// NAMI EAST BAY NEWSLETTER
A local affiliate of the National Alliance on Mental Illness (NAMI)
November-December 2019

NAMI EAST BAY NEWSLETTER

Panel on Dual Diagnosis

Wednesday, November 20

Join us to hear three people with outstanding backgrounds in work with both serious mental illness and substance abuse disorder. They will describe the approaches used by their various agencies to support people in recovery from co-occurring disorders.

Bonita House: Ryan Gardner holds an MBA and is a Licensed Clinical Social Worker (LCSW). He is Chief Clinical and Administrative Officer at Bonita House. He previously worked in government settings including the Veterans Administration.

New Bridge: Brian Campany is a Licensed Marriage & Family Therapist (LMFT). He is currently the Assistant Program Director for the Helios program at the New Bridge Foundation.

East Bay Community Recovery Project (EBCRP): Genica Robbins received her degree from Alliant International University in 2009. She has worked with moderate-to-severe mental illness for 16 years and with co-occurring disorders for six years.

Speaker Meeting starts at 7:30 pm
Albany United Methodist Church
980 Stannage Avenue, Albany
Corner of Stannage and Marin
Meeting is free and open to the public.

Support Meetings

NAMI East Bay offers the following monthly support meetings:

- **Support and Share Group for Families of Adults** is held on the 2nd Wednesday of each month. The next meetings are November 13, December 11, and January 8.
- **Support and Share Group for Families of Children, Adolescents, and Young Adults** is held on the 3rd Tuesday of the month: November 19, December 17, and January 14.

Support Group Meetings are held at the Albany United Methodist Church, 7-9 pm. Enter through the gates to the right of the door on Stannage Avenue, turn left through the large room, go down the hall, and come up the stairs. Signs will be posted.

All support meetings are free to NAMI members and non-members, offering a chance to talk with others who can share ways they have found to cope.

Winter Family to Family Class

Our annual winter NAMI Family to Family class is being scheduled for Thursday nights, January 16 to April 2. This 12-week class covers all aspects of mental illness, such as diagnoses, medications, brain function, problem solving, communication, coping, etc. Participation is free but it is *absolutely necessary* to preregister by contacting our office and leaving your contact information. The class fills up quickly. Even if you had talked to one of us before, please reconfirm your interest.

Nature Walk, Saturday, November 9

In keeping with our desire to practice what we preach, we are scheduling another family walk in nature, aka “forest bathing” or *shin-rin yoku*. On Saturday, November 9, we invite you to meet us at 10 am to walk the Jordan Trail in Berkeley, off Centennial Drive up behind the UC campus and Lawrence Hall at the parking lot for the Mathematical Sciences Research Institute. Google directions. Bring snacks to share.

Share Your ER Experiences

NAMI @ UC Berkeley is collecting data and personal stories on mental health crisis treatment in general hospital emergency departments. We will use the survey information collected to lobby for establishing a statewide requirement of training for hospital ER staff on mental/behavioral health and nonviolent crisis intervention. Please fill out our online form at https://tinyurl.com/nami-ERsurvey, then spread the word to other affected Californians you know.

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SPEAKER NOTES

Ask the Psychiatrist

Summarized by Thomas T. Thomas

A practicing psychiatrist with offices in Berkeley and Orinda, **Jerry Gelbart, MD,** spoke and answered audience questions at our September 25 meeting. He is also the Medical Director of Foresight Mental Health (https://www.foresightmentalhealth.com), which uses technology to advance mental health care. Dr. Gelbart is also the author of *The Potent Mind: A Program for Psychological Wellness and Effectiveness*.[1]

His experience is primarily with bipolar disorder, depression, trauma, schizophrenia, and anxiety disorders including eating disorders and obsessive-compulsive disorder (OCD). His treatments include medications along with cognitive behavioral therapy (CBT) or dialectical behavioral therapy (DBT). He uses cutting-edge technologies, such as genetic and neuropsychological testing to differentiate mental illness from biological impairments and to assist in medication decision-making, and he works with new approaches to treatment-resistant depression (TRD) such as transcranial magnetic stimulation (TMS) and the recently approved medication Spravato.

Q. My stepson, 38, has severe schizophrenia. He can acknowledge his illness but is paranoid and won't take his medication, see a therapist, or join a support group. Should we do an intervention and force him to express and confront his emotions?

A. First, don't ever lose hope. It's sad, but people with mental illness often lack insight, and young people even less insight. The question is how much to confront him. Try to avoid direct intervention. But if you do it, get an intervention specialist, and have a plan where to take your stepson and what to do next.

