

General Meeting



**100 S. San Mateo Drive
San Mateo**

Hendrickson Aud. / Mills Health Center
Free evening parking in front

Wednesday, September 24

6:30pm Reception

7:00-8:30 Program

Cordilleras Redesign Project

**Steve Kaplan, Director, BHRS and
Terry Wilcox-Rittgers, Clinical
Services & Project Manager**

Cordilleras, San Mateo County's 117-bed mental health rehabilitation center and residential housing ("The Suites"), is being redesigned. The county is preparing a feasibility report for presentation to the Board of Supervisors this fall. The goal: "a new campus designed with state of the art practices conducive to aiding recovery," says Terry Wilcox-Rittgers, along with Steve Kaplan.

See concept drawings and hear about what is being considered, including the Cordilleras "community center," a multi-purpose hub for use by clients, staff, families and friends.

Steve and Terry will answer questions about the project. Please send any questions to the NAMI office ahead of time to help Steve and Terry plan their presentation.



NAMI San Mateo County General Meetings are free and open to the public. We welcome all who support our mission to improve the quality of life for people with mental illnesses and their families.

Urge Congress to Improve Mental Health Care in America

Momentum is building to reach an agreement on bills

Take Action NOW

Please contact your U.S. Representative below and urge them to support passage of comprehensive legislation to improve mental health care this year! As concerned Americans, we cannot wait any longer for a solution to the mental health crisis.

What are the two bills?

The Helping Families in Mental Health Crisis Act (HR 3717) was introduced by Rep. Tim Murphy, R-PA, and has 90 co-sponsors. Congressman Murphy, a psychologist with a background working in the public mental health system, has dedicated himself to educating policymakers and the public about the crisis in mental health care in America and his proposed solutions. We are grateful for his leadership in calling attention to the appalling outcomes for too many individuals with serious mental illness and for his tireless efforts to improve their lives.

The Strengthening Mental Health in our Communities Act of 2014 (HR 4574) was introduced by Rep. Ron Barber, D-Ariz, and has 51 co-sponsors. Congressman Barber also has first-hand knowledge about the issues addressed in his bill. A social worker by background, Congressman Barber was with Congresswoman Gabrielle Giffords when she was shot and nearly killed in Tucson in 2011. Congressman Barber himself was shot and seriously injured in this tragic event and he too has called for improved mental health care and attention to these issues.

What are the similarities in the bills?

Both bills authorize federal resources for jail diversion, expand resources for suicide prevention, protect access to psychiatric medications in Medicaid and

(Continued on page 3)

NAMI California Conference Review

From Carol Gosho, board member

The NAMI California 2014 Annual Conference in Newport Beach Aug 1-2 was a sell-out and offered valuable information for families, consumers, providers and the community at large. See below to review and access the MP3 audio recording playlist of all 49 sessions.

Some session highlights: #27 "Improving the Inpatient Setting" - Guy Qvistgaard, Hospital Administrator of John George Psychiatric Hospital and NAMI CA Board Member. Public invited to observe their program with more supportive services for families and patients, such as longer visiting hours and early access to In Our Own Voice facilitators after admission. #14 "Emerging from Crisis" - Officer Doria Neff, Mental Health Liaison, Oakland Police Dept., 5 things to share with 9-1-1 dispatchers and different roles in crisis situations to ensure safety. #19 "Consumer Empowerment Luncheon." #35 "Un Dialogo con El Doctor" - Prof. Sergio Aguilar-Gaxiola.

Mark your calendar: July 6-9, 2015 the NAMI National Conference will be held in San Francisco.

DVDs and mp3s of selected conference presentations are available for purchase. Information about the Affordable Care Act, dealing with Mental Health issues in diverse cultures, Mental Health care in the prison system, and many other interesting topics are covered by our expert speakers. See <http://www.namica.org/annual-conference.php?page=fingertips&lang=eng> for information.

The Dangers of Stage 4 Thinking About Serious Mental Illnesses

By Paul Gionfriddo, President/CEO Mental Health America | 8/5/14

During my first hundred days at Mental Health America, I have frequently made the case that mental health policy-makers and practitioners are too often mired in “Stage 4” thinking when they think about serious mental illnesses.

Here’s what I mean – they use an “imminent danger to self or others” as a standard for determining who gets care. That near-death time typically only comes during the latest stages of a chronic disease process, or Stage 4.

There are several dangers in using such a standard. The first is that it furthers the myth that mental illness causes violence. The second is that it leads to the over-incarceration of people with mental illnesses. The third – and perhaps most dangerous – is that it deflects our attention away from intervening early in the disease process, when we can do the most good and get the best results.

We don’t treat any other chronic diseases this way. Imagine the outcry if we waited until Stage 4 to treat cancers, cardiovascular diseases, or diabetes!

I haven’t come across anyone who thinks there’s a clinical basis for using the “imminent danger to self or others standard” to determine eligibility for care. But this hasn’t stopped us from using it for decades.

Until we take a different approach and move upstream in the disease process, we’re going to continue to put our resources in all the wrong places, and we’re going to continue to fight about all the wrong things. And people will still cycle between homelessness and hospitalization, outpatient treatment and incarceration, and crisis and stability.

At Mental Health America, we believe that it is past time for investing heavily in early identification and intervention. That’s one of the reasons we launched a new mental health screening program this year, with screening tools available on our website or at www.mhascreening.org.

And we’re pretty sure that people agree with us. After all, in just four months, the first 100,000 screens will have been taken, typically by people who are experiencing early symptoms of what may become over time severe depression, anxiety, or bipolar disorder.

They’re concerned about their mental health now, and so are we. And they don’t want to wait ten years or more, and be forced to progress to Stage 4, for everyone else to take notice.

—<http://www.mentalhealthamerica.net/blog/dangers-stage-4-thinking-about-serious-mental-illnesses>

BHRS Family Contacts

Suzanne Aubry, Dir. Family Service & Support: 650-573-2673
Claudia Saggese, Family Liaison (habla Español): 573-2189
Jade Moy, Dir. Chinese Initiative: 573-2952

NAMI Benefit Golf Scramble



Sign up for the October 2nd Golf Scramble at Crystal Springs Golf Course! Register on line at http://www.golfdigestplanner.com/24602-nami_scramble.

