistant professor of psychiatry at Yale University.

He and his colleagues used functional MRI to assess brain activity in experienced and novice meditators as they performed three different meditation techniques.

Regardless of the type of meditation, skilled meditators had decreased activity in the brain's default mode network, which has been linked to attention lapses and disorders such as anxiety, attention deficit hyperactivity disorder, and the buildup of beta amyloid plaques associated with Alzheimer's disease.

The researchers also found that when the default mode network (which consists of the medial prefrontal and posterior cingulate cortex) was active, brain regions associated with self-monitoring and cognitive control were also activated in experienced meditators, but not novices.

This suggests that skilled meditators constantly monitor and suppress the emergence of “me” thoughts and mind wandering. If they become too strong, these two states of mind are associated with diseases such as autism and schizophrenia.

The experienced meditators were able to co-activate the two brain regions both during meditation and while resting, which suggests they have developed a “new” default mode that's more present-centered and less self-centered, the researchers said.

“Meditation's ability to help people stay in the moment has been part of philosophical and contemplative practices for thousands of years,” Brewer said. “Conversely, the hallmark of many forms of mental illness is a preoccupation with one's own thoughts, a condition meditation seems to affect. This gives us some nice cues as to the neural mechanisms of how it might be working clinically.”

FINDING PURPOSE AFTER LIVING WITH DELUSION

by Benedict Carey, *New York Times*,
November 25, 2011

She was gone for good, and no amount of meditation could resolve the grief, even out here in the deep quiet of the woods.

Milt Greek pushed to his feet. It was Mother's Day 2006, not long after his mother's funeral, and he headed back home knowing that he needed help. A change in the medication for his schizophrenia, for sure. A change in focus, too; time with his family, to forget himself.

And, oh yes, he had to act on an urge expressed in his psychotic delusions: to save the world.

So after cleaning the yard around his house - a big job, a gift to his wife - in the coming days he sat down and wrote a letter to the editor of the local newspaper, supporting a noise-pollution ordinance.

Small things, maybe, but Mr. Greek has learned to live with his diagnosis in part by understanding and acting on its underlying messages, and along the way has built something exceptional: a full life, complete with a family and a career.

He is one of a small number of successful people with a severe psychiatric diagnosis who have chosen to tell their story publicly. In doing so, they are contributing to a deeper understanding of mental illness - and setting an example that can help others recover.

"I started feeling better, stronger, the next day," said Mr. Greek, 49, a computer programmer who for years, before receiving medical treatment, had delusions of meeting God and Jesus.

"I have such anxiety if I'm not organizing or doing some good work. I don't feel right," he said. "That's what the psychosis has given me, and I consider it to be a gift."

Doctors generally consider the delusional beliefs of schizophrenia to be just that - delusional - and any attempt to indulge them to be an exercise in reckless collusion that could make matters worse. There is no point, they say, in trying to explain the psychological significance of someone's belief that the C.I.A.

is spying through the TV; it has no basis, other than psychosis.

Yet people who have had such experiences often disagree, arguing that delusions have their origin not solely in the illness, but also in fears, longings and psychological wounds that, once understood, can help people sustain recovery after they receive treatment.

Now, these psychiatric veterans are coming together in increasing numbers, at meetings and conferences, and they are writing up their own case histories, developing their own theories of psychosis, with the benefit of far more data than they have ever had before: one another's stories.

"It's a thrilling time, because people with lived experience are beginning to collaborate in large numbers," said Gail A. Hornstein, a psychologist at Mount Holyoke College and author of *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness*. "They are developing their own theories, their own language about what their experiences mean from the inside."

Mr. Greek is one of the most exceptional, having built a successful life and career despite having schizophrenia - and, he says, because of it. He manages the disorder with medication, personal routines, and by minding the messages in his own strange delusions.

"Schizophrenia is the best thing that ever happened to me," he said. "I know a lot of people with the diagnosis don't feel that way, but the experience changed me, for the better. I was so arrogant, so narcissistic, so self-involved, and it humbled me. It gave me a purpose, and that purpose has been very much a part of my recovery."

The Village Eccentric

Like many idealistic undergraduates, Mr. Greek arrived at Ohio University in Athens on a mission. Only, like many undergrads, he wasn't completely sure what it was.

