National Alliance on Mental Illness

NAMI Syracuse Newsletter

NAMI SYRACUSE
A Better Understanding

JULY/AUGUST 2018

Meeting Schedule

NAMI Syracuse - Support & Sharing Meeting
Third Tuesday of each month, 7:00pm
AccessCNY, 420 East Genesee Street, Syracuse 13202
(parking and entrance in rear of building)
NAMI Syracuse Family Support Group
Second Wednesday of each month, 10:00am
NAMI Syracuse office, 917 Avery Avenue, Syracuse 13204

Events Calendar

July 11, 2018	**NAMI Syracuse Family Support** 10:00am - NAMI Syracuse office
July 17, 2018	**NAMI Syracuse Family Support** 7:00pm - AccessCNY
July 18, 2018	**Peer Support Group** 5:30pm - NAMI Syracuse office
August 8, 2018	**NAMI Syracuse Family Support** 10:00am - NAMI Syracuse office
August 15, 2018	**Peer Support Group** 5:30pm - NAMI Syracuse office
August 21, 2018	**NAMI Syracuse Family Support** 7:00pm - AccessCNY
September 23, 2018	**Harvest Hopela Fundraiser** All Saints Parish Center *(see page 6)*
October 10, 2018	**NAMI Syracuse Educational Conference** **Stand Against Stigma:** **Changing Minds about Mental Illness** *(see page 6)*

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***

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 NAMI members and friends,

Angels among us?

I think we've been blessed with angels.

Sam a senior and Melissa a junior at CNS high school wanted to fight mental illness stigma. They organized an information fair and badminton tournament to raise funds for NAMI Syracuse. They raised over $200 to contribute to our efforts to educate the community.

John McConnell a local musician organized "Music for Mental Health" in January and raised $6,000 for NAMI Syracuse. He engaged fellow musicians and many businesses in Oswego in the effort to educate the community.

Betty Pringle former NAMI President sent us a letter in our last newsletter to encourage us to continue to think about how we can always move forward. She reminded us of our beginnings and our future challenges.

Dr. Malika Carter who approached NAMI about an anti-stigma campaign with ESF last fall got it kicked off in May. We will be working with ESF over the next year to do presentations about mental illness and its impact on individuals and their families.

Mary Bartowski organized our first "May is Mental Health Month" at Liverpool library.

We want to thank our reliable "angels" who volunteer to help at the office to get our newsletters out or do spring clean up at our residences or contribute their talents to our presentations.

Our angels don't realize what an impact they have on our organization.

Not-for-profits always struggle to make ends meet and to share their message. Our message is more difficult than most due to the fear, stigma, ignorance and prejudice that persons with mental illness and their families face.

My own family still doesn't really understand what my son deals with on a daily basis. They wonder why he isn't working or socializing. They are puzzled by his symptoms. We have a long way to go in sharing scientific information about brain illnesses to help people understand our loved ones.

We need each of you to be an angel and share your talents and time to support the NAMI mission of education, support, and advocacy. Get involved and call the office to see where your talents can be utilized.

We will keep pushing forward with the help of our "angels" to make it easier for the next family who faces this journey.

Marla Byrnes

President, NAMI Syracuse

Statement about Border Separation from NAMI 6/20/18

NAMI, the National Alliance on Mental Illness, was created based on the foundation of family involvement and through our years of experience, we believe that strong family support is vital to a child's long-term mental health.

The forced separation of families is highly stressful and can result in trauma-and these separations can profoundly impact children who do not yet have a mental health condition as well as those who are experiencing symptoms by ripping away vital family support. There is growing evidence that exposing young children to trauma is toxic to the development of their brains. Traumatic experiences can negatively impact development and mental health as children grow.

NAMI joins the American Psychiatric Association, American Psychological Association, American Academy of Family Physicians and others in urging an immediate end to the practice of separating families. The future well-being of vulnerable children is at stake. We believe it's critical to children's mental health to be with their families and caregivers.

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

Like

facebook.com/NAMISyracuse

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!