We would appreciate players and T-sponsors, please call Steve Way at 650-572-2528 with any questions. See details on the NAMI SMC web site.

KQED Reports on Schizophrenia

—From Patricia Urbina, Family to Family teacher

This month KQED radio reporter Amy Standen illuminates the problem of schizophrenia. Her informative series of three articles, entitled “New Clinics in California Seek to Stop Schizophrenia Before it Starts,” “What Is Schizophrenia? Scientists Call for New Thinking,” and “Schizophrenia: What It’s Like to Hear Voices,” are found on the KQED radio website or at <http://blogs.kqed.org/science/audio/schizophrenia>.

Amy’s research covers basics of the illness, while interviews with experts and individuals who have had symptoms of psychosis provide an update about the status of how the illness is viewed, new treatment modalities and efforts to diagnose psychotic illness at an early age, possibly affecting the impact of the illness in a positive way. Please check out this great series and consider thanking this journalist for her thoughtful work in an area so much in need of illumination for the general public.

Link to Mental Health Articles

—From Carl Engineer, board member

<http://www.theguardian.com/world/series/us-mental-health-crisis>

This is a link to the entire well-done series *The Guardian* has put together. It will also serve as a pointer to updates and new articles as they arrive.

FAST: Family Assertive Support Team

650-368-3178 or 650-371-7416 (pager)
24-hours, 7 days-a-week

Call FAST when you are concerned about a family member who may be showing signs or symptoms of serious emotional distress - FAST for prompt and caring support!
We Come to You!

See a full article about FAST in our November 2013 web version newsletter at www.namisanmateo.org.

Urge Congress from page 1

Medicare, and provide financial incentives for improved health information technology in mental health care. There are also some differences that reflect contrasting visions of what is needed to improve the mental health system. More information about these two bills including detailed descriptions and a side by side comparison can be found on the website below.

What is NAMI doing?

Efforts are underway to resolve the differences in the two bills and to reach consensus on a version that can be brought to the full U.S. House of Representatives for a vote. NAMI has been working with staff on Capitol Hill to express our strong support of this effort and urging inclusion of all of the provisions that are in both bills. In addition, NAMI staff has been working with colleague organizations on developing a sensible approach to permit communications with caregivers under HIPAA while protecting privacy. NAMI believes that codifying into law existing guidance on HIPAA by the federal Office of Civil Rights would be a major improvement along with resources for educating mental health professionals on HIPAA because of widespread misinformation. We are also supporting efforts to remove barriers in Medicaid for payment for urgent care in psychiatric hospitals (also known as the IMD exclusion).

It is critical for your U.S. Representative to hear from you to reinforce our commitment to action. At a time in which gaps in mental health care in America are more visible than ever, comprehensive legislation is desperately needed to improve the mental health system. This legislation must promote and foster recovery while empowering and supporting families in serving as caregivers and supporters. Any legislative solution must be focused on removing barriers to care for people who need it the most.

—http://cqcengage.com/nami/app/write-a-letter?1&engagementId=53229&ep=AAAAC2F1c0NpcGhlcjAxGw4YZ6fl_sQamj0F0v897LSwuTqXKb44y8zvZBsZnjuuniPXcj_I7PvjPjAVzf-wqLLcVb-al9_tBdq0bxD6N7w&lp=0

COMING SOON:

Be on the lookout for an invitation to NAMI San Mateo County’s 40th Anniversary Celebration!

A most unusual event is being planned and everyone can be a part of it!

STAY TUNED!!

Social Security Issues?

Call Joe Hennen at Vocation Rehab Services: 650 802-6578

Peer To Peer Class Starting

Thursday, October 2 • 2:00- 4:00pm
Heart & Soul

People with mental health issues looking for better living skills, this class held on 10 consecutive Thursday afternoons is for you! It’s taught by a team of trained persons with mental health issues -- Peer to Peer! To sign up for the class, call 650-638-0800 or email namismc@sbcglobal.net.

Nationwide Recruitment: Bipolar Disorder (Adult) Research Study

Clinical Trial Participation Update

Regarding: Bipolar Disorder & Riluzole (Outpatient or Inpatient: 8 weeks)

This study of Riluzole (an FDA-approved drug for Lou Gehrig’s disease, ALS) tests how this drug affects glutamate in the brain and improves treatment-resistant depressive symptoms (failure to reduce symptoms after taking two or more antidepressants.) Recruiting ages 18-70. Info available at: <http://www.nimh.nih.gov/labs-at-nimh/join-a-study/trials/adult-studies/bipolar-depression-and-riluzole.shtml>

For more information on research conducted by the National Institute of Mental Health in Bethesda, MD see <http://www.nimh.nih.gov/labs-at-nimh/join-a-study/index.shtml> [nimh.nih.gov/JoinAStudy](http://www.nimh.nih.gov/JoinAStudy).

Hearing Voices Web Site



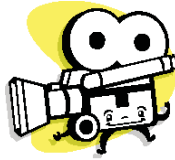
<http://www.hearingvoicesusa.org/links>

The Hearing Voices Network (HVN) USA is one of over 20 nationally-based networks around the world joined by shared goals and values, incorporating a fundamental belief that there are many ways to understand the experience of hearing voices and other unusual or extreme experiences. It is part of an international collaboration between professionals, people with lived experience, and their families to develop an alternative approach to coping with emotional distress that is empowering and useful to people, and does not start from the assumption that they have a chronic illness.

Not enough room in 8 printed pages!

See more articles in our online version of the newsletter at www.namisanmateo.org/

Directing Change Student PSA Contest



<http://www.directingchange.org/>

This is a very powerful new project - take a look at the web site! The Directing Change Student Video Program aims to provide an experience to youth through making 60-second PSAs that would inspire other young people to become agents for change, standing up for and reaching out to others who are experiencing tough times.

Directing Change is part of statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students. These initiatives are funded by the voter-approved Mental Health Services Act (Prop 63) and administered by the California Mental Health Services Authority (CalMHSA). CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families and communities, and administers programs on a statewide, regional, and local basis. For more information on CalMHSA visit: www.calmhsa.org.

The application deadline has been extended to February 2015, so keep checking the web site.