Look for ways to approach him without forcing the issue of schizophrenia. For example, does he have problems with sleeping or appetite? A primary care physician can suggest medications for that which also address his psychotic symptoms. We are training family care physicians—especially in a program at John Muir Hospital—to deal with mental illness.

Be careful, though, not to become codependent: facilitating his resistance to treatment. Sometimes it's necessary to let the system work and have your loved one go to the hospital for treatment.

Q. My son has been through six cycles of withdrawing from his medication. Can an intervention, even with a specialist, work when it goes against a person's will?

A. Generally, no. But you can recruit family members and set up a treatment plan ahead of time. Interventions are a carrot and stick approach—and again, try a softer alternative, working from the fringes, like treating sleep and appetite disorders.

Q. My daughter has previously been hospitalized with a 5150. She has anosognosia, is paranoid, and suspicious of everything. She won't get a prescription, but I bought some lithium carbonate over the counter. Can I give it to her? Also, what about flower or herbal medications?

A. You have to be careful of dosing with lithium. Treatment requires blood-level monitoring, because this medication can cause kidney damage. So it's not a good idea to slip it into her food.

As to herbal medications, there is a lot of evidence that they can be good for anxiety, but they have not been shown to treat psychotic tendencies. They may not be good for bipolar mania.

Q. My daughter has been diagnosed with both bipolar and schizophrenia. She has been admitted to the hospital but refuses medication.

A. Schizophrenia is characterized by acute psychotic symptoms (i.e., hallucinations, delusions, paranoia) but without mood swings or depression. Bipolar is generally characterized by mood swings from depression to mania, but without psychotic symptoms in the middle state. The combination of both symptoms is known as schizoaffective disorder, and it's harder to treat.

Most people on medication learn over time that, when they go off their meds, things don't work so well. One way to help with compliance is injectable medications like Abilify. You can tell your daughter it's all about the convenience: she won't have to remember to take a pill.

Another recourse to medication refusal is Laura's Law, or court-ordered assisted outpatient treatment (AOT). To qualify for the program, however, a person must have a serious mental illness and a recent history of psychiatric hospitalizations.

[1] Based on his blogs and currently out of print.

It can be difficult to get AOT involved with your case. One alternative is in-home outpatient treatment (IHOT), where a team composed of an unrelated family member, a consumer advocate, and a social worker come to your home and work with your family and your daughter to engage her in treatment.

You should contact the Alameda County Behavioral Health Care Services ACCESS Program at 1-800-491-9099,[2] which is staffed by licensed clinicians. Note that the county program only serves people who don't have private medical insurance.

Q. What are the risks of taking antipsychotic medications for years? What are the effects on the brain?

A. Most medications offer no long-term risks. Some of the older, or "typical," antipsychotics such as Haldol have a higher risk of side effects centered in the brain's motor control system: tardive dyskinesia (TD), or involuntary movements, similar to Parkinson's disease. The risk has been calculated at approximately 7% per year, so in ten years you would have a 70% risk of contracting the disease. However, we now have medications to treat TD; they are expensive but available.

Of the newer, or "atypical" antipsychotics such as Risperdal, Zyprexa, or Geodon, the risk of side effects is a tenth of that, or 0.7% per year—but it is still a cumulative effect.

Other than movement disorders, some of the older medications may kill brain cells. But the newer ones actually improve nerve cell growth by promoting brain-derived neutrophic factor (BDNF).

Q. Should someone with depression and psychotic symptoms be put on an antipsychotic?

A. It would be appropriate to treat the psychotic symptoms first, then treat the depression.

Q. I've read that untreated psychosis can kill brain cells. Is this true?

A. Depression can kill brain cells, and antidepressants help protect the brain.

A concept taken from the treatment of seizures, called "kindling," also applies to repeated bouts of depression. Each little seizure, or each episode of depression, makes it more likely for the person to have another seizure or more depression. The first episode makes a repeat 50% more likely, the second 75%, and so on. The same may be true of psychotic episodes.

Q. How do you approach treatment-resistant depression?

A. TRD is defined as a person failing to find relief with two antidepressant medications. Many doctors use as antidepressants one of the selective serotonin reuptake inhibitors (SSRIs) like Paxil or Zoloft or a serotonin norepinephrine reuptake inhibitor (SNRI) like Effexor. Lithium or a mood stabilizer like Lamictal can also help. Doctors can use genetic testing to see what should work.