This Mind of Mine

Peer Support Group

3rd Wednesday of each month

5:30 pm

NAMI Syracuse office

917 Avery Ave., Syracuse 13204

All diagnoses welcome!

for more information, contact Lacey Roy, eroylacey@gmail.com

A LETTER TO OUR COMMUNITY FROM NAMI SYRACUSE

AN URGENT MESSAGE FROM NAMI FAMILIES:

THE CURRENT MENTAL HEALTH SYSTEM IS FAILING OUR LOVED ONES

(Issues we are concerned with: No provisions for long term care/ Shameful blocks to treatment/ Discharge to the streets/ Unrealistic residential-stay criteria)

Some of the information in this letter comes from Sheila Le Gacy, a long time member of the NAMI Syracuse Board. In her capacity as Director of the Family Support & Education Center at Access-CNY she hears anguished reports from families whose relatives are being poorly served by the current mental health system.

NAMI hears frequent stories of individuals with active psychotic and/or suicidal behaviors being refused treatment at CPEP, or held overnight and released the next day - only to make a repeated visit to CPEP or other emergency services.

We know of several instances of patients with active psychotic symptoms discharged to the streets from local inpatient units without adequate follow-up plans.

Local inpatient hospitals rarely take the time to arrange for realistic discharge arrangements. Hutchings Psychiatric Center is the only long term facility in the area. Therefore their staff have time to stabilize individuals who may be released from the shorter term hospitals before they are ready.

Some inpatient staff in local hospitals appear to hide behind HIPAA regulations to avoid enlisting families in discharge plans. Recently a patient was discharged into the streets with active psychotic symptoms - the inpatient psychiatrist accepted the patient's assertion that he had a place to go to without investigating whether this was true or listening to the objections of the parent who had been living with the individual. The parent had to intervene and take the patient back to her home at the risk of danger to herself.

At the present time, the operating criteria for committing a person to the hospital is based on "danger to self or others." These criteria have proven to be ridiculously limiting and so restrictive that some families have commented sadly that a depressed person has to be restrained from jumping off a highway overpass before the authorities will acknowledge the seriousness of their suicidality.

There still exists the designation "In need of treatment" which would allow two doctors to commit a person to an inpatient facility when it is deemed that that person is not capable of judgement. **"In need of involuntary care and treatment" means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment."** (mental hygiene laws 9.01 definitions.) Unfortunately this criteria is rarely invoked.

Restrictions on Residential Programs

Residential programs are faced with unrealistic directives from the Office of Mental Health. The current position is that all residential programs for mental health clients are transitional. This forces residential providers to move residents after a few years from a level of supervision and support that has been working for them to a less restrictive setting. Sometimes this works, a resident gains skills and is able to survive with more independence and less supports. But many others inevitably relapse when their current supports are taken away.

Serious chronic psychiatric disorders are relapsing by nature. Individuals so diagnosed will require a level of interdependence for the rest of their lives. OMH appears to be ignoring the body of knowledge relating to these chronic conditions with their emphasis on recovery. There are no known cures for serious psychiatric disorders. There is recovery, but recovery in the world of serious and persistent psychiatric disorders most often requires ongoing support. OMH appears to be operating on the assumption that individuals diagnosed with chronic psychiatric disorders will transition to a life of independence and recovery. Actually, most individuals so diagnosed will have a lifetime need for varying levels of assistance.

We applaud the Recovery movement and the wonderful development of Peer Supports that have been flourishing in our community. The Peer movement is one of the most powerful developments in mental health and NAMI fully supports it. But supporting the Recovery movement and providing adequate service and support for those needy individuals who require long term support should not be mutually exclusive.

Furthermore, the sad fact that there are no *lifetime supports* for older individuals who are not able to live independently is a shameful situation that the NAMI community and OMH must acknowledge. People served by the Developmental Disability system are able to access lifetime supports. There are residences in that system that allow individuals to live out their lives with dignity. Our relatives deserve the same opportunities for long-term supports.

We would hope that NAMI members reading this will contact us with your stories so that we, as an organization, can offer evidence to the Office of Mental Health of the failure of their current policies regarding inpatient commitment, residential services, and discharge policies. Also, we welcome other NAMI NYS affiliates to add their voices to this appeal. It is time for families to be assertive about issues that have state and national significance.

