LEARN HOW TO BE...

stigma free

and replace the stigma of mental illness with hope and understanding.

1. Learn about mental health—educate yourself and others

2. See the person not the illness—strive to listen, understand, tell your own story

3. Take action—spread the word, raise awareness, make a difference

Steps

www.nami.org/stigmafree
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B uilding a movement is the most critical goal of NAMI’s strategic plan. We seek to grow a community committed to supporting people affected by mental illness and to advocating for justice in access to mental health care and other services.

For NAMI to be successful, the movement must be inclusive and diverse. If we want lawmakers and the public to understand that mental illness affects 1 in 5 Americans, our community must reflect the diversity of nearly 60 million people. Similarly, if our core belief is that no one should face mental illness alone, then we must reach all communities, because mental illness knows no income, color, gender, language, age or sexual orientation and has no racial or religious bounds. NAMI opposes any effort to exclude any group from services or treat them poorly because of factors unrelated to the need for mental health services.

Think of building a movement as writing music, cooking a meal or painting a picture. If we have only one voice, ingredient or color, we have an uninspiring creation. We need more voices, colors and flavors to appeal to a wide variety of people and create impact.

NAMI has work to do in adding voices and perspectives. An effective path forward involves partnering with state and local affiliates. I am proud of the work of NAMI Chicago, highlighted in the Affiliate Spotlight. Their innovative programs spread awareness to diverse communities by starting conversations about mental health and breaking down cultural stigma.

In addition, NAMI’s “Build It Together” initiative provides grants, in-depth technical assistance and training to help NAMI State Organizations develop and carry out goals for inclusion and diversity through becoming more culturally competent. To date, 16 state organizations have participated, and they are seeing clear increases in levels of cultural competence.

We must go further to build an inclusive and diverse movement. We will continue until every person affected by mental illness knows he or she is not alone and has information and support that reflects their perspective and needs. We will continue the fight for justice and equity in mental health care and raise our collective voices, recognizing that some communities have less access to care than others. And we will listen to all communities so we can build our movement together.

Mary Giliberti
NAMI Chief Executive Officer

President’s Perspective

“Home is the place, where when you have to go there, they have to take you in.”—Robert Frost

W henever family members become ill, families rally around to give love and support. Health care providers and the community would be horrified if a family wasn’t involved with the care of an ill member. The family is, in many cases, valued as part of a successful recovery.

But, if the illness is mental illness, health care providers more often than not see the family as “other.” Family is often not welcomed into the care circle. This past year, my husband and I were coming to the hospital (in another state) where our son was, and we asked for a family meeting while there. The reply from the hospital was, “We don’t do family meetings.” Note: Our son had given permission to staff to talk to us. Can you imagine another illness where the family would be shut out in this manner?

How did mental illness become the illness for which you should go it alone, without the support of family? The illness that sees families as a detriment to recovery? Many years ago mothers were blamed as the cause for many mental illnesses, but surely in 2016 health care providers must know better. Provider education and advocacy is essential to fight for good treatment for our family members. They deserve to have their family lovingly help them deal with their illness just like anyone else who has a chronic illness.

The idea that families are detrimental does a disservice to those with an illness. My son once told a psychiatrist, “I know I can count on my family.” I believe his sentiment is that of many living with a chronic mental illness.

The National Alliance for Caregiving released a report in February titled On Pins & Needles: Caregivers of Adults with Mental Illness (see p. 4). NAMI was a partner in this report, which highlights the many important roles that families provide to their members. It shows that families are often vital support for their loved ones.

We must continue to advocate. This election year gives us an opportunity to have mental illness become a priority so that those living with a mental illness and their families are treated like all others with a chronic illness. In this effort, you are not alone. NAMI is available to help you advocate. Go to www.nami.org/advocacy to get involved.

Robert Frost’s line underscores that home and families are there for you when the world becomes difficult, providing the unconditional love that everyone needs to recover.

Marilyn Ricci
President, NAMI Board of Directors
NAMI Chicago Reaches Diverse Communities

By Brendan McLean and Laura Greenstein

A

n important question often comes up in the NAMI world: How can we reach everyone who needs help? While many NAMI Affiliates accomplish this objective, NAMI Chicago has set an example that's challenging to match. This affiliate has been working tirelessly to spread mental health awareness into diverse communities, reduce stigma on mental illness and offer resources and supports to individuals and families.

NAMI Chicago's main programs to reach diverse communities are Compartiendo Esperanza, NAMI FaithNet (e.g., Sharing Hope and Bridges of Hope) and Familia a Familia. Each program is targeted at communities that often have a foundation of unreliable and unfounded information about mental illness. "Mental health literacy is just nonexistent," says Edlyn Rodriguez, Outreach and Volunteer Manager at NAMI Chicago. This issue not only reduces access to mental health care but also prevents people from asking for help because they don't know what they need. "Different communities have different barriers," says Rodriguez. "Whether it’s access or insurance, these populations are often some of the most disadvantaged."

Reaching out to these communities has become a priority for NAMI Chicago. They have been working in the field to help people effectively. "We’re talking to community leaders and asking them, ‘What is the best way to deliver this to your community? What do you need in your community? And how can we support you?’ Then we ask them to help facilitate,” says Rodriguez. They also offer Spanish-language support groups and bilingual staff members to answer Spanish-speaking callers.

Their program that teaches the signs and symptoms of mental illness to the Latino community, Compartiendo Esperanza, has been going strong since receiving a grant from NAMI in 2014. “Whenever we do Compartiendo Esperanza, [people find it eye-opening] that depression is a mental illness,” says Rodriguez. Many Latinos don’t see it as something severe. It’s something that you go through and move on. They don’t address it as something that is reoccurring or chronic.” The first step in spreading awareness to these communities is starting the conversation about mental health, which is how this program works. Four teams of individuals and family members living with mental illness present to various Latino communities and open a dialogue with them.

This initial conversation is critical to break down the barriers that stigma has created. “A common challenge that we’re seeing in diverse communities, as well as the Chicago community as a whole, is stigma. Stigma is a huge barrier, especially in these minority communities,” says Kyra Wilson, Assistant Director of Honest, Open, Proud, a program designed to help people feel comfortable disclosing their mental illness to others.

Stigma also creates challenges related to encounters with the law. For the past 10 years, NAMI Chicago has been a part of Crisis Intervention Team (CIT) training with the Chicago Police Department. But the caveat is, you have to request an officer who is trained in CIT; one won’t automatically be sent. “We’ve heard from several community members who are worried that calling 911 to help a loved one will stay on their permanent record. What they are afraid of is stigma,” says Alexa James, Executive Director of NAMI Chicago. Their big push with the city is to go into communities with very high mental health calls and educate people about the signs and symptoms of mental illness and how to access the appropriate officer if a loved one is experiencing a crisis. James states that a lot of people in the community don’t even know that requesting a CIT officer is a resource. “Minority communities in Chicago with extreme poverty see the most police calls. Those are also the same areas that receive the most mental health calls. But we know that mental health affects people equally,” says James.

Reducing stigma and increasing awareness are related, and NAMI Chicago is doing everything it can to spread mental health education into all communities. “What we need to do in these communities is find credible messengers,” says James. “NAMI wants to be accessible. This is the way we can get more rooted in communities. Our work is not in our office—it’s in the streets.”

Brendan McLean is a former manager of communications and public affairs at NAMI; Laura Greenstein is communications coordinator at NAMI.
Report Finds Families Struggle Over a Decade to Get Help for Mental Illness

At least 8.4 million Americans care for an adult with an emotional or mental health issue, and nearly three quarters report that caregiving causes high emotional stress, finds a new study from the National Alliance for Caregiving in collaboration with Mental Health America and the National Alliance on Mental Illness.

The report, On Pins & Needles: Caregivers of Adults with Mental Illness, identifies startling inadequacies in the U.S. health care system in meeting the needs of families who manage moderate-to-serious mental illness. Four in 10 caregivers struggled to find an accurate diagnosis for their loved one. Families whose loved one had found an accurate diagnosis reported that it took 11.8 years, on average, to get there. Treatment is also an issue. A majority of caregivers found it difficult to find the right drug and dose, and fewer than four in 10 caregivers (37%) reported that their loved one’s medication was effective in providing help.

“The study confirms what NAMI hears every day on its HelpLine and in its family classes and support groups,” says NAMI Chief Executive Officer Mary Giliberti. “It reveals a glaring gap in support for caregivers that is one more example of the inequality between mental illness and other health conditions. The report provides an agenda for action by policymakers, and they should act quickly to provide caregivers with needed parity in access to mental health care and to provide for their overall needs.”

View the report and related materials at www.caregiving.org/mentalhealth.