Other than medication, transcranial magnetic stimulation (TMS) has been found to be effective about 70% of the time—although some practitioners are experimenting with their protocols. (Dr. Gelbart recommends BayTMS as a reliable local provider.) The new antidepressant Spravato is also effective, but it must be administered in the doctor's office.

One caution is that persistent, chronic depression may be confused with dysthymia, which is a psychiatric disorder originating in childhood and best treated with psychotherapy rather than medication.

Q. Is obsessive-compulsive disorder (OCD) related to mental illness?

The rituals and anxieties of OCD differ from the delusions of psychosis. A person with OCD may have habitual activities and anxiety, but they may also have insight into their beliefs and can challenge them. A person with a psychotic delusion usually lacks insight.

In the same way, the autism spectrum and cases of attention deficit disorder (ADD) are separate from mental illness. In these cases, the person is experiencing a cognitive impairment. To establish these conditions as separate diagnoses, the physician does a neuropsychological evaluation.

Dr. Gelbart said he believes in a bio-psycho-social perspective: that illness is the presence of symptoms, and health their absence—but beyond that is *wellness*. And wellness involves self-care routines that include healthy eating, sleeping, time management, self-esteem, and other aspects of a life well lived.

Past articles in the Speaker Notes series are available online at www.thomastthomas.com/ under "NAMI East Bay." Also available is a copy of the brochure "Medications for Mental Illness."

[2] A similar program exists in Contra Costa County.

Musings

So I was attending an open house event for a new resource, Amber House, described elsewhere in this issue. The physical layout was appealing and as I wandered onto the deck, I overheard a staff person start giving a description of the facility to a small group. In her second sentence, she uttered the words "working with the family." Needless to say, that—unfortunately—surprised and delighted me. Too often, family members are dissuaded from the notion that they are to any degree considered part of a team … a team developed to help a person with whom the family has been loving and living with for probably more than ten years.

To be sure, our relatives who carry a diagnosis of mental illness function and are symptomatic in every way possible; there are many variations on a theme. My son with schizophrenia is quite different from a friend's son with schizophrenia who lives in New York City and attends the opera and ballet. And, the individual on the street in a manic phase with his diagnosis of bipolar disorder presents very differently from the fellow with the same diagnosis who takes his meds and has negotiated accommodations at his workplace. And some of these consumers have an involved family while others, for various reasons and history, are estranged from or just not in contact with relatives.

Working from the premise that the class of individuals with diagnosable mental illness is tremendously diverse, our perspective has to deal with the realities of underlying treatment options. The caveat, of course, is that there is no one treatment option that works for everybody. There are treatment models to emulate, and Amber House seems like one of them, but consider what else I heard at the open house.

The range of people present who were introduced as being part of this development included staff from not just host agency Bay Area Community Services (BACS) but also individuals from state, county, and municipal governments, architects, developers, financial experts, and Behavioral Health Care personnel. It took a huge amount of people to put together just this one treatment option … and meanwhile the huge amount of folks across the spectrum of functionality is still out there, desperate for treatment.

So we have a situation where it takes an extremely large number of professionals, resources, and creativity to offer treatment to a diverse group of individuals with mental illness who vary widely in terms of need and functionality. And underlying this conglomeration are issues around federal and state regulations, funding sources, patients' rights, confidentiality, housing issues, stigma, willingness to accept help, etc.

Perhaps it's amazing that anything ever gets done in the system. There is one constant, though, in most of these individuals' lives that is seldom considered part of the treatment team and that is the family. So when family support is mentioned or even considered part of a therapeutic intervention, we cheer!

—Liz Rebensdorf, President, NAMI East Bay

An Alternative to the Appeal Letter

Generally, at this time of year our board members are looking over drafts of our annual fundraising letter, getting it copied, and then mailed out to the 700 of you on our paper mailing list and the other 700 on our e-list. But this year, since you're probably bombarded by similar politically-oriented requests, we are going to rely solely on your generosity and care for the organization to make a tax-deductible donation.

Funds raised go towards our rent, utilities, materials, office help, and costs associated with printing and mailing our newsletter.

Donations may be made through PayPal on our website, through the Amazon Smile process when you purchase something, and through any employee giving program or other such process.

Thank you in advance.

Recovery Support Groups

There are four Connections groups for consumers in Alameda County. These are recovery support groups led by trained facilitators who have lived experience with mental illness.