If you have had negative or positive experiences with local agencies, we want to hear from you. We want to present information from our members that is relevant over the last 6-12 months. We hope to create dialogues with agencies to let them know what is working and what isn't working. We want solutions and not just lip service. However, to be effective we need specifics and current concerns. Family members - speak up! If you are dissatisfied with services call the director of the program you are concerned with. Ask if they have a family advocate or family advisory board. Ask them how to lodge a complaint or suggestion. Get our office involved! We will offer evidence to the Office of Mental Health of the failure of current policies regarding inpatient commitment, residential services, and discharge policies.

NOTHING TO HIDE: MENTAL ILLNESS IN THE FAMILY- PHOTO/TEXT EXHIBIT AVAILABLE FOR LOANING

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.

BOOK REVIEW

submitted by Sheila Le Gacy, Director of the Family Support & Education Center, AccessCNY

How to Change Your Mind. What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression, and Transcendence *by Michael Pollan, author and journalist, professor at Harvard and University of California, Berkeley.*

Research on LSD, Psilocybin (magic mushrooms), MDMA (Ecstasy) and other mind altering substances are providing relief to difficult conditions such as depression, anxiety, addiction as well as helping terminally ill people face their dying. Pollan separates the truth about these drugs from the myths that have surrounded them since the l960's. He also reports on his own experience ingesting these substances, walking the tightrope between objective reporter and spiritual insight seeker. As more and more evidence emerges about the positive effects on the treatment of PTSD and other traumas with substances that previously have been outlawed, this book provides the reader with a non biased understanding of what the future holds.

THE LARGEST HEALTH DISPARITY WE DON'T TALK ABOUT - AMERICANS WITH SERIOUS MENTAL ILLNESSES DIE 15 TO 30 YEARS EARLIER THAN THOSE WITHOUT

***New York Times**, May 30, 2018, Dhruv Khullar*

I didn't think our relationship would last, but neither did I think it would end so soon. My patient had struggled with bipolar disorder his entire life, and his illness dominated our years together. He had, in a fit of hopelessness, tried to take his life with a fistful of pills. He had, in an episode of mania, driven his car into a tree. But the reason I now held his death certificate - his sister and mother in tears by his bed - was more pedestrian: a ruptured plaque in his coronary artery. A heart attack.

Americans with depression, bipolar disorder or other serious mental illnesses die 15 to 30 years younger than those without mental illness - a disparity larger than for race, ethnicity, geography or socioeconomic status. It's a gap, unlike many others, that has been growing, but it receives considerably less academic study or public attention. The extraordinary life expectancy gains of the past half-century have left these patients behind, with the result that Americans with serious mental illness live shorter lives than those in many of the world's poorest countries.

National conversations about better mental health care tend to follow a mass shooting or the suicide of a celebrity. These discussions obscure a more rampant killer of millions of Americans with mental illness: chronic disease.

We may assume that people with mental health problems die of "unnatural causes" like suicide, overdoses and accidents, but they're much more likely to die of the same things as everyone else: cancer, heart disease, stroke, diabetes and respiratory problems. Those with serious mental illness are more likely to struggle with homelessness, poverty and social isolation. They have higher rates of obesity, physical inactivity and tobacco use. Nearly half don't receive treatment, and for those who do, there's often a long delay.

When these patients do make it into our clinics and hospitals, it's clear that we could do better. A troubled mind can distract doctors from an ailing heart or a budding cancer.

For doctors, two related biases are probably at play. The first is therapeutic pessimism. Clinicians, including mental health professionals, often hold gloomy views about whether patients with serious mental illness can get better. This can lead to a resigned passivity, meaning that certain tests and treatments aren't offered or pursued.

As Lisa Rosenbaum, a cardiologist at Brigham and Women's Hospital in Boston, writes: "Many of us have internalized the directive to seek a test or procedure only if "there's something you can do about it." For mentally ill patients with medical illness, however, this principle often justifies doing nothing."

The second is a concept called diagnostic overshadowing, by which patients' physical symptoms are attributed to their mental illness. When doctors know a patient has depression, for example, they're less likely to think her headache or abdominal pain portends a serious illness.

In a recent article in **The New England Journal of Medicine**, Dr. Brendan Reilly, a physician at Dartmouth, describes his late brother's devastating story. Over the course of months, he wrote, countless physicians, hospitals and rehab facilities missed the spinal cord damage that left him quadriplegic - instead variously ascribing his inability to move to his mental illness, his medications or his will. "Once they find out you have a mental illness," Dr. Reilly quoted his brother as saying, "it's like the lights go out." This isn't an isolated event. Patients with mental illness are much less likely to undergo cardiac catheterization when they show heart attack symptoms. They're also less likely to get standard diabetes care like blood tests or eye exams, or to be screened and treated for cancer.