"To discover a psychological code that people should live by, to create world peace," he said. "Something like that."

The town was ready to listen, regardless. It was the fall of 1981, and Athens still had one sandal planted in the 1960s; communes thrived in the Appalachian foothills to the north, and big ideas were in the air, at least

in the streets and bars near campus, where professors and students gathered.

One stood out. "You can't imagine how intense he was back then," said June Holley, a friend and business consultant in Athens. "He had this long, very thick, curly chestnut hair and wild eyes; he looked like a lion. He could be loud, and I think a lot of people just didn't want to deal with it."

Local residents gave him the sidewalk, avoided eye contact, and generally accepted him as one variety of village lunatic - in a town with a rich history of them.

He knew the role, at some level. The son of a college math professor and a lawyer, progressives both, Milton Thomas Greek grew up in Roanoke, Ill., and neighboring Benson, about two hours southwest of Chicago. He declared himself an atheist early and often, which in a devout Christian community was one way to stir the air - and the boys who ruled the schoolyard.

"They told me I was damned - damned! - and came after me," Mr. Greek said. "Now I see that it was just an excuse, like picking on the fat kid for being fat, or the nerd for being a nerd. But at the time I thought it was all about religion."

He did not discover the secret to world peace and, by senior year, was in a troubled marriage, and began seeing and hearing things others did not. One day he saw a homeless man in the Athens bus station with eyes "like landscapes that went back into the man's head infinitely far, stretching on for eternity." God's eyes; who else?

Later, he was hitchhiking, and a man with long hair and sandals pulled over to offer a ride, his eyes rippling with the same eternal light as the street person's. Jesus? It had to be ("I'd already met God, so it made sense.") The man said something about a small town in the woods, and Mr. Greek thought that that town had to be heaven.

His marriage collapsed. His friends stopped calling. He was back at home in Illinois when a doctor finally gave him a diagnosis - schizophrenia - and prescribed medication.

It seemed like a charade, from start to finish. The doctor never asked what he thought his hallucinations meant, or whether the strange thoughts were linked to experiences in his life. He stopped taking the pills.

"I became very suicidal," he said. "I had no idea what's happening to me during this entire time. I had been this big atheist, but here I am thinking that the rapture is about to start and that I'm the Antichrist - all this religious imagery."

Why?

The answer was obvious and ultimately liberating, but he had to spend a long time wandering in the woods - literally - to find it.

It was 1984, he had begged his way back into Ohio University for graduate studies in sociology, still lost in his own mind, his thoughts turning darker by the day. He was alienating classmates, professors, friends.

About the only exception was Ms. Holley, a graduate student some 15 years his senior who enjoyed his company, and one day he decided to visit the commune where she lived, with her family and several other families. It took him two days to find it, the first spent wandering the misty woods until dark in a waking, delusional dream, and the second stumbling into a clearing just off Hooper Ridge Road, where Ms. Holley and her friends took him in.

Over the next several months they sat with him, accepted him as a member of the tribe, and encouraged his mission to improve the world at face value. And save his life they probably did, in part by suggesting that he seek help.

It was Ms. Holley who delivered the message. "I trusted her completely, so when she said I was hallucinating - when she used the word "hallucination" - I knew it was true," Mr. Greek said. "I would have to give the medication another try."

He was lucky. It worked, blunting the psychosis enough that he was able to complete a programming course and find work, first in Illinois and later back in Athens at Ohio University's Information Technology Department. In time he found something more: During a snowstorm in 1996, Mr. Greek knocked on the door of a neighbor he had seen around Athens, a single mother with two teenage children, carrying a full-time job plus graduate classes, who was at that very moment (he would learn later) praying

for something to get her through the winter.

The man at the door did not exactly look like a savior, in his beat-up jeans and unruly hair, his soft eyes and half-smile. But he offered to cook dinner - stir fry - on a day when the fridge was nearly empty.

The two neighbors became friendly, then close, and finally fell for each other. Neither can say exactly when it happened, but she remembers looking out her window one day to see Mr. Greek pull up to his apartment across the street, his old Honda coughing white smoke. He popped the hood and backed away from the car in slow motion, staring at the engine, then turned abruptly toward his apartment - and vanished, falling face-first into some bushes. "I thought, "Well, O.K., he's got something," she said. "I'm not sure what. Absentmindedness, maybe?"