Stigmafree Company Campaign to Launch This Summer

NAMI’s popular stigmafree campaign fights to end the stigma of mental illness through education, increased awareness and social action. In July, NAMI will launch the “stigmafree company” initiative aimed at challenging, highlighting and cultivating a company culture of caring and enhanced engagement around mental health. The campaign will equip companies with tools, resources, assets and information to promote mental health awareness in the workplace. Learn more about the campaign or take the pledge at www.nami.org/stigma.
In Case You Missed It: 2015 NAMI Annual Report

NAMI’s annual report presents highlights of the organization’s considerable accomplishments in the past year. Visit www.nami.org/About-NAMI/Our-Finances to download a copy and learn more about how NAMI is making a difference.

Raising Awareness

May is Mental Health Month, and there is still time to join NAMI in bringing awareness to mental health, educating the public and advocating for equal care. To get involved, visit www.nami.org/mhm for downloadable graphics and social media tools to show your support. In addition, National Minority Mental Health Awareness Month in July is an opportunity to raise awareness of the challenges that some communities face, such as less access to care, cultural stigma and lower-quality care. As summer approaches, NAMI will provide templates, graphics, tips and information to help communities launch and customize awareness activities. Visit www.nami.org/get-involved to learn more.

Get Ready to Raise Awareness about Mental Illness

July: National Minority Mental Health Awareness Month

NAMI offers templates, graphics, tips and information to help you customize awareness activities for your community. Visit www.nami.org/nmmham.

September: Suicide Prevention Awareness Month

Suicide Prevention Awareness Month and World Suicide Prevention Day on Sept. 10 are times to talk about suicide prevention, promote resources and awareness and learn how to help others. Learn more at www.nami.org/suicideawarenessmonth.

Oct. 2–8: Mental Illness Awareness Week

Join mental health advocates across the country to sponsor activities, large or small, for public education about mental illness. Find inspiration at www.nami.org/miaw.
The pressures endured by the “sandwich generation,” the group that is simultaneously raising children and helping elderly parents, are widely known. A flip side to that trend, however, receives much less acknowledgment. Many parents over age 70 are still caring for their adult sons or daughters who are living with a mental health condition. These parents must deal with the typical issues of their age group while continuing to look after their son’s or daughter’s well-being. This situation gives rise to worrisome issues that are tough to think about, especially the concern over what happens when the parent succumbs to illness or dies.

Additionally, these parents may face challenges that parents caring for adults with other medical illnesses do not usually face. Gail Gibson Hunt, president and chief executive officer of the Bethesda, Md.-based National Alliance for Caregiving (NAC), says some parents of sons or daughters living with a mental health condition “have to overcome that stigma.” In fact, On Pins and Needles: Caregivers of Adults with Mental Illness, a research report released in February by NAC in partnership with NAMI and Mental Health America, found that nearly half of the respondents were reluctant to discuss the situation because of stigma. Half of caregivers of individuals living with mental health conditions reported that they feel alone.

Another difference between caregivers of persons with mental health conditions and those caring for persons with other medical illnesses, Hunt says, is “the great difficulty in getting a diagnosis and the amount of time it took.” Some 62% of caretakers responding to the survey said they feel an accurate diagnosis has been made, but it took a median of eight years. That is generally not the case with other medical conditions, Hunt says.

Keys to reducing stresses on parents, experts say, are planning for the future, accessing all available benefits and services and practicing healthy self-care. Certainly, many factors, including the parents’ resources, the state of the son’s or daughter’s condition and the family’s...
location, determine how possible it is to take those steps.

The foundation for a future plan starts with a partnership between the parent and the adult son or daughter living with a mental health condition.

A person living with mental illness can be empowered to contribute meaningfully to the household. Susan Gingerich, M.S.W., an independent trainer and consultant in the Philadelphia area, says, “The more the son or daughter is involved in the functioning of the household, the more they will be able to take care of things on their own. It makes them feel capable.”

Parents should “take stock of what you do” and decide which tasks your family member can do themselves, Gingerich advises. Teach their family member to cook a couple of different meals or how to do laundry, she suggests. Organizations that help persons with disabilities with employment, education and social activities can enhance skills. Clubhouse International, with locations nationwide, is one such organization.

Dr. Lori Tannenbaum, division director of mental health and wellness at Brooklyn Community Services, says that staying under the parent’s roof should be considered “a period of dependence leading to independence.” One pitfall, Dr. Tannenbaum says, is that “people are so stuck. Parents may feel too old to take care of their son or daughter, but they don’t see any other way. Families may also be stuck in the perspective that the person living with a mental health condition has limited capability. “People with mental illness get buried in a culture of low expectations,” she says. Parents and siblings must learn to “see a family member in a different light.”

The partnership between a parent and son or daughter must have clear boundaries, such as the limits of financial support, and expectations, like adhering to the treatment plan, says Donna Schwartz, M.S.W., a psychotherapist and assistant clinical professor of psychiatry and behavioral sciences at the George Washington University School of Medicine and Health Sciences in Washington, D.C. “Being clear about boundaries is one of the most important steps parents can take to alleviate their stress and help the son or daughter reach their potential,” Schwartz says, adding that doing so “takes a little bit of work.”

Parents may feel guilty about having to do this, but “it’s OK to take care of themselves by setting healthy boundaries,” Schwartz says.

Fostering independence through boundaries and responsibilities is an approach that Frank, a NAMI HelpLine volunteer, has implemented with his adult daughter who is living with schizoaffective disorder. The daughter, who is in her 40s, lives in her own apartment. “[I am] just her dad,” he says. “I do the dad things. If it’s a problem related to her condition, I tell her that the psychiatrist and therapist must handle it.”

Lead the family meeting by talking about what the son or daughter does well. For example, point out that the family member is a good cook or does volunteer work.

Frank says he keeps in close touch with his daughter and helps her with what he can, but he wants her to be prepared for the future. “I’m not always going to be here,” he says.

In addition to forming a respectful partnership between parent and the son or daughter living with a mental health condition, family problem-solving, when possible, is optimal. “Everyone in the family has an investment in coming up with a solution,” Gingerich says. “No single family member is going to meet all the individual’s needs. If there are no siblings, choose someone who understands the situation, such as a member of the extended family or a close friend of the family.”

Family involvement starts with educating the members about chronic mental health conditions, Schwartz says. “Family members need to know what the choices are,” she says. “Go in and meet the therapist.” Siblings and other relatives need to know, for example, what is OK to say to a person living with paranoia, she says.

Gingerich shares that sentiment. Parents sometimes want to shield siblings from upset, “but if they know what’s going on (at an early stage), they will not blame the person with mental illness for their behavior,” she says.

The best way to approach family problem-solving is for the parent and the son or daughter living with a mental health condition to talk privately first, says Gingerich. Discuss a plan for finances, the living situation, social support and other quality-of-life issues, says Gingerich, who co-authored, with Dr. Kim T. Mueser, The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life. Next, the parent should speak with each sibling individually before calling for a meeting of the entire family.

Lead the family meeting by talking about what the son or daughter does well. For example, point out that the family member needing support is a good cook or does volunteer work. Then address the question of how the family can help this member lead a pleasant life in the future, Gingerich says. “Talk about what the goal is.”

Keep in mind that not all families can do this, says Dr. Jennifer Wolff, an associate professor at the Bloomberg School of Public Health at Johns Hopkins University in Baltimore. If conflict already exists in a family, a crisis situation can either bring them together or tear them further apart, she says.

In addition to having a plan for care, families must also make a relapse-prevention plan, Gingerich advises. “If there is a relapse, evaluate the situation,” she says. “Think about what the triggers were. What were the first signs?” Then, using that information, decide on the best approach to try to prevent a future relapse.

Key to ensuring the right treatment in an emergency is an advance directive that includes a health care proxy, so that the person living with a mental health condition can state his or her wishes in advance of a psychiatric or any other medical emergency, Dr. Tannenbaum says.

Dr. Wolff says it is important to get permission from the family member to be part of the health care team. Establish in advance that a family member will contact health care providers if a situation warrants, she says. “That’s a
challenge across (medical) conditions, though it may be harder with mental illness,” she adds.

Any plan must include tapping into community resources and government benefits for which the adult living with a mental health condition is eligible.

Knowing the resources available in the community is vital, says Schwartz. “It is most important to get help outside the family,” she says. “There should also be a community connection.” Schwartz helps patients’ families find those resources and believes that psychiatrists and therapists should help with resources and referrals when requested.

“Amid budget cuts,” Dr. Wolff says, “[mental health care] agencies are shifting toward trying to provide better documentation of services that are available” when they have to trim or restrict growth of their own services.

Still, “there’s more out there than there has ever been,” Dr. Tannembaum of Brooklyn Community Services says. Resources vary by state, however. For example, in New York, anyone living with a mental health condition plus one other medical illness is eligible for a case manager.