MHSARC Meetings - open to the public

Wednesday, September 3 • 3:00 - 5:00pm
(first Wednesday of every month)

Time/locations vary, please check with 650-573-2544
or www.smchealth.org/MHSARC
Health Services Building Room 100
225 W. 37th Ave., San Mateo

AGED-FOCUSED COMMITTEES:
225 W. 37th Ave., Diamond Room, San Mateo

Older Adult Services Committee • 10:30am - 12:00

Adult Services Committee • 1:30pm - 3:00

Children and Youth Services Committee • 4pm - 5:00
(2000 Alameda De Las Pulgas., Room 209)

Board of Supervisors Meeting

Tuesday, September 2 • 9:00 a.m.

Board Chambers
400 County Center, First Floor, Redwood City

Board of Supervisors agendas are found at
<http://www.co.sanmateo.ca.us/portal/site/bos>.

NAMI SMC Facilitator Change at San Mateo Medical Center

Thank you to Juliana & Rosemary!

After leading the NAMI Support Group at SMMC for the past several years, Juliana Fuerbringer and Rosemary Field are stepping down. We wish to thank them for their dedication, leadership, support and advice. Over the period of their involvement, they have made a significant difference to several hundred people!!

We are pleased to introduce Judy Singer and Carol Metzler who are taking over from Juliana & Rosemary. We know that you will find them to be effective and supportive facilitators for this busy support group.

To all of our volunteers, thank you. We couldn't do it without you.

—NAMI Board of Directors and
Penney Mitchell, Support Group Facilitator Coordinator

California Clubhouse Progress Report

By Diane Warner, 30 year NAMI member and teacher

With the support of Clubhouse International, Putnam House in Concord, CA and others, a Start-up Group in San Mateo County is up and running. Thanks to the tireless efforts of Juliana Fuerbringer, California Clubhouse Start-up Group Chair and the other volunteer working board members, a pre-launch in San Mateo will happen in the near future. Check the website for updates: info@californiaclubhouse.org.

If you wish to support California clubhouse please send an email to San Mateo Behavioral Health and Recovery Services, c/o destremera@smcgov.org. Include your name, address, phone number and brief information about your personal situation with mental illness in San Mateo County. Also include your reasons for endorsing the clubhouse model.

“Continuity of care, especially continuity of caregivers, is essential for good care of individuals with serious mental illness... The best model that combines access to decent housing, vocational opportunities, and opportunities for socialization is the clubhouse model,” according to Dr. E. Fuller Torrey.

The board is putting out feelers for a Director, someone with strong director skills and experience, the Clubhouse instinct, and abundant start-up energy. In the meantime Ruth Parson, a former employee of Fountain House in New York, recently moved to San Diego, is consulting and guiding the San Mateo start up. We know what we are doing!

More info at californiaclubhouse.org or call 650-342-5849, or contact us at info@clubhouse.org or Juliana at julianafuer@gmail.com.

NOTE: NAMI-SMC endorses Clubhouse.

SUPPORT GROUP MEETINGS (for information on NAMI Support Groups call 650-638-0800)

- **NAMI Cordilleras MHR Center Family Group**, 1ST Mondays (2ND Monday if 1st is a holiday), 6:30-8pm, 200 Edmonds Road, Redwood City, 650-367-1890. Penney Mitchell & Julie Curry, NAMI SMC co-facilitators
- **NAMI Parents of Youth**, 2ND Mondays, 7-8:30pm. NAMI SMC, 1650 Borel Pl, Ste 130, San Mateo, 638-0800. Kristy Manuel and Ginny Traub, facilitators.
- **Dual Diagnosis Group for Consumers**, Mondays, 2:30pm. The Source, 500 A Second Ave., San Mateo. Info: 650-343-8760

MONDAY

- **NAMI Coastside Support Meeting** for family members, 2nd Tuesdays, 7-8:30pm. Coastside MH Cntr, 225 S. Cabrillo Hwy, #200A, Half Moon Bay, 650-726-6369. Karina Marwan, NAMI facilitator
- **NAMI Jewish Family & Children's Services**, family and friends are welcome. 4TH Tuesdays, 7:00pm. 200 Channing Ave., Palo Alto, 650-688-3097. Sharon & Ron Roth, NAMI SMC facilitators; John Bisenivs, LCSW.
- **NAMI San Mateo Medical Center** for family members. 1st and 3rd Tuesdays, 6:30-8pm. 222 W. 39th Ave. & Edison, Board Room (main entrance elevator to 2nd floor, left to the end of the hall). Terry & Polly Flinn, Carol Metzler & Judy Singer, NAMI SMC facilitators.
- **NAMI South County Support Meeting** for family members, 2nd Tuesdays, 6-7:30pm. Mental Health Clinic, 802 Brewster St., Redwood City, 650-363-4111. Pat Way, NAMI SMC facilitator; Liz Downard RN, MSN.
- **DBSA Mood Disorder Support Group** for persons with uni- and bi-polar disorders, mania, depression, or anxiety; family members welcome. Tuesdays, 7-9pm, College Heights Church, 1150 W. Hillsdale Blvd, San Mateo. Contact at DBSASanMateo@um.att.com or 650-299-8880; leave a message.
- **HOPE** (Hope, Offering, Prayer and Education), for those with mental illness and/or in supporting roles. 1st and 3rd Tuesdays, 6:30pm, First Presbyterian Church, 1500 Easton Dr., Burlingame. Call 355-5352 or 347-9268 for info.
- **Korean Support Group**, a family/consumer group. 4TH Tuesdays, 6:30-8:30pm. Full Gospel Mission Church, 20920 McClellan Rd. (opp. De Anza College), Cupertino. Info: Kyo, 408-253-9733.
- **Women Living With Their Own Mental Illness**, Tuesdays, 1-2:30pm. Redwood City - sliding scale fees apply for this meeting. Contact Deborah at 650-363-0249, x111.
- **Spanish-Speaking Support Group** for family members. 2ND Tuesdays, 6-7:30pm. South County BHRS, 802 Brewster Ave, Redwood City. Contact Claudia Saggese at 573-2189.