This is, at times, understandable, particularly when it comes to managing complex chronic diseases. For both clinicians and loved ones of patients with serious mental illness, contending with an episode of psychosis or severe depression can be so overwhelming that controlling cholesterol or managing blood pressure seems like mowing the lawn while the house is on fire.

It may help to organize and pay for mental health care more like physical health care. We've been redesigning care for patients with diabetes, heart failure or knee problems, but have made few dedicated efforts for those with mental illness. A recent review, for instance, found that there are currently no good trials on how to increase cancer screening for people with mental illness.

The few tailored programs that do exist have shown promise in meeting the distinct needs of these patients and overcoming the health system's biases. One study recruited nearly 300 overweight patients from community-based psychiatric programs and randomly assigned them either to "usual care" - general nutrition and exercise information - or a behavioral weight loss program. The weight loss program was devised for patients with serious mental illness, who often struggle with memory, attention and learning issues. The patients were taught material in small chunks with frequent repetition; role-played the selection of healthy foods; and got help organizing their homes to enable a healthier lifestyle. At the end of the study, patients in the control group weighed essentially what they did at the beginning. But those in the specialized program lost on average 7.5 pounds; nearly 40 percent had lost 5 percent of their total body weight.

Across the country, heart failure patients leaving the hospital are routinely seen in specialized clinics within a week of discharge. Not so for psychiatric patients, who often wait months before seeing a mental health professional. To narrow that gap, UT Health San Antonio created a transitional clinic for patients with mental illness discharged from hospitals and emergency departments throughout the city. The goal is to get these patients evaluated within days. They meet with psychiatrists, social workers and therapists. They receive training in how to buy groceries and use public transportation. They're visited at home by case workers who help organize not only their psychiatric drugs, but also their cholesterol and blood pressure medications. "With the right kind of care, people with serious mental illness can integrate back into society," said Dr. Dawn Velligan, professor at UT Health San Antonio and a director at the clinic. "They can have regular jobs, relatively normal lives. We just need to intervene before things get unmanageable."

Early results are promising: Historically, about 7 percent of psychiatric patients return to the hospital within a month, but only 1 percent of those seen in the transitional clinic do. Despite the program's success, inconsistent funding has limited the number of patients the clinic can reach - a reflection of how society continues to undervalue mental health. "When there's a commitment to these patients, there's a lot we can do," Dr. Velligan said. "But right now, they're not a priority. People have to want to care for them. We have to care."

After decades of fragmenting medicine into specialties and subspecialities, it's perhaps not surprising that a siloed system often fails those in need of whole-person care. I still sometimes wonder if I had let my patient's mental illness overshadow his physical needs. Did I overlook some subtle cue? I may never know the answer, but next time, I hope I'm not asking the question.

~~Dhruv Khullar, M.D., M.P.P., is a physician at New York-Presbyterian Hospital, a researcher at the Weill Cornell Department of Healthcare Policy and Research, and director of policy dissemination at the Physicians Foundation Center for Physician Practice and Leadership.

BOOK REVIEW: PLAYING HURT: MY JOURNEY FROM DESPAIR TO HOPE

by John Saunders and John U. Bacon, Da Capo Press, August 8, 2017

For the first time ever, the popular late host of ESPN's The Sports Reporters and ABC's college football openly discusses a lifelong battle with depression.

During his three decades on ESPN and ABC, John Saunders became one of the nation's most respected and beloved sportscasters. In this moving, jarring, and ultimately inspiring memoir, Saunders discusses his troubled childhood, the traumatic brain injury he suffered in 2011, and the severe depression that nearly cost him his life. As Saunders writes, **Playing Hurt** is not an autobiography of a sports celebrity but a memoir of a man facing his own mental illness, and emerging better off for the effort. I will take you into the heart of my struggle with depression, including insights into some of its causes, its consequences, and its treatments.