Frank successfully established Social Security disability insurance (SSDI) and now Medicare benefits for his daughter and secured a Section 8 housing voucher for her. “It took a while to get all that done,” he says. To ensure that those benefits will be there for his daughter, he does not provide financial support or help provide basic needs. “I can’t do anything to jeopardize her benefits,” he says.

He also set up a special-needs trust. Frank says he learned about steps to take from parents like him in NAMI’s Family Support Group. The steps he has taken reassure him that his daughter’s needs will be met.

Establish these plans—benefits like SSDI, food stamps and Section 8 housing—“sooner, rather than later, because of the time it takes to do everything,” Gingerich says. “Don’t wait until there’s a serious illness.”

Parents’ worries often go beyond the basic needs of their sons or daughters, especially if siblings live far away or are busy with their own lives and families.

“Interpersonal relationships have always been a problem” for his daughter, Frank says. His son’s career took him to California, but he still communicates with his sister.

Gingerich says parents and other family members should do what they can to encourage social relationships through religious groups, volunteering or other activities. “Social relationships are one of the things that keep us all going,” she says.

Just as the son or daughter needs friends and activities, so do the parents. Parents must have activities that nurture them, Gingerich says.

Frank says he has a positive relationship with his daughter, keeps in close touch and shows her fatherly support. Because his daughter lives independently, he can take a short trip without worry.

“I have a strong faith. I do the best I can,” he says. “I never give up hope; there’s millions of us out there. We support each other.”

Roseanne Geisel has been a NAMI HelpLine volunteer since 2013. She worked as a business journalist for more than two decades. Now, her primary interest is to use her communication skills to educate people about mental illness and to improve the lives of those affected by mental health conditions.
Bipolar Disorder: A Fire that Can Fuel Creativity

By Ken Duckworth, M.D.

Kay Redfield Jamison is a rock star in the mental health world. She may not have the same name recognition outside her area of expertise as Paul McCartney or Bruce Springsteen do, but her work on bipolar disorder has helped change the way the world has come to view mental health. Often drawing on her own experience with bipolar disorder, Jamison has published over 100 academic articles and written a New York Times bestselling memoir. She is also the author of Touched with Fire: Manic-Depressive Illness and the Artistic Temperament, which discusses how bipolar disorder can often be found in artistic individuals. A new film released this past February borrows the title of her book. I had the opportunity to get the background story of her book, her own experience with mental health and how she felt about the movie, which she encourages NAMI members to see.

What led you to write the book Touched with Fire?
I was always interested in this area—the states of normal and pathological states and imagination and creativity. I had my first experience of deep depression in high school, and I wondered about this connection more. My English teacher must have known something was happening for me, as he gave me poetry and said I might like these. They were books by Robert Lowell, which spoke to my heart and soul. I later read The Varieties of Religious Experience by William James, which gave me more insight into how fiery and feverish moods can produce incredible creativity.

You are a remarkably successful public figure living with bipolar disorder, and a great inspiration to many. What was your process of coming out as living with bipolar disorder in the academic world?
It took me a long time. I felt more like a hypocrite over time talking with people who had mood disorders. I realized that I had an obligation. If a professor at Johns Hopkins cannot come out, who can be expected to? My late husband, Richard Jed Wyatt, who was a leader at the National Institute of Mental Health, was very supportive of this, even though we both knew it could be embarrassing.

What was the reaction like when you revealed your condition?
The most common response was overwhelming support. I did get some sharp criticism—along the lines of “this is private, don’t discuss it,” and worse. Also, people who cared about me were protective; for example, my mother and brother felt like I was taking an unnecessary risk with my mental health and my job. They were just concerned about me, but now they see that it’s OK. Interestingly, medical professionals were very supportive; they framed it as a medical problem like diabetes. It seemed more ordinary to many of them. I found that refreshing.

Do you think attitudes are getting better over time?
When I speak to students at college campuses, I see they have more access to information, they know more about where to go for help and they are more open. I see that as progress.

Can you tell me about your relationship with NAMI?
NAMI members are the ultimate badgers who never give up. They are a truly resilient group. NAMI’s legislative outcomes have been profound to reduce discrimination. We need more of that and better science to truly change attitudes.

I recently watched the movie inspired by your book. I felt that the characters and director really showcased what it’s like to live with a mood disorder. Do you agree?
Yes. The portrayals of the characters were quite real and sympathetic. The two main characters are intelligent, they have limitations and they want to love. The families are clearly kind and caring people who are just trying to learn. The filmmakers also got the point across that they keep learning as they go along; there are no shortcuts. They didn’t demonize the treaters, either, which is a common problem in films about mental health. The scene where the leads are under blankets undergoing a depressive cycle captured that state very well.

One character says he wants to be manic, which is something patients have said to me before. Can you comment on that?
Well, being manic can feel like it’s as good as it gets—ideas flow faster, invincible moods—but it’s unstable; it doesn’t last. But that feeling is addictive, and in some regard, so is mania. You can get addicted to your brain in that state. The film accurately conveys that you have to give up something when you give up manic states, just like an addiction.

You mentioned you are sending another book off to your editor. May I ask what it is?
It is a book about Robert Lowell and his incredible story of courage. He faced powerful mood states of both mania and depression. Imagine getting removed from your class at Harvard and having to keep coming back. The bravery that it takes to re-enter your life after a manic state is remarkable.

Dr. Ken Duckworth is NAMI’s medical director.
Early Intervention in Psychosis:
Creating a Broader Mental Health Community

By Dr. Rachel Waford and Dr. Carina Iati

People living with psychotic disorders often experience hallucinations, delusions and disorganized thinking and behavior. While schizophrenia is often the most talked about psychotic disorder, a number of other illnesses can include symptoms of psychosis.

Early symptoms of schizophrenia and psychotic disorders typically develop in late adolescence to early adulthood, which is also a time of academic, vocational, social, and biological challenges and changes. During this time, young people are battling to understand themselves and their place in the world. They are also “trying on” different ways of being, so changes in mood and behavior are the norm. This can make it quite difficult to tell what behavior is typical and what is not and to know whether a young person is experiencing problems that may reflect a mental health concern.

When an adolescent or young adult is experiencing a big challenge, mental health or otherwise, changes are notable in the areas of school, work, friendships and behavior. Changes in these areas are different from previous functioning and behavior and are more likely to be seen across multiple areas—rather than present only in school performance or only with peers. While evaluating the significance of such changes can be difficult, identifying the early signs of psychosis is critical, and the mental health system is slowly becoming more sensitive to this need.

Current Treatment Models
In recent decades there has been a strong focus on efforts to increase awareness of and decrease stigma surrounding mental health issues. This shift has led to a focus on early intervention—addressing mental health issues as quickly as possible, instead of ignoring, avoiding or delaying. This concept has energized people who work on mental health issues and prompted new types of treatment. We have seen how early intervention drastically improves interpersonal relationships and overall quality of life.

Historically, early signs of psychosis were considered a “death sentence” hinting at a terrible outcome. Fortunately, these early signs are now seen as a warning of a manageable and recoverable illness, similar to many other health issues.

In recent years, increased attention has been given to young people with emerging psychotic illness in popular media coverage of current events, in policy shifts and in an increasing number of efforts to provide specialized services to people at risk.

Research into early intervention has shown what happens when the first signs of psychosis are acknowledged and treated as quickly as possible. John Kane of the Feinstein Institute for Medical Research and his colleagues’ publication of the RAISE trials in 2015 demonstrates the many benefits of early intervention: Young people are more able to return quickly to school and work and renew previous relationships, are less likely to require re-hospitalization and are more capable of managing their symptoms.

Not only do young people receive many benefits through early treatment, but they are more likely to contribute their skills and abilities to their communities. When people are able to work and function more independently, they have more educational and economic opportunities.

In 2003, the World Health Organization (WHO) estimated that schizophrenia was the second-most costly illness in the U.S., with over $15,000 spent per person each year. Fortunately, a study in 2016 led by Robert Rosenheck, a professor of psychiatry and public health at the Child Study Center at Yale Medical School, showed that investing in specialized treatment may result in cost-savings for the individual and community.

Creating a Broader Mental Health Community
While we have strong support for effective early intervention approaches that decrease the length of untreated psychotic illnesses, lessen the impact of symptoms and promote recovery, young people often are quite ill and have already experienced a notable amount of trauma due to their symptoms and experiences by the time they reach a specialized mental health professional.
Research has shown that people who have often experienced an emergency room visit or hospitalization are more likely to have participated in trials of psychotherapy and medication treatments that were not effective, to have been misdiagnosed or to have experienced behavior that disturbed them. However, along the way someone likely observed warning signs that, if addressed earlier, could have changed the path of the person’s experience in treatment.