TUESDAY

- **DBSA Mood Disorder Support Group** Wednesdays, promptly 6:30-8:30 pm. Contact: DBSAPaloAlto@gmail.com. Supporters may attend with their consumer. VA Hospital, 3801 Miranda Ave, Hosp Bldg 101, Room A2-200, Palo Alto.
- **Jewish Support Group** (open to all denominations), for those with mental illness and families and friends. 2nd Wednesdays, 6:15-8:30pm. For info, call Carol Irwin 408-858-1372. Beit Kehillah, 26790 Arastradero Rd., Los Altos
- **Telecare** for family and friends of residents. 2nd Wednesdays, 5:30-7pm. 855 Veterans Blvd, Redwood City. 650-817-9070

WEDNESDAY

- **Asian-Language Family Support Groups** Last Thursday, 6-7:30 pm, Cantonese/Mandarin. 1950 Alameda de las Pulgas, BHRS main entrance. Info: 650-573-3571.
- **Coastside Dual Diagnosis Group**, development for clients in all stages of recovery. Thursdays at 4-5pm. 225 S. Cabrillo Hwy #200A, Half Moon Bay. 726-6369 for information.
- **Hoarding Education Group** for significant distress with clutter. 1ST and 3RD Thursdays, 5:30 - 6:15pm. Mills Health Center, Room 4104, 100 S. San Mateo Dr. Contact hoarderdoctor@gmail.com or 650-799-3172. \$5 donation requested.
- **H.E.L.P. for those coping with a mental illness and/or those in a supporting role**, Thursdays, 6:00pm optional dinner; 6:30-7:30 program, 7:30-8:30 prayer. Menlo Park Pres., 950 Santa Cruz Ave. Garden Court. Contact Jane at 650-464-9033
- **North County Support Group** for clients, family and friends. 2ND and 4TH Thursdays, 5:45-7pm, 375 89th Street, Community Room, Daly City. More info: 650-301-8650.

THURSDAY

- **NAMI Connection - Consumer Recovery Support Group**: 1ST & 3RD Saturdays, 3:30-5pm. 500 E. 2nd Ave, San Mateo, Heart and Soul. Questions, call NAMI SMC at (650) 638 - 0800.
- **Eating Disorders Support Group** (for parents and loved ones). 2nd & 4th Saturdays, 9:30-11am. El Camino Hospital, 2500 Grant Rd, Mountain View, new building, Conf. Rm A. Contact: 408-559-5593 or info@edrcsv.org.
- **Eating Disorders Support Group** for parents and friends of loved ones. 1st and 3rd Saturdays, 9:30-11am Mills-Peninsula Hosp., Rm 4104, 100 S. San Mateo Drive. Visit www.edrcsv.org or call Kira Olson at 408-356-1212.
- **Japanese Education & Support Group**, call (415) 474-7310 for information.
- **Obsessive-Compulsive Foundation of SF Bay Area**, 3RD Saturdays, 1:30-3:30pm, Seton Medical Center, 1900 Sullivan Ave., 2nd Fl. Conf room near cafeteria, Daly City. For more information: 415-273-7273; www.ocd-bayarea.com.
- **Consumer Support Groups**, Heart and Soul, San Mateo. Call 650-343-8760.

SATURDAY

Psychiatric Grand Rounds Programs

Open to the Public

SMC BHRS Division

Health Services Building, Room 100
225 W. 37th Ave., San Mateo / 650-573-2530
12:15 - 1:30 pm **BRING LUNCH**

Sep 9 **Assessing Suicide Risk with Culture-Based Evaluations in Chinese-American Immigrants**

Sep 23 **Integrating the Recovery Model into Clinical Practice**

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Mills-Peninsula Health Services

Saigy Conf. Rm., Ground Floor
100 South San Mateo Drive, San Mateo / 650-696-5813
12:15 - 1:45pm **BRING LUNCH**

Schedule not available - contact 650-696-5813 for info

PLAN of California

Planned Lifetime Assistance Network offers two Master **Special Needs trust** plans for California families with funds to bequeath (minimums \$150,000 and \$300,000). These trusts provide for contract with PLAN for oversight (both fiduciary and personal support services) without endangering public entitlements.

San Francisco contact: Baron Miller 415-522-0500
Los Angeles contact: Carla Jacobs 888-574-1258

*Check out Wellness Matters,
the San Mateo County BHRS newsletter
<http://smchealth.org/wm>*

NAMI Education Programs

Call 650-638-0800 to register

Sign up for the evidence-based education class that fits your needs (Support Groups on page 5). Courses are FREE, comprehensive, and popular. Gain skills and understanding in an interactive, supportive environment. Registration is required.

- **Family to Family**—For adult relatives with a family member with mental illness. Class meets once a week for 12 weeks, every spring and fall.
Class currently in session and filled.
- **Peer to Peer**—Better living skills for people with mental health issues taught by people with mental health issues.
Class starting Thursdays, October 2, 2-4:00p
- **Provider**—An overview program for Mental Health and AOD professionals, para-professionals and all others serving individuals with serious mental illnesses and their families. CMEs pending approval for qualified attendees.
- **Basics**—Focuses on the fundamentals of caring for you, your family and your child with mental illness.

NAMI Connection



Individuals with mental health conditions are WELCOME to this recovery support group for people living with mental illness. They meet the **1st and 3rd Saturdays from 3:30-5:00pm** (after the movie), at The Source (Heart and Soul), 500 E. 2nd Ave., San Mateo. Led by trained individuals who are personally experienced at living well with mental illness. No registration required, call NAMI SMC with any questions: 650-638-0800.

San Mateo County Mental Health Emergency Numbers

Police: 911

Tell the dispatcher you are calling regarding a person who has a mental illness. Request a CIT (Crisis Intervention Team) trained officer and/or someone who has experience in dealing with the mentally ill. For non-emergency situations, call your local police department.

24 Hour Crisis Line & Support Help: 650-579-0350 / 800-784-2433

Calling the local number will get you someone in San Mateo County. Calling the 800 number will get you the first person available. This person may not be in San Mateo County.

Psych Emergency: San Mateo Medical Center: 650-573-2662
Mills Peninsula Hospital: 650-696-5915

Kaiser South San Francisco: 650-742-2511
Kaiser Permanente SMC: 650-991-6455

FAST: 650-368-3178 | 650-371-7416 (pager)

Family Assertive Support Team - When your loved one is in emotional distress. Available 24x7.

For additional non-emergency numbers relating to Mental Health issues, access www.namisanmateo.org.