They married in 2003 (Mr. Greek's wife, an artist, asked that her name not appear in this article, for her own privacy), and she helped him fit his religious delusions, now controlled by medication, into a coherent personal story that has guided his day-to-day life.

The frightening voices and ominous signs saying that he was damned were no more than embodiments of his very real childhood terror of being cast out, as the schoolyard boys threatened. His search for heaven on earth was in part an attempt to escape that fate, to find a secure place. But it also dramatized a longing to put the world right, a mission that may have started as vain fantasy, but in time became an emotional imperative, a need to commit small acts of kindness, like cooking dinner for a snowed-in neighbor.

A Regimen for Coping

"He has this long list of causes that he's extremely passionate about, and he has strong opinions about almost everything, but he's also very sensitive to his relations with people and open to other philosophies," said Melissa Van Meter, who has worked with Mr. Greek at the university and holds very different political views. "It has just impressed me that he could handle so much personally and do so well professionally."

"When I began to see the delusions in the context of things that were happening in my real life, they finally made some sense," Mr. Greek said. "And understand-

ing the story of my psychosis helped me see what I needed to stay well."

Mr. Greek's regimen combines meditation, work and drug treatment with occasional visits to a therapist and a steady diet of charitable acts. Some of these are meant to improve the community; others are for co-workers and friends, especially those dealing with a psychiatric diagnosis.

To help others experiencing psychotic delusions, he relies on his own theory of what delusions may mean. In an analysis of 20 delusional experiences, all described by sufferers in the first person, Mr. Greek identifies four story lines.

Among them are the rescuer (on a mission to save a particular group); the self-loathing person (lost in a sense of extreme worthlessness); the visionary (on a journey to spiritual realms to bring back truth); and the messianic (out to transform the world through miracles, or contact with deities) - the last of which is his own psychosis story.

Each, in Mr. Greek's reading, grows out of a specific fear or trauma, whether isolation, abuse or family dysfunction, in the same way his own delusional story symbolized a fear of being a social reject. He is preparing the study for publication in a psychiatric journal and has put much of his thinking into a manual for families dealing with psychosis, called *Schizophrenia: A Blueprint for Recovery*.

Mr. Greek's analysis of the story lines in psychosis is certainly not the first of its kind, nor the most comprehensive. Psychiatrists, psychologists, therapists and brain scientists have spun out hundreds of ideas about what goes on during a delusion.

But until recently patients themselves - that is, nonprofessionals who have lived with hallucinations and delusions - had little more than their own strange story to study, in any detail. Now they have dozens, and Mr. Greek is one of a small number of such "native" theorists who argue that the content of a delusion should not be ignored but engaged, carefully, once a person has his or her hallucinations under control.

Underlying Needs

"By exploring a person's anomalous beliefs and experiences, we are better able to understand the underlying feeling and needs that give fuel to these experiences," said Paris Williams, a psychologist who has struggled with psychosis and recently

published a doctoral dissertation analyzing the content of six people's delusions, which has informed Mr. Greek's work.

For instance, said Dr. Williams, who is working on a book called *Rethinking Madness*, "we can find ways to make them feel safe when they believe they are being persecuted by malevolent forces, or find ways to help them feel empowered when they experience demanding voices."

One place Mr. Greek feels safe is in a clearing in the woods behind his house, where on a recent afternoon he disappeared wearing a tie-dyed shirt and old jeans with the knees worn completely through. He practices mindfulness meditation here, tuning in to the rhythms of life that usually pass unnoticed.

Back at home, he runs thoughts and perceptions by his wife. "He says things like, "Is that a marching band I'm hearing, or am I just hallucinating?," she said. "I'll say, "Uh no, I don't hear a band, Milt," and he's fine."

And he visits a therapist when stress levels are running very high. The therapist has given him diagnoses of schizophrenia and "mood disorder, not otherwise specified," according to his medical records, and she treats him in sessions and with an antipsychotic drug, adjusting the dosage up or down depending on his mood.