Youth experiencing such difficulties are more likely to interact with teachers, professors, campus police officers and other law enforcement, primary care doctors, guidance counselors, coaches, peers and resident assistants than mental health clinicians. These individuals may be potential “first responders” and are vitally important in the steps toward care because they are more likely to have established relationships with the young person, to have witnessed signs that concerned them, and to be viewed as a “helper.” Thus, these individuals have a unique opportunity to support a young person experiencing early warning signs of psychotic illness.

Fortunately, you don’t need an advanced degree to identify potential warning signs and risk factors for mental illness in young people. However, it is easy to understand that these other professionals may not be aware of the early signs of psychosis or feel comfortable or able to intervene and assist the person. We would like to empower individuals who have a unique opportunity to assist in the earliest stages of psychosis to feel confident in doing so. We need everyone’s help to address this issue and reduce the burden of untreated psychoses by introducing treatment options as early as possible.

Tools for Non-mental Health Professionals
Diagnosing mental illness is a complicated process that requires knowledge about the nuances of different disorders and the interplay among biology, environment, developmental stage, family history and other potential factors. However, concerns about troubling signs or changes in behavior in another person are natural experiences that anyone can have—that “gut feeling” that something isn’t quite right.

We feel that if potential first responders have important knowledge and tools for effectively intervening during an acute state or concerning situation, they can be critical components in the path toward care and specialized early intervention. While a more detailed discussion of this topic and specific tools can be found in our recently published book, The Psychosis Response Guide: How to Help Young People in Psychiatric Crises, we provide some important points below.

Early Warnings Signs
• Changes in mood or behavior that persist and impact functioning
• Changes in school or work performance
• Changes in family or peer relationships and interactions
• Changes in self-care or hygiene
• Evidence of psychotic symptoms such as talking to self or to others who are not present, seeing visuals or objects that are not really there, suspiciousness or paranoia, and disorganized thinking and behavior

Tips for Initiating Assistance
• Consider the audience and the context: This is a young person experiencing something very unpleasant and perhaps scary.
• Observe verbal behavior:
  ▪ Ask simple, direct questions.
  ▪ State concerns clearly.
  ▪ Use a calm, neutral tone.
  ▪ Incorporate summaries and reflective statements about what the person is sharing.
  ▪ Ask permission before taking any action (for example, ask if you can sit with the person).
  ▪ Inquire about what he or she feels would help.
• Observe nonverbal behavior:
  ▪ Provide personal space.
  ▪ Limit physical contact.
  ▪ Maintain good eye contact.

Providing Help
• Be knowledgeable about your organization’s and community’s policies and resources for reporting concerns.
• Prepare yourself with a few different resources and ways to help.
• Suggest involving a friend or family member.
• Offer to provide information about mental health treatment or call on the person’s behalf.
• Expect to hear “no.”
• Always call emergency services if unsure.

Other Important Notes and Take-Home Messages
Many of these points generally apply across a number of different problems. We are not asking first responders to diagnose an issue; rather, we encourage people to help and intervene, no matter what the cause. Below are some important issues we’d like everyone in this unique helping position to consider:
• Don’t be a victim of the “bystander effect” and assume someone else will help. The person may be thinking the same thing as you.
• Use the “better safe than sorry” approach when considering assisting. If you are having a reaction to changes or behavior, chances are the young person needs some kind of assistance or support.
• There are many right ways to help and only one wrong way: to do nothing at all.
• Trying to help may not always work out perfectly, but initiating contact and offering support starts a very important dialogue. Whatever step you take is important.

We invite everyone to join in the fight for early intervention and recovery.

Dr. Rachel Waford is a psychologist and assistant professor at Emory University in Atlanta. She is also a private practitioner serving individuals with severe mental illness.

Dr. Carina Iati is a psychologist at the Prevention and Recovery for Early Psychosis (PREP) program in Boston. She is also a psychology instructor at Harvard Medical School and Bunker Hill Community College.

Learn more about first episode psychosis at www.nami.org/fep.
Have you ever had a conversation with someone that tempted you to open up about something incredibly personal, but you hesitated due to the fear of that person’s reaction? Were you worried that telling them would alter their perception of you? Many people experience this feeling as they attempt to determine whether or not to be forthright about their symptoms and their struggle. If you are considering opening up about your mental health condition, here are some tips.

Deciding Whether You Should Say Anything
Before telling someone, be certain that the decision is right for you. Making a list such as the following can help you determine if the pros outweigh the cons.

Pros:
• The person may be supportive and encouraging.
• The person can help me find the treatment that I need.
• I may gain someone in my life to talk to about what I’m going through.
• I may have a person in my life who can look out for me.
• If a crisis were to happen, I would have someone to call.

Cons:
• The person may be uncomfortable around me after I tell them.
• The person may not want to associate with me after I tell them.
• The person may tell other people that I know, and I could be stigmatized.

Dr. Patrick Corrigan, principal investigator of the Chicago Consortium for Stigma Research and Distinguished Professor of Psychology at the Illinois Institute of Technology, leads the Honest, Open, Proud program, which offers advice for talking about mental health conditions. He encourages people to open up about their mental health condition but to do so in a safe way. “Be a bit conservative about the process,” he says. “Once you’re out, it’s hard to go back in, but the important thing is that the majority of people who come out and tell their story feel more empowered.”

Also consider the potential benefits of telling someone. Perhaps being open would help your loved ones understand why you can’t always spend time with them, or you might ease their concerns by making them more aware of what’s going on in your life. Or maybe you need special accommodations at work or elsewhere. To learn more about accommodations at work, visit www.nami.org/succeeding-at-work.

Deciding Whom to Tell
Once you feel confident in your decision to share, you should consider how the person you confide in might react. Think about what kind of relationship you have and whether it’s built on trust. If you still have concerns, try a test conversation. Mention a book or movie that includes mental illness and ask their opinion about it in a context that doesn’t involve you.

Deciding When You Should Tell
Once you feel confident in your decision to share, you should consider how the person you confide in might react. Think about what kind of relationship you have and whether it’s built on trust. If you still have concerns, try a test conversation. Mention a book or movie that includes mental illness and ask their opinion about it in a context that doesn’t involve you.

Initiating the Conversation
You have a few different options for telling someone about your mental health. Perhaps scariest is to come out with it without setting up the conversation because you might catch the person off-guard. Another option would be to let the person know in advance that you want to talk about something significant so they can prepare for a serious conversation. Once you have told them that you live with a mental health condition and experience certain symptoms because of it, use examples to help them understand what it’s like. For example, “Everything I do every day, even something simple like taking a shower, is exponentially harder when my symptoms are more serious.”

Share only what you’re comfortable with. Dr. Corrigan states, “You can disclose in steps, start with safe things and see how you feel, and going forward you can choose to disclose more. Anything that’s still traumatizing, you should consider keeping private.”

If someone is supportive and encouraging, let the person know how to help you, such as if you need a ride to an appointment or someone to listen.Tell them that you’ll let them know if you want advice and that you would prefer support rather than counseling. Refer them to resources to learn more, such as information from NAMI.

The more people who talk about their mental health, the more acceptable it will be for people to be more open about the topic. “The best way to change stigma is not education—it’s contact,” says Dr. Corrigan.

Laura Greenstein is communications coordinator at NAMI.
Staying Alive for My Son

by Danielle Euglow

On March 17, 2015, I was pronounced dead from attempting suicide for the third time. March 17 will be a bittersweet day for the rest of my life.

I was diagnosed with chronic depression when I was 13. I tried counseling when I was younger, but I felt judged, so I stopped going. Things were going OK until I turned 16. Then things went back to being very dark. I was young, dumb and in love. I hung around the wrong people, and that pushed me over the edge with my family.

When I turned 18, I was excited to graduate, go to college and live the adult life! I was ready to conquer the world. In 2011, everything changed. I found out I was pregnant. The fantasy world in my head crashed down. I was so emotional. When I was about five months pregnant, the depression came back, and it was terrible.

I had my son July 31, 2012, and I was happier than I had ever been. It was instant love. I had the most beautiful baby boy, and I was so excited. I could feel myself realizing that this is my purpose in life.

That happiness died out in me when I turned 19. I was exhausted, alone, and could feel myself more sad, more often. It was 2013, probably the longest year of my life. I was turning into a person I used to mock—that emotional but more angry human being.

It was 2014, and I trained myself to be numb. Numb from feelings and love, and I didn’t allow happiness. It was a cold year. The only thing that kept me going was my son. He’s always been my motivation.

Then 2015 came, and I was going to be 21. It was the worst year of my life. I was doing stuff that made me so miserable. The first time I attempted suicide was in the beginning of the year. I stayed alive. The second time was painful. I stayed alive.

The third attempt in 2015 was the last attempt. I was pronounced brain dead. But then a miracle happened. I woke up to a white light and I could hear in my head my son saying, “Hi, Mommy, I love you.” He wasn’t there, but I swear I heard him say that. I woke up and I was fine. I went home and felt more alive than ever in my life. My son is my motivation and my purpose.