Psychological First Aid Kit

By Christina Koch, Intern, U.S. Department of Education 8/6/14

Psychological First Aid, also known as PFA, is an intervention model to help people of all ages deal with trauma-related stress. It does not assume that anyone that suffers something traumatic will develop mental health problems, such as anxiety disorders.

There are many different reactions that people can have after an emergency. Sometimes these reactions can lead to distress that can get in the way of proper coping. If needed, PFA can help people cope with their reactions and recover.

PFA's goals are to establish a human connection in a compassionate way, enhance safety, calm overwhelmed survivors, allow survivors to express their needs, connect survivors to support networks, provide recovery information, and empower survivors.

Trained professionals can give support to help people recover from their reactions. People can become trained on PFA face-to-face or online through a six-hour interactive training. There is also a PFA mobile app that can assist responders.

PFA-S brings this model into schools to help students, staff, and family members. It can be used by anyone who is trained. PFA-S reduces initial distress that is brought on by emergencies and helps people cope and deal with the feelings of fear and trauma.

Whether the emergencies occur on school grounds or off, schools are a crucial and central part of the community. PFA-S is most effective when used directly following an incident or while it is happening, if it is safe. An example of this would be a school lockdown situation.

PFA-S can also identify people who may need additional help, therefore reducing the potential of long-term mental health problems.

People trained to use PFA-S can assist students, family members, school staff, and community members. Any staff member can be trained to deliver PFA-S in schools because PFA-S is not psychotherapy or a mental health intervention. Trained members of a community emergency response team or mental health professionals can also provide PFA-S. Additional training resources for schools can also be found online.

All children should be able to live in safe neighborhoods and attend nurturing schools that provide them with the services and supports that they need to thrive. A cross-agency, comprehensive approach, such as PFA-S, can promote the safety and security of students, families, and entire communities.

—<http://www.mentalhealth.gov/blog/2014/08/psychological-first-aid-kit.html>

New Compound To Treat Depression Identified, May Also Lead To Future Therapy For Alzheimer's, Parkinson's

There is new hope for people suffering from depression. Researchers have identified a compound, hydroxynorketamine (HNK), that may treat symptoms of depression just as effectively and rapidly as ketamine, without the unwanted side effects associated with the psychoactive drug, according to a study in the July issue of *Anesthesiology*, the official medical journal of the American Society of Anesthesiologists® (ASA®). Interestingly, use of HNK may also serve as a future therapeutic approach for treating neurodegenerative disorders such as Alzheimer's and Parkinson's diseases, the authors note.

"The clinical use of ketamine therapy for depression is limited because the drug is administered intravenously and may produce adverse effects such as hallucinations and sedation to the point of anesthesia," said Irving Wainer, Ph.D., senior investigator with the Intramural Research Program at the National Institute on Aging, Baltimore. "We found that the HNK compound significantly contributes to the anti-depressive effects of ketamine in animals, but doesn't produce the sedation or anesthesia, which makes HNK an attractive alternative as an antidepressant in humans."

HNK is one of several different compounds produced when ketamine, an anesthesia medicine-turned-antidepressant, is broken down (metabolized) in the body. Using a rat model, researchers tested HNK to see if the compound alone could produce the same beneficial effects attributed to ketamine without ketamine's unwanted side effects.

In the study, rats were given intravenous doses of ketamine, HNK and another compound produced by ketamine metabolism known as norketamine. The effect each had on stimulating certain cellular pathways of the rats' brains was examined after 20, 30 and 60 minutes. Brain tissue from drug-free rats was used as a control.

Researchers found the compound HNK, like ketamine, not only produced potent and rapid antidepressant effects, but also stimulated neuro-regenerative pathways and initiated the regrowth of neurons in rats' brains. HNK also appears to have several advantages over ketamine in that it is 1,000 times more potent, does not act as an anesthetic agent, and can be taken by mouth, the authors report.

Surprisingly, HNK was also found to reduce the production of D-serine, a chemical found in the body, overproduction of which is associated with neurodegenerative disorders such as Alzheimer's and Parkinson's diseases. HNK's ability to reduce the production of D-serine, while stimulating the regeneration of neuron connections in the brain, may present a potential new therapeutic approach to the treatment of these disorders.

Source: <http://www.medicalnewstoday.com/releases/278398.php?tw>

Please Become a Member of NAMI San Mateo County
1650 Borel Place, Suite 130, San Mateo, CA 94402

- Regular Member (\$35 to \$99)*
- Sustaining Member (\$100 to \$499)*
- Patron Member (\$500 to \$999)*
- Benefactor Member (\$1,000 or more)*
- Mental Health Consumer (\$10)
- Renewal or New Membership Amount Enclosed: \$ _____
- Change Address (print new address below, include bottom half of page with old address)
- * A portion of your membership donation is sent to National NAMI and to NAMI California

Name _____

Address _____

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Is This the Worst Time Ever to Have a Severe Mental Illness?

By Allen Frances. 08/06/2014 http://www.huffingtonpost.com/allen-frances/is-this-the-worst-time-ev_b_5654808.html?page_version=legacy&view

My personal response to this depressing question would have to be an ashamed 'Yes' for the United States; a relieved 'No' for most of the rest of the developed world. Admittedly, though, I am not the best person to provide a long view answer. We will soon be turning to Professor Edward Shorter, an eminent historian of psychiatry, to compare our current mistreatment of the severely ill with the practices of past epochs.

But I can speak from painful experience about the slippery downward slope of the past 50 years. When I first began work as a medical student on a psychiatric ward, we were very very optimistic that three new advances would dramatically improve the lives of our patients: 1) the availability of effective medication; 2) the availability of powerful research tools; and 3) the hope that state hospitals would disappear as patients were deinstitutionalized into the community.

Forty years ago, my optimism collided with reality when I was given charge of a short term inpatient ward. The medicines sometimes did work wonders, but often brought only partial relief and caused unpleasant side effects. The research findings were fascinating, but didn't have any impact on patient care. And worst of all, it was clear from the outset that deinstitutionalization was being carried out so badly it was bound to fail.

Patients were irresponsibly discharged at breakneck speed with little or no provision for their housing or treatment in the community. They were left to sink or swim on their own and not surprisingly many sank.