I invite you behind the facade of my apparently "perfect" life as a sportscaster, with a wonderful wife and two healthy, happy adult daughters. I have a lot to be thankful for, and I am truly grateful. But none of these things can protect me or anyone else from the disease of depression and its potentially lethal effects.

Mine is a rare story: that of a black man in the sports industry openly grappling with depression. I will share the good, the bad, and the ugly, including the lengths I've gone to to conceal my private life from the public.

So why write a book? Because I want to end the pain and heartache that comes from leading a double life. I also want to reach out to the millions of people, especially men, who think they're alone and can't ask for help.

John Saunders died suddenly on August 10, 2016, from an enlarged heart, diabetes, and other complications. This book is his ultimate act of generosity to help those who suffer from mental illness, and those who love them.

Fundraising Efforts Always Hopeful!

Our fall fundraiser is well under way. We have the tickets printed and we need to sell 200 this year. We have included a chance to win $100 by August 1st if you purchase a ticket and another chance to win $500 at the Hopela with your ticket. We hope to encourage sales by stressing a ticket could win up to $600 and you get admission to our Hopela with music, food, wine, and a huge silent auction. We think it's quite a deal and you support the NAMI organization!

Please promote our Hopela Sunday, September 23rd at All Saints Parish, 3pm-6pm.

Please share the announcement from our website and facebook page. Please "like" our webpage. Ask your friends to "like "our page. Spread the word via social media, share our newsletter, ask friends to support NAMI and buy a ticket. (Remember it's better odds than a scratchoff!

YOU can help us by seeking donations from businesses you frequent or ask family or friends who own or manage businesses for a silent auction item. IF you believe in the vital work we do to educate the public, fight stigma and support families, than get out there and ask people for donations! We depend on our silent auction to raise money for supporting our year long efforts.

Other ideas how to raise money for NAMI Syracuse:

- throw a birthday party or summer party and ask for donations for NAMI
- hold a garage sale that benefits NAMI
- consider NAMI when your church or rotary club or book club wants to raise money for a good cause (bake sales, rummage sales, pancake breakfast, walks, or pass the collection plate)
- consider NAMI in your will
- encourage your children or grandchildren to raise money at school with an awareness campaign (see the president's letter about CNS students)
- ask your bank or credit union for a donation or sponsorship of our event

Always looking for new ideas. We would love to switch our Hopela to spring or organize another fundraiser for springtime but we can't do it alone. The board of directors is very active in putting our conference together, doing speaking engagements, writing grant requests, and donating to NAMI. We need our membership to help. IF each of our over 400 members sought one donation from a business that would be wonderful!

Little actions from lots of folks equals big results!

Save the Date! ***NAMI Syracuse Educational Conference***

Stand Against Stigma:
Changing Minds About Mental Illness

Wednesday, October 10, 2018, 8:45am-3:30pm
Rosamond Gifford Zoo, Syracuse, NY

~~presenters~~

Dr. Malika Carter
CEO's Against Stigma Campaign:
A NAMI Syracuse/SUNY ESF Partnership

Sherie Ramsgard
DNA/Pharmacogenetic Testing

Dr. Julio Licinio
New genetic findings that show common genes for many disorders. What does this mean?

Dr. Christopher Brown
How to Integrate Mental Health Education & Awareness into School Districts

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***S*teven W. DiMarzo, Jennifer A. Crider**
LGBTQ+ Concepts in Cultural Diversity

CEU's available ***~~~*** ***brochures will be mailed soon!***

Harvest Hopela

a fall fundraiser presented by NAMI Syracuse
Sunday, September 23, 2018
3:00pm-6:00pm
All Saints Parish Center
1342 Lancaster Avenue, Syracuse

Food & Drink/Silent Auction
Entertainment by Grassanova
$50.00 per person

Ticket purchase automatically enters holder for a chance to win up to $600! There will be a pre-event drawing of $100 on August 1st and a $500 drawing the day of the event! Need not be present to win!

Call to purchase your ticket today! 315-487-2085 or go to our website www.namisyracuse.org

THE CRAZY TALK ABOUT BRINGING BACK ASYLUMS

by The Editorial Board of ***The NY Times,*** *June 2, 2018*

When President Trump mused that the mass shooting at a high school in Parkland, Fla., in February might have been prevented if the United States had more mental institutions, he revived a not-quite-dormant debate: Should the country bring back asylums?