It’s been a year, and today I am not that person I was nine years ago. I am the most loving mother to my son and I am living out my life. I have had medical problems since that day. I got treatment and am still going to counseling. It has positively changed my perspective on my entire life.

The next step is going to college. I want to be a mental health advocate and a psychiatrist. I’m taking it one day at a time. I still get sad. It will always be a part of me, but I’ve learned to like that part of me. I know how and what to do to cope with it. I am thankful I am alive, and I’m excited to see what the rest of my life looks like. Life is way too beautiful to end it on your terms. Wake up every morning and just breathe.

To read Danielle’s story in its entirety, visit www.nami.org/Personal-Stories/Drowning, where you may also share your own story of hope, struggle or recovery.
Mental illness has deeply impacted my life. I have experienced the flooding of anxiety and the drowning of depression. I have waged, and won, several battles with postpartum depression and been through loss and grief. I know how painful it can be to find oneself in the throes of mental illness and how helpless it can feel when a loved one is caught in its grasp. As a clinical psychologist, I have witnessed the sting of mental illness and the struggle to find healing. People come desperate to learn the tools that can break the chains of mental and emotional symptoms. Too often, individuals and their friends and family are ready to seek and find help, only to find barriers halting their progress.

Barriers to Mental Illness Treatment
An astonishing 60% of American adults, and almost half of children ages 8–15, receive no treatment for their mental illness diagnoses. Though valid treatments—like mental health medications and psychotherapy—are available, too many people encounter barriers to treatment. This occurs for many reasons, but the most common are the stigma of mental illness and its treatments, like medication and therapy; the side effects of medication treatments; and the cost of long-term therapy or medical interventions.

Benefits of Exercise for Mental Health
Exercise has been researched and validated for treating a variety of mental issues and mental health conditions, including depression, anxiety, eating disorders, bipolar disorders, schizophrenia, addictions, grief, relationship problems, dementia and personality disorders. Additionally, exercise alleviates such conditions as bad moods, stress, chronic pain and chronic illnesses.

Exercise is not only free from negative stigma, it is safe when done appropriately, with a doctor’s approval. Any side effects are ultimately positive, and even better, exercise is free of charge, easy to access and available for everyone. Exercise can be used as a stand-alone treatment for some mild-to-moderate conditions or, more effectively, in conjunction with other mental health treatments.

Like medicine in the treatment of mental illness, exercise can increase levels of serotonin, dopamine and norepinephrine in the brain. It improves and normalizes neurotransmitter levels, which ultimately helps us feel mentally healthy. Other important benefits include enhanced mood and energy; reduced stress; deeper relaxation; improved mental clarity, learning, insight, memory and cognitive functioning; enhanced intuition, creativity, assertiveness and enthusiasm for life; and improved social health and relationships, higher self-esteem and increased spiritual connection.
8 Keys to Mental Health through Exercise

If exercise is so good for physical and mental health, why aren’t more of us exercising for mental health? Why aren’t medical and mental health practitioners not only recommending exercise but also showing us how to safely start and continue exercising for mental health? The following overview of my 8 Keys to Mental Health Through Exercise can help you, your loved ones and those who provide medical and mental health care tackle underlying beliefs about exercise, change exercise-related thinking, overcome barriers and implement an effective exercise program.

<table>
<thead>
<tr>
<th>Key</th>
<th>Topic</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Heal Your Mind and Body with Exercise</td>
<td>If you struggle with a particular mental illness, exercise has specific abilities to help you, too. From calming the anxious mind to regulating mood swings in bipolar disorder, exercise may be the best thing we can do for mental, physical, emotional, social and spiritual well-being. To receive the benefits of exercise, however, we must first believe that exercise can heal body, mind and soul.</td>
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<td>2</td>
<td>Improve Your Self-Esteem with Exercise</td>
<td>Exercise improves self-esteem, which is associated with greater mental health. Exercise has also been shown to increase self-confidence, self-efficacy, self-acceptance and self-concept. When we exercise, we feel more loving, positive and confident.</td>
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<td>3</td>
<td>Exercise as a Family</td>
<td>Family has a big influence on how we perceive exercise and mental health. Family beliefs can either promote or impair mental health. Exercising as a family not only gets the entire family moving to reap the benefits of exercise but also models healthy beliefs about physical activity and improves family relationships.</td>
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<td>4</td>
<td>Get Motivated</td>
<td>Motivation, or rather lack of it, is probably the biggest block to exercise for mental health. We know we should exercise. We may even want to exercise, but we often can’t make ourselves do it. Remember that motivation is a skill that can be learned and improved upon.</td>
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<td>5</td>
<td>Change How You Think about Exercise</td>
<td>What thoughts do you have about exercise? What promotes physical activity? What holds you back? As we identify these thoughts, we can choose to change them. One tool for this is called a “thought record.” As we list our thoughts and feelings about exercise on a thought record, we have the power to question and change our thoughts. We can put new, healthier thoughts into our brains—thoughts like, “I know if I go for a walk, I will feel more energized and less depressed.”</td>
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<td>6</td>
<td>Overcome Roadblocks</td>
<td>While exercising can be physically challenging, exercise is just as much, or even more, about mental fortitude. What are your biggest roadblocks to exercise? If you look carefully, you’ll see that almost all of them have to do with mental perceptions and beliefs. Lack of time or energy? Not being able to get to the gym? Perhaps you face the challenge of having young children, or a job that’s taking over your life. Whatever the roadblocks, you can overcome them as you acknowledge and challenge them.</td>
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<td>7</td>
<td>Get FITT—Physically and Mentally</td>
<td>To stay with exercise for mental health, you must first build mental fortitude. That’s why I’ve waited until Key 7 to discuss how to set up an exercise program. The FITT Principle shows how. FITT stands for Frequency (how often you exercise), Intensity (how hard you exercise), Type (of exercise you’re doing) and Time (how long you exercise). Through FITT, you can create a tailored program for your unique needs.</td>
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<td>8</td>
<td>Implement Your Vision and Flourish</td>
<td>Finally, we need a long-term vision of health and wellness to keep exercising for mental health for the rest of our lives. Exercise is beneficial at all ages and stages; as we look to the future, we find that by exercising for our mental health, we can help overcome mental illness and become who we are meant to be. We will flourish.</td>
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Christina G. Hibbert, Psy.D. is a clinical psychologist specializing in women’s mental health, motherhood, grief/loss, self-esteem and personal growth. She is the author of This Is How We Grow, Who Am I Without You? and 8 Keys to Mental Health Through Exercise, and host of the weekly series “Motherhood” on WebTalkRadio.net. For more on this topic, visit www.DrChristinaHibbert.com and www.Exercise4MentalHealth.com.
In early 2016, the U.S. Preventive Services Task Force, an independent panel of experts in primary care and prevention that systematically reviews evidence of effectiveness and develops recommendations for clinical preventive services, released two recommendations that primary care doctors screen all adults and adolescents (12 years of age and older) for depression. The federal task force urged primary care doctors to perform screenings whether or not they have mental health services readily available. While doctors are not required to act on the recommendations, doing so could result in some important changes in the health care system—and possibly in Americans’ health outcomes.

A screening is a way to assess a person for early signs of illness or disease. Screenings are commonly performed on individuals for high blood pressure, high cholesterol, diabetes and some cancers. Depression screenings are typically short 10-question surveys that can be incorporated into wellness exams. Primary care doctors are the ideal professionals to screen for depression because they assess and treat individuals for general needs, including respiratory, hearing, vision and cardiovascular issues. Shouldn’t mental health be one of them as well?

Mental health is often overlooked in primary care visits. I cannot remember a time when my primary care doctor initiated an in-depth discussion about my mental health. I was always the one to bring it up at my annual visit. Maybe he was reluctant to open up the topic because he had no rapid referral route to a mental health professional if a patient needed psychotherapy. Maybe my primary care doctor, like many others, was too pressed for time to include a depression screening.

People who are experiencing depression might not seek help from a mental health professional and often trust their primary care doctors. Having primary care doctors regularly screen people for depression could eliminate many barriers and make recovery more attainable.

Here are some goals the recommendations seek to achieve:

Relieve Personal Distress
People should no longer struggle in silence. A screening provides the possibility of starting the conversation for people with undiagnosed depression. It lets people describe their feelings and find ways to get well. It enables people to get the attention and help they need sooner. Intervening early with effective therapies and medications can reduce the burden of depression and help people better manage their health.

By Elena Schatell
Integrate Mental and Physical Health Care

Mental and physical health are tightly related. Untreated and unmanaged behavioral health problems can worsen and lead to physical illness. People may find it hard to stay active, eat healthy meals and take medication to control physical ailments. Having a doctor who can integrate physical and mental health can benefit the individual.