Since his mother's death, Mr. Greek and his wife have taken several more emotional blows, with other close relatives dying. He has been especially stretched, between his work, various community projects, and traveling to speak, often to police groups about how to understand psychotic thinking when dealing with people on the street.

It was too much, and in August he visited his therapist again, and soon after made a deal with his wife. "She and I signed a contract identifying and limiting volunteer work I will do next year," he said in an e-mail. "I am being coached on how to say no."

The world is not yet saved from itself, nor for that matter is Athens. But even a messianic rescuer needs a day off, if only to come back stronger the next.

NY'S CHANCE FOR BETTER MENTAL HEALTH CARE

by Glenn Liebman, *Albany Times Union* Commentary, November 30, 2011

New York is transforming the system of care for almost 1 million people on Medicaid, using the federal health care reform known as health homes.

The health home concept is a good one. It says that the locus of control of one's care is patient-centered and coordinated through a network that, in many cases, will include hospitals, mental health organizations, health plans, community-based organizations, health centers and addictions disorders providers. A designated care manager will help coordinate these services.

It is hard for a mental health advocate to argue against a concept that provides a more comprehensive approach to mental health and other health care. Many people with mental illness have substance abuse issues and health-related issues like diabetes and high blood pressure.

For many people in the mental health system, getting access to non-mental health professionals has been an exercise in futility. They sometimes have to wait months before seeing a health care professional who will take Medicaid patients.

Gov. Andrew Cuomo and his staff should be commended for putting together a strong process in a short amount of time. State agencies have worked hard to provide information and education to the public and to health home applicants.

However, as we know, the devil is in the details. There is still much that has to be worked out before there are guarantees of successful outcomes. Our concerns include:

Mental health services: According to the state Health Department, all applications to serve as a health home must have a strong mental health component. We agree and want to make sure that the applicants selected as health homes have robust community mental health systems in place that include peer services, trauma-based care, family services, employment and educational support, suicide prevention training and access to emergency services.

Funding: There are real concerns that health homes will not be able to sustain effective care coordination long term without additional funding. This is especially relevant because the federal government is providing 90 percent of the Medicaid funding over the next two years.

Choice: The state plans to create only one or two health homes in smaller counties and three to five in large counties. In the Capital Region, that means that there may only be one health home for each county.

What individuals most want is choice. If one health home does not offer the kind of mental health services they think would help in their recovery, then other options should be available. Limited choices mean limited opportunities.

Oversight: There now are limited mechanisms to provide a level of oversight to ensure that health homes provide the kinds of measures that positively affect patient care. The last thing anyone wants to see happen is a health home that underperforms and hurts patients. Each region should also have a strong oversight mechanism and an advisory body that includes recipients and families whose job is to meet regularly with the local health home to follow up on any concerns.

The half-full side says that health homes will lead to much needed access to quality services for people with mental illness. The half-empty side says that without full access, choice and oversight, mental health services will be even more diminished. Continued advocacy is critical to ensure that the half-full side comes to fruition.

Glenn Liebman is CEO of the Mental Health Association in New York State.



NON-ADHERENCE COMMON IN SCHIZOPHRENIA PATIENTS

Published 12/9/11 by Magpie Media

A recent study on medication compliance shows that 40 percent of schizophrenia patients do not take their medication as prescribed. The study also showed that the severity of the illness and the patient's attitude towards medication significantly affected their non-adherence.

"Lack of adherence to medication regimens is a critical issue in the treatment of schizophrenia and has serious impacts on the course of the illness, including worsening of symptoms, relapse, suicidal attempts, repeated emergency room visits or re-hospitalization, and poor functional outcomes," says Seung-Hyun Kim, of the Korea University Research Institute of Mental Health in Seoul, Korea, and team. "The most common methods of assessing adherence are self-reports and physician reports. However, adherence to medication regimens in patients with schizophrenia may be over-estimated by both patients and clinicians."

An assessment on 51 schizophrenia patients was completed over an eight-week period on medication adherence. The investigation used four different methods of assessment, including pill counts, a self-reporting system, a clinical rating scale, and a Medication Event Monitoring System (MEMS), in which a microprocessor on medication bottles records the number of times the bottle is opened.