Psychiatric facilities are unlikely to prevent crimes similar to the Parkland shooting because people are typically not committed until after a serious incident. Still, a string of news articles, editorials and policy forums have noted that plenty of mental health experts agree with the president's broader point.

The question of whether to open mental institutions tends to divide the people who provide, use and support mental health services - let's call them the mental health community - into two camps. There are just 14 or so psychiatric beds per every 100,000 people in the United States, a 95 percent decline from the 1950s. One camp says this profound shortage is a chief reason that so many people suffering from mental health conditions have ended up in jail, on the streets or worse. The other argues that large psychiatric institutions are morally repugnant, and that the problem is not the lack of such facilities but how little has been done to fill the void since they were shut down.

Neither side wants to return to the era of "insane asylums," the warehouselike hospitals that closed en masse between the 1960s and 1980s. Nor does anyone disagree that the "system" that replaced them is a colossal failure. Nearly 10 times as many people suffering from serious mental illnesses are being kept in jails and prisons as are receiving treatment in psychiatric hospitals.

What's more, both sides broadly agree that mental institutions alone would not be the solution. "Bring back the asylums" sounds catchy, but here are some more useful slogans to help steer the conversation:

1. DEMAND SENSIBLE COMMITMENT STANDARDS Exact wording varies by state, but commitment standards in general dictate that people cannot be hospitalized against their will unless they pose a clear and significant danger to themselves or others. That sounds reasonable, but with so few inpatient facilities, mental health workers have a strong incentive to determine that even someone who needs to be committed - perhaps someone dangerously delusional - does not meet that standard.

2. CREATE A CONTINUUM OF CARE Deinstitutionalization was predicated on the 1963 Community Mental Health Act, which was supposed to create well-staffed, well-funded community mental health centers in about 1,500 catchment areas across the country. These centers were supposed to provide clinical care, housing and employment support, and community outreach. When President John F. Kennedy announced the legislation, he estimated that it would ultimately return about half of the 500,000 or so people then living in state psychiatric hospitals to be "treated in their own communities and returned to a useful place in society."

If only the law had been given a chance to work. States failed to devote their savings from the closure of large institutions to community-based care, and few communities were willing to host the centers in their backyards. In the end, only about 750 centers were ever built, and zero were ever fully funded. Today, less than half of all adults suffering from mental health conditions receive help, and mental illness is the leading cause of lost workdays in the United States, costing about $193 billion in lost earnings a year.

People who suffer from behavioral and psychiatric disorders need and deserve a wide range of care options: community mental health centers, short-term care facilities, and - yes - longer-term arrangements for the small portion of people who can't live safely in the community. The pro-asylum camp is right that the number of people needing those longer-term placements is greater than zero. But the figure is also small enough to avoid the need for the thousand-plus-bed facilities that were once the sites of so much abuse.

3. STAND UP FOR INSURANCE PARITY This October marks 10 years since Congress passed the Mental Health Parity and Addiction Equity Act, which requires health insurers to provide the same level of benefits for mental health treatments and services as they provide for medical and surgical care. On paper at least, both the Affordable Care Act and the 21st Century Cures Act bolstered that 2008 statute by requiring plans on the health insurance exchange to cover a list of essential behavioral health benefits and by enacting greater enforcement of the parity rules.

In practice, though, the three laws have yet to create true equity. "In some situations, you still can't get into a psychiatric facility unless you are suicidal or otherwise near death," says Ellen Weber, vice president for health initiatives at the Legal Action Center, a nonprofit that is fighting parity violations in several states. "That's an abhorrent double standard. We don't do that for medical or surgical need."

And because regulators at the federal Departments of Labor and Health and Human Services are required to investigate complaints, not prevent them from happening, the burden of proving a parity violation falls on the consumer. "This is a law that's almost impossible to enforce as it stands," Ms. Weber says. "It requires a tremendous amount of information gathering and sophisticated analysis that most consumers are not equipped to take on, especially in the middle of a medical crisis."

Why not have regulators certify that plans meet parity rules before they go to market? Officials at H.H.S. and the Department of Justice could then step in to police insurers for violations - before problems become clear. While we're at it, Medicaid ought to lift its longstanding exclusion of inpatient psychiatric care.