Early identification of mental illness may not only increase the effectiveness of treatment, it can also reduce long-term personal costs and large-scale health care costs. Dealing with mental and physical health issues can get expensive.

Address the Mental Health Workforce Shortage

Finding a mental health professional can be difficult. The field is not growing quickly enough to meet increased demand, and many available professionals either do not accept new patients or do not accept insurance. If primary care doctors are capable of assessing people for general needs, they are also capable of starting conversations about mental health needs. Primary care doctors can help compensate for the national shortage of mental health care providers. In fact, they already prescribe most antidepressants taken in the U.S.

Draw Attention to Mental Health Policy

Katy Kozhimannil, an associate professor of public health at the University of Minnesota, believes that policymakers will pay attention to the task force’s guidelines. “Increased screening and detection of depression is an enormous health need,” Kozhimannil says in a New York Times article published in January.

The task force brings attention to needed policy changes. For one, federal and state mental health policies can establish ways to address the mental health workforce shortage. They can fund the coordination and integration of behavioral health into primary care services or fund psychiatric telemedicine or tuition-reimbursement programs for students wanting to go into the mental health field. The screening guideline also draws attention to promoting early treatment intervention and covering the cost of mental health screenings for all.

Reduce Stigma

In a USA Today article that also appeared in January, NAMI Senior Policy Advisor Ron Honberg says that screening for depression at the primary care level helps bring it “out of the shadows.” Making depression screenings a more regular occurrence in wellness exams, even if only once a year, may also help reduce the stigma of mental illness. Such screenings would increase awareness that depression is common. Talking about the depression survey results with a doctor can bring mental illness into the open, just as discussions about hypertension and diabetes do during routine wellness visits. In the future, people may be more comfortable bringing up mental health concerns on their own.

If primary care doctors are capable of assessing people for general needs, they are also capable of starting conversations about mental health needs.

Critics, however, have pointed out some negative consequences that could result from the task force’s published recommendations.

Dr. Allen Frances, a medical doctor and professor emeritus of psychiatry and behavioral sciences at Duke University School of Medicine, thinks that screening for depression could lead to over-diagnosis and overtreatment. The screening tool is a brief, generalized test that lumps depression diagnoses together. It cannot judge clinical significance, so patients could be diagnosed as depressed when they are not actually clinically depressed. Medication could be over-prescribed, and patient costs could increase. “Routine screenings of all adults and adolescents would ramp up this already excessive treatment of the mildly ill and worried well,” Dr. Frances states in STAT, a publication that focuses on health and medicine. He is also concerned that primary care depression screenings will take away precious time spent caring for patients and their already diagnosed illnesses.

Another concern is that people given antidepressants may have a risk of mania without the prescribers’ first receiving a thorough medical history of themselves and their family. A depression screening should also require training and resources to teach primary care doctors how to properly assess for that risk, he says.

Additionally, even if more individuals are accurately diagnosed with depression, the issue of how to get someone to a therapist or mental health care professional remains. Even with this screening in place, there will still be a workforce shortage of behavioral health specialists and a cost barrier for many patients.

Although valid concerns exist, depression screenings in primary care settings could be a conversation-starter and a beginning effort at an organized, effective health care system that has a person’s well-being in mind. Such screenings could be one more step toward having a system that is thoroughly integrated and connects patients to the supports they need in the early stages of mental illness. As Dr. Ken Duckworth, NAMI’s Medical Director, notes, “Untreated depression is a serious public health issue in the United States. These individuals report to their primary care physicians increased medical concerns, and treating the underlying depression can help with both issues.”

Elena Schatell is an intern at NAMI and has B.A. in neuroscience from Kenyon College.
Exploring the minds of the women and men who have shaped our world is something that many writers have attempted. The more we begin to explore some of these historical figures, the more we find traits that hint at connections to mental health conditions. While there is controversy in assessing diagnoses to people who are no longer alive, doing so makes for an interesting read, and perhaps most importantly, it allows a reader who also has a mental health condition to connect with individuals who changed the world not regardless of their condition but sometimes because of it.

Claudia Kalb is an award-winning journalist who has written for many years on health and science topics. In writing Andy Warhol Was a Hoarder: Inside the Minds of History’s Great Personalities, she spoke to many mental health experts and consulted published medical reports, biographies, autobiographies, letters, diaries, books and journal articles. Several figures, such as Princess Diana and Betty Ford, had confirmed mental illnesses that they wrote about or talked about publicly. For others, Kalb had to make inferences based on her research. Her goal in writing the book “was not to assign labels,” she writes, “but to contextualize mental health characteristics using both historical and contemporary psychiatry, and to explore the mysteries of the brain and human behavior.” Kalb does so deftly. Her brief portraits of these historical figures, combined with the right amount of scientific description, allow the reader to understand how these traits—perhaps those of a diagnosable mental health condition—helped fashion them into the people they became.

To get a closer look at Kalb’s goal for writing her book and how she became interested in the topic and conducted her research, I connected with her by email.

What first intrigued you about taking a closer look at prominent historical figures and their mental health? I reported on mental health for many years as a medical and science writer at Newsweek, and I continue to be drawn to the subject. The human mind is like the universe—vast and complex—and there is so much to learn. Often, we hear about
mental health conditions through medical reports and news stories, but these short blips never tell the full story, and they can, at times, be fairly clinical. People like storytelling. I wanted to write about mental health through the prism of 12 extraordinary individuals—their lives, their minds, their journeys.

In conducting your research, what was the most unexpected item or fact that you discovered? It could be a small, personal revelation or something more significant.

There were so many discoveries. I was surprised that Andy Warhol hoarded old prescription bottles, unpaid medical bills and empty toothbrush boxes; I had no idea that Princess Diana struggled relentlessly with emotional pain; I didn’t know that George Gershwin composed “Rhapsody in Blue” in just a matter of weeks. One of the most significant revelations for me was that brilliant minds can be so deeply riddled with insecurities and torment. I knew that, but these stories brought it all to life.

There are most certainly more than a dozen historical figures who experienced symptoms of a mental health condition. How did you end up selecting the 12 that you did?

For each profile, I wanted to be sure that I had an abundance of biographical material—autobiographies, letters, journals—and, most importantly, solid science. I eliminated some individuals after concluding that theories about their mental health were not well supported. I also sought a wide range of mental health conditions. The 12 who made the cut allowed me to explore anxiety and depression, as well as borderline personality disorder and gambling disorder. I wanted to include a breadth of historic eras and livelihoods, as well. The book spans more than 200 years, from 1809 to 2011, and includes everyone from a president (Lincoln) and a scientist (Einstein) to a novelist (Dostoevsky) and a princess (Diana).

I don’t believe you have any formal training as a psychologist or psychiatrist. How did you go about assessing diagnoses for the historical figures you selected?

I have interviewed mental health experts throughout my career, and I called on them immediately as I launched into the research for this book. Their input was essential. Several of the individuals profiled spoke openly about their conditions. Betty Ford documented her experience with alcohol and prescription drug addiction in an autobiography and in her work with the Betty Ford Foundation; Princess Diana spoke publicly about her struggle with bulimia. In every other case, I grounded my assessment in reports and hypotheses that had been put forth by experts themselves. For example, numerous specialists have written about Darwin and anxiety, including the late Columbia psychiatrist Dr. Ralph Colp, Jr. in his comprehensive book, Darwin’s Illness. Simon Baron-Cohen, the autism expert, and others have hypothesized about Einstein and autism spectrum disorder. Howard Hughes’s OCD has been studied by UCLA’s Dr. Jeffrey Schwartz. In each case, I pored over what the experts had proposed, dug into biographical material and medical studies and interviewed leaders in the field.

You write that your goal “was not to assign labels but to contextualize mental health characteristics using both historical and contemporary psychiatry, and to explore the mysteries of the brain and human behavior.” How do you think taking a look at figures throughout history can affect the way we look at individuals with mental health conditions today?

There is much to learn from the past—about how people viewed mental health conditions, about how brain science has progressed, about how our assumptions and judgments regarding behaviors have evolved. Historical figures can provide inspiration and solace to people living with mental health conditions today: A person struggling with anxiety might be reassured by Darwin’s great successes, despite the stress and worries he endured. Ideally, these famous lives will motivate all of us to focus not only on the challenges that people with mental health conditions face, but on the positive attributes—the talents, skills and potential—that lie beneath.

What did you hope to accomplish by highlighting these famous people, like Marilyn Monroe and Darwin, who lived with mental health conditions?

My overarching hope is that readers will gain a greater appreciation for the depths of human experience and behavior—and a greater understanding of themselves and the people they love. Above all, I hope that these stories inspire compassion and chip away at stigma.