Researchers analyzed the relationship between patients' medication adherence and their scores on the Positive and Negative Syndrome scale (PANSS), the Drug Attitude Inventory (DAI), as well as the Clinical Global Impression of Severity (CGIS) scale.

The MEMS identified that over the study period, 58.8 percent of patients were adherent to their medication routines. This was determined by medication containers being opened within three hours of each scheduled dose.

The MEMS method of assessing adherence rates was significantly lower

than the other three methods of assessment, including the self reporting questionnaire which presented a 74.5 percent adherence rate, as well as the clinical rating scale and pill counts, which both reported a 92.2 percent adherence rate.

It was also discovered that patients who were considered non-adherent by the MEMS had much higher PANSS scores than adherent patients in terms of poor impulse control, excitement, and preoccupation symptoms.

Adherent patients also appeared to have a more positive attitude towards medication, represented by their higher DAI score, 4.30 compared to 2.38 in non-adherent patients.

"The results of this study agree with those of previous studies showing that non-adherence to antipsychotic medication in schizophrenia is common in outpatient practice settings," Kim and his colleagues concluded. "Factors associated with non-adherence in the present study were higher symptom scores and attitude toward medication. These may represent modifiable risks that, if addressed, could lead to improved adherence and improved patient outcomes."

Source - MedWire News

EAT FEEL-GOOD FOODS

Published 12/14/11 by Magpie Media

It is no surprise that the foods we eat play a significant role in our emotions, moods, and mental health. Here are some foods that can help improve the feel good hormones in our brain:

Omega-3 fatty acids - Foods that are rich in omega-3 fatty acids such as salmon, sardines, ground flaxseed, and walnuts are good foods for your brain. Omega-3s help improve the communication between our brain cells. They also enhance the concentration of two neurotransmitters that regulate our mood, dopamine and serotonin.

Magnesium - Magnesium helps produce the feel good hormone serotonin, and should be an essential part of your diet to help beat depression. Magnesium can be found in foods such as bananas, almonds, artichokes, brown rice, pine nuts, and tuna, amongst others.

B vitamins - Vitamins in the B family, including folate, B12, and B6 are very important for healthy brains. They can be found in foods such as mackerel, shellfish, liver, lean beef, cheese, and eggs.

Saffron - Saffron is a red spice common in Persian foods that can help raise your spirits. It has been traditionally used in Persian medicine, often steeped as a tea or cooked in rice to help boost moods. It has the same affects as some modern antidepressants by making serotonin more available in the brain.

Dark chocolate - Apart from the delicious taste, the antioxidants in chocolate are known to help lower levels of the stress hormone cortisol. A study from the Nestle Research Center in Switzerland showed that stressed individuals who ate 1.4 ounces of dark chocolate every day for two weeks experienced lower levels of stress. But be cautious and don't over indulge: 1.4 ounces of chocolate has 230 calories.

Carbs - Carb-cutting may help you lose weight, but it will also have an unintended effect on your mood. Carbohydrates help produce serotonin in the brain, so cutting carbs out of your diet can result in heightened anxiety, anger, and depression.

Here are foods you should avoid:

Coffee - A recent study showed that women who drank two cups of coffee a day were less likely to suffer from depression. At the same time, coffee is a stimulant, and the quick pick-me-up buzz that comes from the caffeine does not last long. Caffeine also gets in the way of your body absorbing essential depression-fighting vitamins and minerals such as magnesium and zinc.

Meat - Meat is full of saturated fats and omega 6 fats. In moderation, there is no problem; however, an excess of meat can help contribute to mood disorders, as omega 6 fats affect the absorption of omega 3 fats needed to fight depression.

Alcohol - Although some may think otherwise, alcohol is a known depressant. It reduces the absorption of magnesium and the B vitamins, and also affects feel good serotonin levels.

Junk food - The high glycaemic index and trans fatty acids in junk food cause large spikes and low drops in blood sugar. This makes it difficult for your body to sustain energy, which can also result in lower moods. Junk food is also stripped of essential nutrients needed for a healthy nervous system.

Source - Huffington Post

**“A BITTER COLD NIGHT” -
PERSONALLY SPEAKING**

from The Treatment Advocacy Center

Many years have passed since I was mentally ill and homeless. Today I think many services to help the homeless and mentally ill are state-of-the-art.