The dream of deinstitutionalization turned into nightmare because most state governments didn't, as promised, use the money saved by closing beds to provide adequate community treatment and housing. Deinstitutionalization was great for the state budget, but often terrible for the patients.

Many wound up on our unit. I am still haunted by a man I had to cut down after he had hanged himself in our shower room -- he couldn't tolerate his fallen status from chief car washer in the state hospital to deinstitutionalized street person.

In Europe, deinstitutionalization was usually done much better -- with a sense of social justice, adequate funding, decent housing, and greater family involvement. Originally, there were also some excellent programs in the United States, but most of these have been eroded with time under pressure from shrinking budgets and the cherry picking of easier patients that accompanied privatization.

The severely ill are now often jailed or homeless -- worse off than they were when I started psychiatry. For more on this heartbreaking development, see this blog post and a dozen others I have written.

Now we're going to shift gears from my personal experiences to Edward Shorter's historical perspective. He is professor of the history of medicine and professor of psychiatry at the University of Toronto and has written widely on the past and current problems of psychiatry. Professor Shorter writes: "What was it like being a psychiatric patient in the remote past? Before 1800, before Philippe Pinel, things were quite grim. People often believed that mental symptoms were caused by demonic possession and took the ill to priests for painful, sometimes fatal, exorcism. Psychiatric patients were sometimes, if female, regarded as witches and burned at the stake.

Physicians, while not believing in demons, thought the abdomen—especially the spleen and colon—was the site of mental illness and treated patients with laxatives. Bleeding and many other futile and dangerous treatments were also routine.

There were no dedicated mental hospitals. Patients who needed to be swept off big-city streets were thrown into 'hospices,' together with the criminal, the medically sick, the elderly, and the poor. In smaller communities, mentally affected relatives might simply be locked in the attic or chained in the barn.

A fantasy has arisen among the followers of Parisian philosophy professor Michel Foucault that traditional societies viewed the mentally ill benignly -- permitting them to drink red wine on the village commons all afternoon as the neighbors looked on smilingly. In the Foucauldian version of history, the downward slide of the mentally ill begins with 'capitalism' and the modern state, as the former benignly neglected denizens of the village commons were now 'confined' in barrack-like asylums.

Nothing could be further from the truth. Around 1800, proper mental hospitals were founded. These were intended to be, and originally were, humane institutions—the well-ordered routines of a hospital would restore a sense of order and normalcy; its high walls would grant a sense of safety; and medical reassurance constituted an early form of psychotherapy.

The wheels started to come off the wagon when these praiseworthy intentions were overwhelmed by the sheer press of numbers. Yet a core reality remained: For many, the asylum was a place of safety.

Since deinstitutionalization and the death of the asylum, the care of very ill psychiatric patients has gotten much worse. Psychiatry's dirty secret is that if you had a severe mental illness requiring hospital care in 1900, you'd be better looked after than you are today. Despite a flurry of media hand-waving about new technologies in psychiatry, the average hospital patient probably does less well now, despite the new drugs, than the average hospital patient a century ago.

How can this be? Above all, the old asylums were committed to keeping the patients safe. A major source of mortality (aside from tuberculosis) was suicide, and the best way to

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preserve patients from suicide is to hold onto them until they are better. As David Healy's research group has determined, in one British mental hospital around 1900, the average stay was 302 days, versus 41 days in the same hospital today. Suicide rates within ten years of discharge are much higher now despite the availability of drugs. In 1900, among patients with schizophrenia, 4 had killed themselves within ten years of discharge; today in a roughly similar population, it was 29. Note that most psychiatric inpatient units in the US now have a length of stay that has been shortened to an incredible 7 days -- far too short to stabilize patients and keep them safe.

I am not trashing today's psychopharmaceutical palette. Many patients are clearly better off with drugs than without them. Yet the crucial factor here is length of stay: the stays then were long (sometimes far too long); the stays now are ultra-brief and patients are discharged well before they are able to cope--especially since so few services are available in the community and adequate housing is in such short supply.

The old institutions were not wonderful -- they were overcrowded, noisy, and often had a distinctive odor. Patients were neglected and mistreated. Yet those problems have been replaced with a different set: patients today are far too often relegated to jails and prisons, where their vulnerability leads to frequent solitary confinement and physical and sexual abuse. Patients used to work at productive jobs within the institutions; no longer available now that we've abolished the shelter the hospitals provided.

When in the 1970s the hospital administrators and state legislators began the massive program of deinstitutionalization -- returning the patients to the community -- it was under the pretense that they were being discharged to 'community care,' to a network of halfway houses and day clinics where they would be looked after and kept safe.

Guess what? Never happened. The well-meant institutions of community care foundered and sank, sometimes because of lack of money, or an antipsychiatry inspired belief that there was no such thing as mental illness and that problems could be treated with kindness alone. I am not against kindness, but some patients are very ill and need genuine medical treatments. Many patients today, booted from the former security of the asylum, find themselves on the street with no care at all or in prison. This is a national scandal and the term "progress in psychiatry" turns out to be cruelly ironic."

Thanks so much, Professor Shorter, for providing this brief but illuminating historical context. There are two contradictory views on the study of history: 1) If we don't learn from history, we are doomed to repeat it, versus 2) The one thing we learn from history is that we don't learn from history. I am inclined to believe the second, but am unwilling to give up on the possibilities suggested by the first.

So what are the lessons and how do we apply them? Responsible deinstitutionalization requires money, time,

treatment, social and vocational support, and compassion. Done well, it can work wonders (as in much of Europe). Done poorly, as in most of the United States, deinstitutionalization has led to disastrous transinstitutionalization from dreary hospitals to much worse jails and prisons.

What we need now is a new round of deinstitutionalization for the severely ill -- getting them out of prison and into decent housing and accessible, compassionate community programs. This would be a difficult, but not impossible transition. The money is there if we only we allocated resources rationally. Housing the mentally ill in prisons is not only cruel, it is terribly expensive. States would actually save money by investing in adequately funded community programs and housing. We need to identify the hundreds of thousands of prisoners who have been incarcerated for nuisance crimes that could have been avoided if they had enjoyed adequate community care. We need now belatedly to provide them with that care -- to keep them out of jail and off the streets.