Brendan McLean is a former manager of communications and public affairs at NAMI.
Showing What It Means to Have Bipolar Disorder

By Laura Greenstein

People often portray bipolar disorder as a condition that causes someone to have constant and extreme mood swings at any given moment, but that doesn’t truly capture the nature of this condition. Representing bipolar disorder in popular culture accurately is critical toward achieving awareness, understanding and acceptance. One way to learn and promote understanding is to imagine yourself going through the symptoms. Here are two books that show what living with bipolar disorder is like.

**Lily and Dunkin**

*By Donna Gephart*

*Delacorte Books for Young Readers (2016)*

*Lily and Dunkin* is easy to read, appropriate for kids and realistically depicts what it’s like to live with bipolar disorder. The story switches between the perspectives of two eighth-graders facing incredible challenges—being transgendered and living with bipolar disorder.

Norbert Dorfman, also known as Dunkin, moves to south Florida with his mom, where they live with his exercise-obsessed grandmother, Bubbe. Although we don’t get the whole picture until later, it is clear that Dunkin’s father is the reason they had to move. His father also lives with bipolar disorder and seems to have done something drastic, prompting the move. Dunkin is trying to block out thoughts that pass through his mind about his dad’s behavior.

Upon arriving in south Florida, Dunkin quickly makes a friend, Tim/Lily McGrother, an androgynous transgendered person who spends her time reading in a Banyan tree named Bob. Their friendship quickly encounters obstacles, including when Dunkin is invited to be friends with the popular basketball players, who continuously bully Tim/Lily for her lack of a clearly defined gender.

Dunkin is initiated into the cool crowd due to his height, which leads them to believe that he’s going to be a great basketball player. To impress his new friends, Dunkin lies about his basketball-playing skills and agrees to try out for the team. His natural ability is less than satisfactory, even after many training sessions with Bubbe. But Dunkin knows an easy shortcut to becoming a better player: He could “forget” to take his medication.

Taking medication decreases Dunkin’s energy, so he believes that by stopping he’ll have more energy and play better. But when he starts skipping doses and his energy starts to skyrocket, so do the symptoms of his mania.

The author of the book, Donna Gephart, tells this story in a way that’s both simple and profound. To be able to take on two distinct and unique challenges and concisely put those troubles into the minds and bodies of kids is worthy of recognition. This is a true teaching novel, perfect for young people first learning about mental health and mental illness and for adults who want to learn more.

**Liar: A Memoir**

*By Rob Roberge*

*Crown (2016)*

*Liar*, a memoir with an adult audience in mind, opens up the experience of a writer undergoing personal crises, substance abuse, and the harrowing symptoms of bipolar disorder. Each chapter contains a non-chronological listing of dates. Each vignette contains an event or memory that provides a piece of the total picture of his life. Author Rob Roberge is sharing his personal story with the reader. He’s telling the story of his life in the order that makes the most sense to him. The book is Roberge’s method of preserving his identity through recording important pieces of his life. He does this after learning that his many concussions have increased his likelihood of developing a memory-eroding disease.

Roberge tells his story in the second person as if he is outside of his life looking in. While discussing his bipolar disorder, he says, “Technically, to be diagnosed with rapid-cycling bipolar, you need to have four manic episodes within a calendar year. But four episodes a year doesn’t seem very rapid to you at all. In the year leading up to the release of your fourth novel you are firing off a few a month.”

Roberge details how both bipolar disorder and his substance abuse affected various aspects of his life and explains the biggest difference he noticed between the two: “Using addicts know how they’re going to feel in five minutes. Mental illness, on the other hand, is the ultimate loss of control.”

This book is not a traditional, feel-good memoir; it shows struggles in a light that is raw and real. Roberge has a lot of wisdom to share, and you can learn a lot about mental illness, substance abuse and stigma from reading his powerful words.

Laura Greenstein is communications coordinator at NAMI.
Dear NAMI Members and Leaders:

The NAMI Board seeks highly qualified leaders of all backgrounds and experiences to serve on the national board of directors that leads NAMI’s mission and commitment to build better lives for the millions affected by mental illness. The NAMI Board will lead the organization through an important period of change and growth in the coming years. Nine individuals who want to bring their local experience to that national effort are nominated in this year’s elections.

NAMI Board service demands experience, knowledge, commitment and time to help others. Board members must be passionate about NAMI’s goals, values and beliefs. Service on the board of a large nonprofit organization and an understanding of complex legal and fiduciary decisions are also critical to good NAMI Board service. Candidates are encouraged to evaluate professional and other volunteer obligations to ensure they can focus their attention on this important work.

Some prior experiences that lend themselves to successful Board service are:
1. Service on the Board of a NAMI State Organization or NAMI Affiliate
2. Participation in NAMI Board Advisory Councils
3. Participation in subject-specific national workgroups for NAMI
4. Professional or volunteer experience involving legal, financial or fundraising expertise

This year, five candidates will be elected to serve for three-year terms. Five current Board members’ terms will expire, and their seats will come up for general election. One cannot seek re-election, and two current members have chosen not to seek re-election. The two other current board members have served a single term and are seeking re-election.

What Expertise and Experience Are Needed
Beyond passion for the NAMI mission, Board members should have high-level decision-making experience and knowledge in one or more of the following areas:
- Nonprofit and Change Management, to steward NAMI in a rapidly changing environment
- Fundraising and Donor Cultivation, to ensure NAMI’s future and ongoing viability
- New Media and Technologies, especially in service of education and peer support
- Marketing, Outreach and Communications, to grow the organization and increase visibility
- Financial Management and Investments, to ensure sound fiscal health
- Public Policy and Grassroots Advocacy, to shape critical systems that impact people whose lives are affected by mental illness
- Diversity and Inclusion, to ensure the movement represents the perspectives of all people
- Membership Development and Volunteerism, to cultivate and honor the NAMI movement

NAMI Board Service Commitment
NAMI Board service is an honor and a privilege. For those who earn the opportunity, NAMI Board service is and must be their top volunteer priority. NAMI Board members must:
- Serve a three-year term with the opportunity to serve another consecutive term if re-elected
- Attend quarterly two- to three-day meetings in Arlington, Va.
- Dedicate 6–10 hours/week to NAMI Board service, including:
  - service on three or four standing committees
  - frequent conference calls
  - other work groups as necessary
  - travel for Board and other meetings
- Represent the organization before the general public, NAMI members, professional service providers and public officials
- Understand and protect the fiduciary health of the organization
- Understand and adhere to the legal and fiduciary responsibilities of a nonprofit board
- Understand and support NAMI’s programs and public policies
- Make what the individual believes to be a significant financial contribution to NAMI, on an annual basis
- Make NAMI Board service their primary volunteer commitment
- Be a NAMI member of record and be nominated by a NAMI State Organization or NAMI Affiliate in good standing
NAMI bylaws require that a minimum of 75% of the Board comprise persons who have or have had mental illness, or their parents or relatives, including civil and domestic partners. To ensure compliance with this requirement, all candidates are asked to identify if they have had a lived experience with serious mental illness. (Candidates’ statements to this effect will be published in the special election mailing with their campaign statements.) NAMI currently has no Board members who do not self-identify under this definition.

**When Considering Voting**

If you have questions about the election process, contact voting@nami.org or visit www.nami.org/voting. Service on the NAMI Board is a fulfilling experience. Board members are honored and humbled to represent the members who elected them and want to do the best job possible for NAMI. We are pleased that so many of your peers are seeking this role with NAMI—and we thank the thousands of NAMI members who inspire and focus us in our work.

Thank you for all that you do, every day, to support NAMI.

Sincerely,
NAMI Board of Directors

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Dear NAMI Members,

As a grassroots organization, NAMI draws strength from its members and leaders. That strength comes in the form of a skilled and active board of directors, bylaws that support the organization’s mission, and vision and resolutions that promote and advance that mission and vision.

NAMI’s Board and bylaws can be changed only by vote of the membership—NAMI Affiliates and NAMI State Organizations—that is, by you. NAMI’s future lies in your hands.

This issue of the *Advocate* includes this election section to help you make those decisions. Please read on—and join the election debate within your NAMI Affiliate.

Service on the NAMI Board is a fulfilling experience. We are honored and humbled to represent the members who elected us, and we want to do the best job possible for NAMI and its vital mission. We thank the thousands of NAMI members who inspire and focus us in our work.

You can help shape NAMI’s future. Your vote counts.

Sincerely,

Marilyn Ricci
President, NAMI Board of Directors

Janet Edelman
NAMI Board of Directors, 2016 Election Chair
NAMI elections include selection of board members, possible amendment of bylaws and consideration of resolutions posed by the membership.

NAMI Affiliates in good standing (those embracing the NAMI mission, having at least five members and fully paid dues) and NAMI State Organizations may vote, either by absentee ballot or at the NAMI National Convention.