I have written newsletters on homelessness and mental illness over the years including a 35-page article I had published about my experiences while homeless called *My Life on the Street*. This was written under the pseudonym, Rose, because I did not automatically want to be linked to homelessness. I needed some privacy during those years. That feeling changed over the years; and I write about many mental health issues including homelessness. I have never used a pseudonym again.

One experience I had during the years of homelessness toward the end of my odyssey was at a shelter - one of the first in existence to deal with homelessness I believe. There was staff available to try to link persons with services. I did not take advantage of these services since I believed my “voices” with my whole being that I was living as I was supposed to be. I don’t know what the staff thought of me nor did I think of that. My focus was on being in sync with my “voices.”

At this shelter there was a person who I would see on the street during the day since shelter persons had to leave the shelter during the day. He may have had a drinking problem, but I am not sure. I never saw him in conversation with himself so I don’t think he was hearing “voices.” Maybe he was. Each time I saw this person he would mumble loudly something negative about me, or he would shout out “here comes the homeless woman.” I knew enough to ignore him and avoid him when I could. He would continue his verbal insults when we were both at the shelter at night. Again, I ignored him.

One bitter cold night at the shelter he became out of control with his rage at seeing me at the shelter and picked up a chair and threw it at me. He missed me for which I am thankful. The staff immediately stepped in. To my great surprise,

they told me I would have to leave the shelter. I asked why I had to leave since I had not provoked the situation. There was no discussion, and I was escorted out of the shelter.

I remember that night vividly. I had no money. The streets were bare so I could not even try panhandling. I did survive the night somehow without shelter. In all the years since this experience, I never wrote about this because in my writing I wanted to try to be positive about the goodness I did find while homeless and mentally ill. Today I want to document this experience.

Through my eyes today looking back, I think it was known I was mentally ill. It would not be hard to figure out I don’t think. I think that was why the choice was made for me to leave. I remember being so very hurt that I was given no warmth on this bitter night. I never tried to return to the shelter again.

Today with at least some shelters there are mental health counselors present so I don’t think something like this experience would happen again. Maybe this experience and a few other similarly harsh experiences can be credited with giving me the gift of empathy toward others. To close, I again give thanks to my higher power for seeing me through this tumultuous time in my life.

Valerie Fox
(a person in recovery)

**ELDER SUICIDE: A PUBLIC
HEALTH CHALLENGE OF THE
ELDER BOOM**

*by Michael Freidman, Adjunct Associate
Professor, Columbia University Schools of
Social Work and Public Health
Huffington Post, January 2012*

By the age of 88, Mr. W. had lost most of his closest friends to death or dementia. His children had moved to other parts of the country. He saw them and his grandchildren rarely. He had retired from his long career as a teacher without finding new interests. But he and his wife were happy. They both read a great deal, and every day they took a walk together, talked about books and the state of the world,

stopped for happy hour at a local restaurant where “everyone knew their name.” When his wife developed lung cancer, he took her for treatment and nursed her at home. But her cancer was more virulent than most. She died quickly. The children came for the funeral and stayed a couple of weeks, but then they went back to their homes. He was alone, and he felt lost. He began to have bouts of dizziness and severe heart burn. He went to the doctor, who prescribed medications that helped a bit. One day after a doctor's visit he went home and took his own life.

Nearly 15 older adults take their own lives every day in the U.S. -- about 5400 per year. The frequency of suicide among older adults is not well-known, probably because older adults die from many other causes. Suicide is among the top three causes of death for teenagers and young adults; it is not among the top 20 causes of death for women over 65 and is only the 17th leading cause of death for older men. But the fact of the matter is that older adults complete suicide at a rate nearly 50 percent greater than people 15-24 years old. Older white men are particularly vulnerable, completing suicide at a rate three times that of the general population. White men over 85 are the population at highest risk; they take their own lives at about four times the rate of the general population.

There are a number of striking facts about suicide among older adults.

Older men are far more likely to take their own lives than older women, despite the fact that women are far more likely to have a major depressive disorder.

Most older adults who complete suicide have seen their primary care physician within 30 days of taking their own lives but have not been identified as a suicide risk.