This is the worst of times and places for many people with severe mental illness. It need not be if only we put our hearts and minds and pocketbooks behind providing cost effective, compassionate treatment and We owe it to them and to ourselves. If a civilized society is judged by how it deals with its most vulnerable, we now deserve an F grade. Let's learn from our shameful history instead of mindlessly repeating it.

--Allen Frances is a professor emeritus at Duke University and was the chairman of the DSM-IV task force.

California Prisons to Restrict Pepper Spray, Segregation of Mentally Ill Inmates

By Julie Small | 8/1/14 | (Julie Small/KQED)

Bunk of an empty segregation cell at California State Prison-Sacramento.

California prison officials proposed major policy changes Friday to curtail when and how correctional staff use pepper spray on mentally ill inmates or segregate them from the general prison population.

The California Department of Corrections and Rehabilitation (CDCR) planned to vest mental health clinicians with greater say in whether correctional staff may use force or segregate inmate patients. The agency also set strict time limits on the segregation of mentally ill inmates who had committed no serious violations or crimes in prison.

CDCR proposed these changes to comply with a court order issued by U.S. District Judge Lawrence Karlton. Judge Karlton ordered the changes to California's policies in April, after a lengthy evidentiary hearing.

In court the judge viewed videotapes of custody staff repeatedly pepper spraying mentally ill inmates to force them from their cells. Judge Karlton called such use of force on mentally ill inmates “horrific” and said the state’s policies “demonstrate deliberate indifference to their mental illness and the harms caused by the weapons.”

In papers filed Friday in the U.S. Eastern District Court, CDCR agreed to limit the amount of pepper spray that custody officers can use and to ban completely the practice in certain types of housing, unless the prison’s warden authorizes it.

CDCR also proposed changes that would allow mental health clinicians to block the use of force if they believed it would harm their inmate patients. Correctional officers could no longer override such objections. Instead, senior managers would resolve any disputes.

Michael Bien, an attorney who represents mentally ill prisoners, called the proposed changes “meaningful reforms that go a long way to addressing some of the critical issues we raised during the trial last fall.”

Bien is the lead attorney in a 1990 case — yet to be resolved — to improve psychiatric care in prisons.

Gov. Jerry Brown tried to get the case dismissed last year, saying that the state had met its constitutional obligation to provide prisoners with mental health care.

The move back-fired, however, when attorneys for inmates presented fresh evidence of problems, prompting the judge to order new improvements.

Bien said that one of the most significant changes CDCR agreed to would reduce the number of strip searches of mentally ill inmates in segregated housing units.

Corrections officials also agreed to transfer some inmates out within 72 hours, if they were placed in segregated housing only because there was no other housing available.

California prisons isolate prisoners who violate rules or commit new crimes in prison. But they’ve also placed mentally ill inmates in those same segregation units when they couldn’t find space for them in a psychiatric treatment unit.

Inmates in segregation spend more time each day inside their cells than inmates in the general population and must submit to strip searches each time they leave and return to those cells.

Prison officials testified last year that mentally ill inmates suffered no harm from those conditions because the department still met their needs for mental health care.

Judge Karlton rejected that claim. In his ruling he asserted segregated housing “can and does cause serious psychological harm, including decompensation, exacerbation of mental illness, inducement of psychosis, and increased risk of suicide.”

Karlton wants prisons to develop a more rigorous process for deciding whether inmates with mental illness who violate the rules, or commit new crimes should be segregated.

Prisons officials are still negotiating those changes with the federal court’s special master. The parties must reach agreement and file those plans by August 15.

Diverting Mentally Ill to Treatment, Not Jail

By Lisa Aliferis | August 20, 2014

<http://blogs.kqed.org/stateofhealth/2014/08/20/diverting-mentally-ill-to-treatment-not-jail/#more-20931>

Officers Ned Bandoske and Ernest Stevens are part of San Antonio’s mental health squad — a six-person unit that answers the frequent emergency calls where mental illness may play a role.

This week, Julie Small has reported on this blog about court-ordered overhauls in caring for mentally ill inmates in California prisons. About one-fourth of California’s inmates — 37,000 people — have mild to severe mental illness.

As Small reported, U.S. District Judge Lawrence Karlton ordered the California Department of Corrections and Rehabilitation (CDCR) in April to draft new policies for use of force and has signed off on CDCR’s plans. Now the department is working on plans to comply with Karlton’s orders to change how it handles segregation for inmates with mental illness.

So, I was riveted by a report this morning from NPR and Kaiser Health News about a different approach — a coordinated, comprehensive approach — to a county-run mental health system. The story was set in Texas’ Bexar County, (pronounced “bear”) home to San Antonio and the Alamo, and the program is now a model for the nation.

It used to be — as recently as 15 years ago — that Bexar County’s jail was so overcrowded with people suffering from serious mental illness that the state was getting ready to impose fines, NPR reported.

Then Leon Evans, took over as head of San Antonio and Bexar County’s mental health systems and had a vision: For people with mental illness, treatment works. Jail does not.

Evans wanted to stop the expensive revolving door from jail back to the streets. From the NPR/KHN report:

When people with a serious mental illness are released from jail, many end up living on the street, sick and often addicted.

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And then almost invariably, they end up back in jail for a minor nuisance crime, like panhandling (which is illegal in San Antonio), urinating in public, digging in dumpsters or sleeping on someone's porch.

Evans saw the most pressing problem in treatment: scattered services. The county and city agencies, the nonprofits, the jails, the hospitals — none of them were talking to each other. "People who fund these services only look at their little small piece of the pie and whether there is a return on investment," Evans told NPR.

It wasn't easy or fast, but Evans brought people together and, among many other things, looked at how much money all the players were spending on mental health. They discovered enormous sums being spent to care for people — and doing it poorly. Pooling money could offer significant savings. More from NPR/KHN:

The courts, the jails, the hospitals, the county government and the police department agreed to work together on the issue. Everyone provided funding— the police even contributed their drug seizure money – to build a system where people with mental illnesses could get better.

Today, there is one centralized complex offering services, and it's located across the street from San Antonio's "state-of-the-art homeless shelter." Police officers all take a 40-hour course in handling mental health crises. The police department now has a six-person mental health squad — officers specialize in responding to calls where mental illness may be a factor.