Because "asylum" is a loaded term, it can draw attention to crucial issues facing vulnerable Americans, but it also tends to foreclose discussion of real solutions. Most of those solutions aren't even controversial. There just needs to be the collective will, and basic decency, to act.

NUTRACEUTICALS MAY TREAT NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

by Fran Lowry, June 13, 2018

Recent clinical trials on the use of herbal and nutraceutical agents as adjunctive treatment for schizophrenia show that these agents have some benefit in alleviating the negative symptoms of the disease.

Herbal and nutraceutical agents have anti-inflammatory, immunomodulatory, antiapoptotic, and antioxidant effects and can potentiate N-methyl-d-aspartate (NMDA) receptors, which could be useful in the treatment of schizophrenia, researchers say.

These mechanisms are not addressed by dopamine-receptor antagonists, the current mainstay of treatment.

"Antipsychotics do not treat schizophrenia's negative symptoms, such as impaired cognition, restriction of emotions, and lack of ambition, symptoms that prevent people with the disorder from leading productive lives," said Alan Breier, MD, Indiana University School of Medicine, Indianapolis.

The findings were presented at the American Society of Clinical Psychopharmacology (ASCP) 2018 annual meeting.

COMMON DRUGS MAY BE CONTRIBUTING TO DEPRESSION

by Roni Caryn Rabin, June 13, 2018

Could common prescription medications be contributing to depression and rising suicide rates?

Over one-third of Americans take at least one prescription drug that lists depression as a potential side effect, a new study reports, and users of such drugs have higher rates of depression than those who don't take such drugs.

Many patients are taking more than one drug that has depression as a side effect, and the study found that the risk of depression increased with each additional such drug taken at the same time.

About 200 prescription drugs can cause depression, and the list includes common medications like proton pump inhibitors (P.P.I.s) used to treat acid reflux, beta-blockers used to treat high blood pressure, birth control pills and emergency contraceptives, anticonvulsants like gabapentin, corticosteroids like prednisone and even prescription-strength ibuprofen. Some of these drugs are also sold over-the-counter in pharmacies.

For some drugs, like beta-blockers and interferon, the side effect of depression is well known, but the authors of the study were surprised at how many drugs were on the list.

"It was both surprising and worrisome to see how many medications have depression or suicidal symptoms as a side effect, given the burden of depression and suicide rates in the country," said Dima Mazen Qato, an assistant professor and pharmacist at the University of Illinois at Chicago who was the lead author of the paper, published in JAMA.

She acknowledged that there are still "a lot of unanswered questions," and that the study only points to a correlation, not a cause-and-effect relationship.

"We didn't prove that using these medications could cause someone who was otherwise healthy to develop depression or suicidal symptoms. But we see a worrisome dose-response pattern: The more of these medications that have these adverse effects that you're taking concurrently, the higher the risk of depression," Dr. Qato said.

The researchers used a large and nationally representative database, the National Health and Nutrition Examination Survey, to analyze the medications used by a representative sample of more than 26,000 American adults from 2005 to 2014. They researched side effects of commonly used prescription drugs, compiling a list of more than 200 medications that have depression or suicidal symptoms listed as potential side effects.

The overall use of any prescription medication that had depression as a potential adverse effect increased to 38.4 percent in 2013-14, up from 35 percent in 2005-6, the study found. The percentage of adults who were concurrently taking three or more drugs with the side effect increased to 9.5 percent in 2013-14, up from 6.9 percent in 2005-6, the report said.

The use of medications that have suicidal symptoms as potential side effects also increased, to 23.5 percent of the population in 2013-14, up from 17.3 percent in 2005.

Among patients using one drug that could cause depression as a side effect but who were not taking an antidepressant drug, 6.9 percent had depression, while the depression rate for patients taking three or more drugs with the side effect was 15.3 percent. By contrast, patients who were not taking any such drugs had a depression rate of 4.7 percent.

The researchers adjusted for other risk factors that can cause depression, including poverty, marital status, unemployment and certain medical conditions, like chronic pain, which themselves are associated with depression.

"The study is an important reminder that all medicines have risks, and most medicines have rare but serious risks - yet another reason that even commonly used medicines such as beta-blockers or proton pump inhibitors should not be used cavalierly," said Dr. Caleb Alexander, co-director of the Center for Drug Safety and Effectiveness at Johns Hopkins Bloomberg School of Public Health, who was not involved in the study.