1. Hayward, 1st and 3rd Tuesdays, 7-8:30 pm. Call Kathryn at 510-560-6498 for information.
2. Fremont, 2nd and 4th Tuesdays, 7-8:30 pm. Also call Kathryn at 510-560-6498 for information.
3. Asian/Pacific Islander group, Fremont, 2nd Saturday, 11 am-12:30 pm. Contact Elaine Peng at

510-362-1456.
4. Pleasanton, Wednesdays, 7:15-8:45 pm, contact marsha@nami-trivalley.org.

New Short-Term Housing and Hospitalization Alternative

Amber House Crisis Facility is a short-term, voluntary residential and/or support alternative to psychiatric hospitalization. Individuals in active psychiatric distress or just out of the hospital may receive support to cope and heal.

There will be a 12-bed Crisis Stabilization Unit (CSU) available for up to 24 hours. The 14-bed voluntary Crisis Residential Treatment (CRT) program will serve individuals who do not meet criteria for psychiatric hospitalization but need short-term treatment and supportive programming. Catchment area is for residents of North County, and services are available only for those Alameda County clients who possess and/or are eligible for MediCal.

The site is off Telegraph Avenue near the Pill Hill area of Oakland. Email BACS@bayareacs.org for referral information.

New Referral Service

The website www.neb.health offers a free service to help you find a mental health provider anywhere in California. The process starts off with a 20-minute phone call to ascertain needs and ends with a sharing of a few available matches within a week. Specialty, availability, culture, and affordability factors are taken into account, and if necessary, insurance plans can be contacted on your behalf. Please give us feedback if you use this service, since it's new to us.

Along these lines, another resource: Find a Therapist—with the filters you insert—is available at www.psychologytoday.com.

Psychotic Disorder and Neural Abnormalities

Psychiatric Times offered this interesting presentation by our friend Sophia Vinogradov, MD. The essential gist is: Cognitive dysfunction is a more significant determinant of functional outcome than are symptoms, even though most psychiatric treatments focus primarily on symptom management. Such dysfunction ranges from earliest stages of auditory and visual processing in the brain to higher level abilities to learn and encode new information, to read social cues and engage in meta-cognition.

Cognitive remediation seeks to improve cognition by improving brain information processing but research is needed regarding the right program, cognitive targets, and frequency for each individual. Sensory and perceptual processing, along with learning and memory deficits, impacts how the individual learns and makes decisions based on new information. At the same time, there is executive dysfunction, which affects attention and working memory, lack of inhibitory control, and abstract reasoning, planning, and sequencing. When all we see is chaotic and unreasonable behavior in our loved one, we are perhaps missing the underlying contributors.

Comments from a Psychiatrist

"Has the way we care for one another improved? Are you still devastated to see mentally ill people, psychotic and disheveled, lining our streets like discarded byproducts of a polarized society? Do we still abdicate higher ground by hiding behind ill-conceived mental-health laws that value autonomy over dignity and individualism over compassion? I'm reminded of Francis Peabody's 1925 proclamation, 'The secret of the care of the patient is in caring for the patient.' Those words remain most urgent in the care of those who cannot care for themselves. …

"In 2019, if my patient has a brain tumor that compromises decision making capacity, we seek surrogates to act in their best interest and provide compassionate care. Severe mental illness can also rob people of their ability to comprehend reality and destroy their capacity to render rational decisions. Sadly, current laws distinguish mental from physical health so that we cannot apply the same standard of compromised brain function. Our laws remain uninformed by science, and mandate that I release my patients from care if they are not in danger, even when they lack the capacity to think clearly."

—Dr. Steven Siegel, Chair of the Department of Psychiatry and the Behavioral Sciences at USC, www.keck.usc.edu/psychiatry (Thanks to Tree Gelb-Stuber for sending this to us.)

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Please check your mailing label. If the code "19" is over your name on the right side of the label, your dues are current through 2019. If your mailing label indicates a previous year, or nothing at all, your dues are not current.

We urge you to mail your 2019 dues now. And if you can afford to add a bit more, please do so. Your $40 NAMI East Bay membership gives you our newsletter six times a year, the quarterly "Connection" from NAMI-California, and the NAMI-National "Advocate." NAMI East Bay is nonprofit [501(c)3] and your dues and contributions are tax deductible.

☐ **Family Membership, $60 per year** ☐ **Open Door Membership, $5 per year**

Make checks payable to "NAMI EAST BAY" and mail to NAMI East Bay, 980 Stannage Avenue, Albany, California 94706

☐ **Contact me for Family to Family Education Class**

Name: ______________________ **Phone No.:** ______________

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