Advocates call the new approach a big success, plus it's saving money, about \$10 million annually.

"One thing that's really important about the San Antonio approach is that they've integrated services together for mental health and substance abuse and homeless services, because most people have overlapping needs," says Laura Usher, a program manager at the National Alliance on Mental Illness who helps set up collaborations between law enforcement agencies and mental health departments.

The center has a 48-hour inpatient psychiatric unit, sobering and detox centers, outpatient primary care and psychiatric services, a 90-day recovery program, housing for people with mental illnesses, and even job training and a program to help people transition to supported housing.

"San Antonio realized that it's more cost effective to provide mental health services and supports to people on the front end, rather than pay for jail beds and prison time," says Usher.

As the piece wrapped up, I tried to imagine how great the savings could be in California, the most populous state in the country, if mental health care could be so coordinated and comprehensive here.

To Know the Darkness and the Light

By William Rivers Pitt 15 August 2014 | Truthout | Op-Ed
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<http://www.truth-out.org/opinion/item/25564-william-rivers-pitt-to-know-the-darkness-and-the-light>



Robin Williams, during a tour of 30 cities, backstage before his performance at the Ted Constant Convocation Center in Norfolk, Va., Oct. 26, 2009. Williams, an Oscar-winning actor and comedian, was found unconscious at home around noon on Aug. 11, 2014.

*Ye must welcome the phantoms that scream through the night
Take heed to the visions and presences bright
Lest ye waste up your life with the weight of street
In fear of the banshees ye'd happen to meet...*
— "Jo'rneyman's Song," Barleyjuice

I know about the darkness. I have seen it, smelled it, tasted it. I have felt it invade me through my pores, had it envelop and encompass every river and sea and valley of me. I have been staggered as it conquers and pillages me, I have choked on the soot of its burning, and I have wept tears of ash as the hoofbeats of its raiders tear my soil and thunder up the road to batter down my gates.

There is that. There is also this:

The wind in the trees. The sun on my skin. The taste of rain. The morning light dappling the ripples on the pond. The swell and crescendo of music. The caress of a lover. The coo of a child. A long embrace. A turn of phrase, a rhyme of verse, a finely-told joke. The taste of chocolate, or whiskey, or wine. The way wildflowers look in Spring, and the leaves in Autumn, the low susurration of snow in Winter, and the cobalt blue aftermath of sunset on Summer nights.

All of these, and so much more, and everything, are electric to me. For as long as I have had memory, the world around me and within me has left me gasping in a way that beggars the word "overwhelmed." I am in a state of perpetual astonishment, because I am wired that way. I came into this world a human tuning fork, humming with the tones surrounding me entirely against my will. I cannot stop it, and would not if given the chance. Mine is wonder, and awe, and I am overtaken by it, as if the air itself is transformed into high waves breaking on the beach. I drown daily, hourly, in minutes and in seconds, I drown in moments, and smile as I sink, because it is beautiful beyond words and space and time.

There is, however, a price. That price is the darkness, bleak and cold and forbidding, and I must make room for it as I also make room for the astonishment, because it comes relentless, remorseless, and it will have its way. When it comes to hold

court - and it always comes, and always will - I cling to what is simple and good in this incredibly strange life I have been gifted to live. I hold tight the basics - my wife, my daughter, my family, my friends - and furiously remember that this, too, shall pass. It always does, I tell myself.

It always has, so far.

Such is the bewilderment of bipolar depression. It is both reaper and reaver, a joyful destroyer, a Technicolor wrecking ball. With one supple hand it gives you the whole wide world that thrums against every nerve and fiber of your being, the world like diamonds dropped on a gilded plate. The other hand is a taloned fist, crusted with old blisters and older blood, and that hand takes. And takes. And takes.

Balance is all. You come to see your life as a long sine wave, all valleys and peaks, which are to be ridden out. Chronic depression has a dreadful way of transforming you into a demented walking contradiction, a deeply empathetic narcissist, at once all-embracing and self-absorbed. You are a thunderstorm, beautiful and terrible, bringing rain to cleanse and restore along with wind and lightning to destroy and scorch. You ride it out. You tame yourself. You learn. You endure.

Most of the time.

The darkness took Robin Williams from us. On Monday, he was found hanged in his home, a suicide, another triumph for the torment of depression suffered by so many. Comedians, more often than not, are the saddest people in the room, as Richard Jeni, Freddie Prinze, and now Robin Williams could attest to, were they still here.

Robin Williams never knew me, never met me, could not have picked me out of a line-up, but the news of his death hit me like a physical blow. I had, of course, reveled in the body of work he assembled over so many years, but it was more than that. We had something in common, after all: that darkness, which is the price of the light.

"The funniest people I know," writes comedian Jim Norton, "seem to be the ones surrounded by darkness. And that's probably why they're the funniest. The deeper the pit, the more humor you need to dig yourself out of it. In the 25 years I've been doing stand-up, I've personally known at least eight comedians who committed suicide. There is simply no way Robin could have understood the way the rest of us saw him. And there is simply no way he could have understood how much respect and adoration other performers had for him. At least I hope he couldn't have understood. Because it's too sad to think that maybe he did understand, and it just wasn't enough anymore."

That's it, right there, and perfectly said. Depression is a thief that steals your ability to see the ground under your feet for

what it is. You find yourself, instead, lost in a contradictory autobiography, a self-created narrative drafted by demons in a hall of mirrors where all the glass is cracked. It is all too easy to get lost in there, and Robin Williams, like so very many others before him, could not find his way out.

I see the ground under my feet. I know it for what it is. I lose it sometimes, but after many hard years, I know full well how to find it. I have put my malady in the traces, and it plows my fields with a durable reliability I will never not find surprising. When I hear the raiders coming, I brace the gates, and bring the provisions inside the walls, and prevail.

But I know the darkness, and I damn it with curses unspeakable, because it steals people like Robin Williams every day. Even in my wrath, however, I am forced to bless it as well, because it is Janus of two faces, and the other face of the darkness is that great, good, glorious light. It shined so brightly out of Mr. Williams, and out of so many others who bear this burden. It is the price, implacable, utterly immutable. It is what it is.

If you share this with me, you are my brother, my sister, the wind on my skin. You are not alone. Reach for the light, always. It is there. I know. I've seen.