Older adults may not attempt suicide more frequently than younger people, but their attempts are generally more lethal.

Men usually use guns to take their lives. Women usually take pills.

Reducing suicide among older adults is an important public health imperative that will become even more important over the next two decades as the population of older adults booms. But it will not be easy to achieve.

Frequently the onus is placed on primary care physicians because a majority of older

adults who take their own lives have made a doctor's visit shortly before they choose to end their lives. And it is likely that if doctors screened for depression as a matter of course, asked more questions and explored what was going on in their patients' lives, they would identify more of their patients who are depressed and might be able to provide treatment that would avert suicide.

But suicide risk is not easy to identify. Most people who are depressed are not going to kill themselves, some people who kill themselves are not depressed, and a great many people who do kill themselves hide their intention very effectively. Let me rush to say that some do not hide their intentions, and people who say they are considering suicide must be taken seriously.

If you are worried about yourself or someone you know, call the National Suicide Prevention Lifeline -- 1-800-273-TALK or visit <http://www.suicidepreventionlifeline.org/>

There are other warning signs of suicide in addition to talking about suicide, including depression, substance abuse, history of suicide attempts, and more. For older adults, recent loss, severe physical illness, social disconnection or increased dependency and loss of dignity sometimes contribute to the decision to attempt suicide.

But most people who exhibit warning signs do not attempt suicide, and people like Mr. W., who are stoic by nature, keep their feelings to themselves and who have guns at home are very hard to identify as suicide risks.

Yeates Conwell, perhaps the nation's leading expert on suicide among older adults, uses the interpersonal theory of suicide to explain the complex factors that contribute to older adults' decisions to take their own lives. According to this theory the decision arises in large part from a mix of "thwarted belongingness" and "perceived burdensomeness."

The implication of this theory is that prevention of suicide cannot be accomplished solely through improved identification of risk, timely intervention and access to help. These are important; but, in addition, older people need a place of belonging and a sense that becoming

dependent does not mean becoming an intolerable burden.

That will be a tremendous challenge in our ageist society, which tends to disparage age. Even in families who choose to be care-givers, older adults with disabilities are often not treated with enough dignity and respect.

In other contexts, the kind of societal change that is needed has been called building "age-friendly communities". It may well be that in the long run the public health challenge of elder suicide is more about building such communities than about traditional preventive interventions.

MENTAL CRISIS AND WEAPONS SPELL TROUBLE

Last year, officers shot three men in Syracuse who had mental health issues, one fatally. The following letters appeared in the Syracuse Post Standard newspaper after the third shooting.

Treatment of mentally ill is failing them and us

To the Editor:

The unfortunate incident in which a mental patient was shot by police officers will generate public scrutiny over police training and preparedness. That is a valid concern, but the much more relevant issue is how the medical profession and society now treat mental illness in the decades following deinstitutionalization. Closing state mental hospitals nationwide was considered a progressive move for those compliant patients whose condition can be controlled by medication. The public only hears about the people who create headlines, but there are many others who choose not to take their medications or who do not respond to medication.

For many years I have observed some of the best psychiatrists in Syracuse and in Manhattan. In most cases, these well-trained professionals have little idea how any specific patient is going to react to treatment. CPEP, the psychiatric emergency room, has a revolving-door policy. Patients can legally refuse to enter an ambulance. Coupled with this, we have an abysmal mix of county social services to

care for these patients at home. The net result is that some become homeless and others are left to be cared for by frustrated family members who have zero training or experience for the task.

In many cases, these various services have failed to fill the void created by deinstitutionalization. I believe that we need an expansion of state mental facilities such as Hutchings where patients who are resistant to treatment or non-compliant can be treated safely, thus eliminating the tragic consequences of confronting the police.

David L. Feiler
DeWitt

Recent shooting points to need for programs

To the Editor:

The latest police shooting of a mentally disabled man in Syracuse is beyond words.

I have attended mental health conferences where presenters told us there is a special training program for police to deal with the mentally disabled. Has the Syracuse Police Department received this training? If not, they certainly should.

What people need to understand is that when you see a mentally disabled person out of control, it may be the result of a lack of proper care and humane treatment for many years.