Dr. Philip R. Muskin, a professor of psychiatry at Columbia University Medical Center and secretary of the American Psychiatric Association, said physicians must keep these side effects in mind when prescribing medications, and ask patients about whether they have a personal or family history of depression.

But he said it is hard to say whether the increased use of drugs, and combination of drugs with side effects including depression, has had an impact on society.

"There's been an increase in suicide, that we know," Dr. Muskin said. "Does it correlate to the use of these medications? The honest answer is we don't know. Could it play a role? The honest answer is yes, of course it could."

TRICHOTILLOMANIA AND EXCORIATION: DISTRESS TURNED ON THE BODY

Have you heard phrases like "I'm so stressed I'm tearing my hair out" or similar sentiments? What about images of people looking upset and grasping their hair? Often, such comments and depictions are facetious representations of stress. However, in rare cases, people literally pull out their hair.

Trichotillomania disorder and excoriation disorders are two illnesses in which people use their body to alleviate emotions such as anxiety, stress, tension, a need for control, or sometimes even boredom. Trichotillomania is the compulsive pulling out of one's hair (especially scalp, eyebrows, and eyelashes), while excoriation is compulsive skin picking (particularly face, arms, and hands).

These disorders share characteristics:

They're classified as obsessive-compulsive and related disorders (they involve compulsions - repetitive behaviors - but not obsessions)

The behavior is repetitive, done either sporadically throughout the day or done in bursts that can last hours at a time

Hair pulling or skin picking can be ritualistic - there is a specific method, time, setting, etc. for the behavior

Alternately, some people aren't even fully aware that they're doing it

People try to stop but are unable to do so without help

Experts disagree on whether these disorders should be considered an act of self-harm. Self-harm or not, trichotillomania and excoriation are distressing. Professional help is often needed, but people can overcome them.
~~from HealthyPlace.com

Save the date!

Thursday, November 1, 2018 - 4pm

Grand Rounds area, 2nd floor

713 Harrison St., Syracuse

The Addiction Solution: Treating Our Dependence on Opioids and Other Drugs

presented by Lloyd Sederer, MD

Medical Director NYS Office of Mental Health

This talk is open to everyone!

Thank you to those who have recently joined or renewed membership to NAMI Syracuse

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Janette Albrecht
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Mark & Sandra Tuori Bell
Paul & Virginia Boatman
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Jeanne Brown
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William Townsend
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Arthur Vinette
Susan Zdanowicz

Thank you to those who have made donations to NAMI Syracuse

Joan Carlon
Andrew & Christine Fioramonte in honor of Spence & Marie Plavocos
George Kitkpatrick
Jeanette Spottek
William Townsend

In Memoriam

We offer our sympathy and condolences to Michael Amodio and family on the passing of his wife, Gabrielle.

Michael & Gabrielle have been NAMI members since 1989 and Gabrielle worked in the NAMI Syracuse office.

We thank the family for designating donations made in memory of Gabrielle be sent to NAMI Syracuse.

Thank you to:

Kenneth Arnold
Patricia L. Delledera
Elizabeth Diaz
Frederick Jennis
Eileen B. Phillips
Frances M. Rice

There is no right or wrong way to manage your mental illness. You are not less of a person for needing medication or having to go to therapy multiple times a week.

If something helps your mental health, take the time to do it. Don't stop, no matter what other people think.

Hayley Lyvers
HealthyPlace.com

BECOME A MEMBER OF NAMI SYRACUSE TODAY!

_____ Household Membership $60.00

_____ Individual Membership $40.00

_____ Open Door Membership $ 5.00 (for those on a limited income)

Donation $_____ In Memory/Honor of $_____ Name: _____

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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 speciality 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**

NAMI Syracuse
Family Support Group

2nd Wednesday of each month

NAMI Syracuse office
917 Avery Avenue, Syracuse

10-11:30am

Facilitated by:
Ann Canastra
Marla Byrnes

NAMI Syracuse
Family Support Group

3rd Tuesday of each month

AccessCNY
420 E. Genesee St., Syracuse
(parking & entrance in rear of building)

7:00pm

Facilitated by:
Sheila Le Gacy
Spencer Gervasoni