We need a state-of-the-art brain center (like the many state-of-the-art cancer centers) to give mentally disabled patients all the programs, tools and latest technology to help make them better. Most important, we need research to find a cure for these devastating illnesses.

Betty Pringle
Manlius

**Injustice anywhere
is a threat to justice everywhere.**

~~Martin Luther King, Jr.
January 15, 1929 - April 4, 1968

FAMILY MEMBERS AS PARTNERS WITH THE TREATMENT TEAM

Family members are often called upon to play a significant role in the support of their ill family member. Because family members can have insight that is incredibly valuable to the treatment team, such as family health history, the history of a loved one's illness, the patient's current strengths and deficits, what was the level of his/her functioning before the onset of the illness, and/or knowledge of their loved one's use/abuse of alcohol or illegal substances, they are an important resource. Family involvement and collaboration with the treatment team should be actively encouraged and supported whenever appropriate.

Unfortunately, some facilities may not encourage family involvement with the treatment team, even though organizations such as the American Psychiatric Association recognize in their guidelines the considerable benefits to treatment by doing so: "A guiding principle is that the patient's family members should be involved and engaged in a collaborative treatment process to the greatest extent possible." (American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Schizophrenia, second ed. 2004, pp 70, 106),

Furthermore, with respect to facilities operated by the New York State Office of Mental Health, Section 29.13 of the Mental Hygiene Law requires the development of a written treatment plan. The treatment plan outlines treatment goals, what programs or therapies will be undertaken to achieve these goals, and a timetable for assessing progress. Under this law, parents of minors in OMH operated facilities must be involved in the development of a treatment plan, (unless the minor is over 16 years of age and objects to such participation, and a clinician determines it is not clinically appropriate to involve them.) If an adult patient in an OMH operated facility requests that a family member be involved in the development of his/her treatment plan, that person must be included in its development.

Other accrediting organizations, such as the Joint Commission, have stated that "patients and, when appropriate, their families (must be) informed about the outcomes of care, treatment and services." (The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH), 2006, RI 2.90, second ed., 2004.)

Tips for working with treatment team members:

- Act professionally - be calm, polite and persistent
- Respect others' time - be prepared for meetings, and don't be late
- Prepare for meetings by writing down the points you want to cover (to be submitted at the meeting, as necessary). Be concise but thorough in your communications.

~reprinted from NAMI News Update, NAMI Rochester Fall 2011 Edition

OFF-LABEL ANTIPSYCHOTIC USE HELPFUL FOR GENERALIZED ANXIETY AND OCD

Some newer generation antipsychotic medications may be useful for treating generalized anxiety disorder (GAD) and obsessive-compulsive disorder (OCD), a new study has found.

American researchers looked at "off-label" uses of antipsychotics, in which they're prescribed for conditions not included in the U.S. Food and Drug Administration approval. Quetiapine was associated with benefits in the treatment of generalized anxiety disorder, and Risperidone was associated with benefits for obsessive-compulsive disorder.

The study, which appeared in the *Journal of the American Medical Association*, was entitled "Efficacy and comparative effectiveness of atypical antipsychotic medications for off-label uses in adults."

~~from esperanza, Fall 2011

FAMILY AND COMMUNITY EDUCATION SCHEDULE 2012 HUTCHINGS PSYCHIATRIC CENTER

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, NY. 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. All classes are **10am to 12 noon**.

January 10, 2012

Overview of Mental Health Resources and Residential Programs

Patricia Moore, LCSW-R
HPC Director of Social Work

February 14, 2012

Impact of Disability on the Family

Lynn Chapman, MS
HPC Director of Rehabilitation Services

March 13, 2012

Borderline Personality Disorder & DBT

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

April 10, 2012

Overview of Medications

Geralyn Carcasas, Nurse Administrator I
HPC Education and Training Department

May 18, 2012

Co-Occurring Disorders:

Mental Health and Substance Abuse

Danielle Cadden, LMSW
Phyllis Creamer, CMHN
HPC Outpatient Clinicians

June 12, 2012

Overview of Schizophrenia

Marla Byrnes, RN
HPC Director of Nursing

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The NAMI Syracuse Support & Sharing Meeting facilitated by Sheila Le Gacy and Patricia Hetrick 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.)