NAMI State Organizations each get one vote in NAMI elections. NAMI Affiliates have “weighted votes” based on the number of members in the group as of 70 days prior to the election. The more members a NAMI Affiliate has, the more votes it gets, ranging from one vote for groups of five to 50 to 10 votes for groups of 800 or more.

Individuals do not vote in NAMI’s national elections, but all NAMI members may participate in the election by helping to decide how their NAMI Affiliate or NAMI State Organization will cast its vote. Contact NAMI Affiliate and NAMI State Organization leaders for more information about how and when they will decide how to cast a vote. Each NAMI Affiliate and NAMI State Organization chooses someone to serve as a credentialed delegate or proxy. That person will cast the ballot on behalf of the group.

Voting Packet
In late May, a packet of voting information, including instructions for voting, credentialing forms and a copy of this election issue of the Advocate, will be mailed to each NAMI Affiliate and NAMI State Organization in good standing. To be sure that your voting packet gets to you, please work with NAMI Member Services to update your mailing address in NAMI 360. If you have not received your voting packet by June 1, 2016, please email voting@nami.org so we can fix the issue and deliver a packet to you.

Members may begin convening now to consider who will serve as delegate or proxy for their NAMI State Organization and NAMI Affiliate. Credentialing forms must be submitted to the NAMI office by July 1, 2016.

Online & Absentee Voting
NAMI’s online voting system will allow easy access for both absentee voting and on-site voting. NAMI Affiliates and NAMI State Organizations will receive more details about the online voting process to cast absentee ballots in the mailing packet going out in May. For the 2016 Elections, there will still be an option to return a physical absentee ballot, which will be due to NAMI by July 1, 2016.

Credentialing Before the Convention
Voting at the NAMI National Convention will be completed by individuals who have been designated as proxies by the leadership of their NAMI Affiliates and NAMI State Organizations. Pre-credentialing allows affiliates and state organizations to tell NAMI in advance who the person casting the vote for their group will be. This saves valuable time at the convention for voters because they can receive their voting credentials quickly.

If someone arrives to vote who has not been pre-credentialed, NAMI will have to confirm on Elections Day from leadership at the affiliate or state organization that the person is authorized to vote. On-site credentialing often takes time away from the potential voter that could be spent in other ways at the convention. Pre-credentialing needs to be completed with NAMI by July 1, 2016.

Voting at the NAMI National Convention
Voting will take place on Friday, July 8, 2016, in Denver. The convention program will include a map with the voting area. Only credentialed delegates or proxies may cast votes in the elections (see previous section). Voting will open at 9:00 a.m. and close at 6:00 p.m.

NAMI Affiliates and NAMI State Organizations that do not return voting credentials to NAMI by July 1, 2016, will be subject to on-site review and qualification.

Election Results
Election results will be reported at the NAMI business meeting on Saturday, July 9. Results will also be posted on www.nami.org/voting.

Candidate Information
Candidates are listed in the order in which NAMI received their nominations. All candidate statements are unedited and presented as submitted. Candidate profiles begin on page 25.

Candidates provided a personal statement identifying their lived experience with mental illness. NAMI bylaws require that a minimum of 75% of the board comprise persons who have or have had mental illness, or their parents or relatives, including civil partners. Candidates were also asked to respond to two topics, in a total of 300 words:
1. Explain what brought you to NAMI and what roles you have played in your NAMI Affiliate and NAMI State Organization; and
2. Summarize how you will use your position on the Board of Directors to drive NAMI forward as laid out in the 2015–2017 Strategic Plan.

Those responses are included in this issue of the Advocate.

Extended responses about each candidate’s plans for how he or she will help drive forward the 2015–2017 Strategic Plan in their tenure on the board can be found at www.nami.org/voting. Plans address the following areas:

• Driver 1: Build A Movement—NAMI will broaden public awareness and inclusion in every part of the alliance.
• Driver 2: Leverage Technology—NAMI will expand use of technology to build capacity and connection.
• Driver 3: Drive Advocacy—NAMI will lead advocacy efforts that drive increased access and quality.
• Driver 4: Focus on Youth—NAMI will develop and implement strategies that engage youth, young adults and their families, expanding our reach across the lifespan.
• Driver 5: Strengthen the Organization—NAMI will grow and develop financing, infrastructure and capacity that support a vibrant and bold organization.
More Information Available Online
Visit www.nami.org/voting for more resources on each candidate, including letters of nomination, five-minute speeches and expanded responses to the questions above.

Candidate Speeches and State Caucuses
Candidates will deliver their speeches at the NAMI National Convention on Wednesday, July 6. Candidates will each have five minutes to address attendees.

CONSIDER THE BYLAWS AMENDMENTS

Bylaws amendments may be proposed by NAMI Affiliates, NAMI State Organizations or a NAMI Director (member of the NAMI Board of Directors). Bylaws changes require a two-thirds majority of those voting to pass.

Text proposed for removal is struck through; text proposed to be added is bolded and underlined. For a complete copy of the current NAMI bylaws visit www.nami.org/bylaws.

Rationale: The following three amendments were recommended by NAMI's legal counsel to reflect alignment with the Missouri Nonprofit Corporation Law (the jurisdiction in which NAMI is incorporated) and reflect the best practices of nonprofit organizations in the United States.

Upon a review of these amendments at their meeting on March 6, 2016, the NAMI Board of Directors voted to support these amendments.


ARTICLE I Membership
(2) Local Affiliates (“Affiliates”)

(d) Voting rights

(ii) Within NAMI - Each Affiliate in good standing shall be entitled to cast, in any election or other vote on NAMI matters the number of votes determined by the following table. These members must have paid dues in the last twelve months to be counted.


ARTICLE I Membership
(3) State Organizations

(c) Eligibility for Application for Organization Charter - A charter shall be granted to Organizations that meet the criteria established by the NAMI Board. Whether an Organization meets those criteria or the requirements of these Bylaws shall be determined by the NAMI Board in its sole discretion. Any three or more geographically dispersed Affiliates of NAMI within a state that a) does not have an Organization in existence and recognized by the NAMI Board of Directors or b) in which the previously recognized Organization shall fail to meet the criteria for state chartering may organize as an independent body to seek charter by NAMI as an Organization.


ARTICLE IV Board of Directors

Section 1. Directors. The Board of Directors shall consist of sixteen (16) in number, including fifteen (15) regular directors elected by the membership and one (1) Consumer Council director elected by the Consumer Council. Any action taken by the Board of Directors in compliance with Article IV hereof during any vacancy of one or more members of the Board of Directors, shall constitute the action of the Board of Directors.

Proposal #4: Proposed by Deborah Michael, NAMI Central Virginia

Rationale: Because both Directors and Officers insurance and General Liability insurance are now a requirement of an Affiliate (regardless of number of members), and because at least a compilation of financial data is required every three years, it has become financially too burdensome for a group of just five members to shoulder these costs.

ARTICLE I Membership

Section 1. There shall be three categories of members:

(1) Members (“Members”)
(2) Local Affiliates (“Affiliates”)
(3) State Organization (“Organization”)

(2) Local Affiliates (“Affiliates”)

(a) Definition - Affiliates shall be groups of five ten or more Members that have (i) become members of NAMI prior to the issuance of a NAMI state charter to their respective Organization, or (ii) become members of their respective Organization after the Organization having been chartered by NAMI pursuant to the provisions of Section 2 (3).
In 1978, while a PhD student in NYC, I thought horns were growing out of my head, and I would not deny being Jesus. Then in 1988, after working as a parent, minister and then a salesman, I walked on a taxiway of Miami International Airport. NAMI saved me.

In the 1990s a Seattle psychiatrist suggested that I join NAMI. NAMI leadership roles have been with medication and exercise my escalator to regaining sanity. Currently, I am on the Board of Directors of NAMI Washington and am our state’s representative to the NAMI Consumer Council.

I joined the state board while president of NAMI Kitsap County where I helped schedule speakers at monthly meetings which I conducted, wrote letters to the editor on mental health topics and organized annual mental health weeks. Prior to being president I was a board member. The state board and the affiliate have both sent me to national conventions where I have learned so much about resiliency, recovery and wellness.

I will, if elected, strengthen NAMI’s presence and our Strategic Plan, in nearly every state. Among the positions that need expansion, nationally, is the increased use of vocational-rehabilitation programs to increase employment both at the entry and middle class levels. More of us should be vocational-rehabilitation programs to increase employment both at the entry and middle class levels. More of us should be

In day and residential treatment programs we need more interactive activities, including cardio. At only one hospital in Florida did we have a dance party. At only one hospital in California was there a basketball hoop. By suggestion, NAMI can make exercise a mental illness theme for recovery. Concomitantly, NAMI can encourage doctors and therapists to help consumers have relationships with significant others of all races and nationalities.

I am the parent of a child with mental illness struggling with my own lived experience. I have dedicated my life to bringing awareness, education, advocacy, resiliency and hope to those without a voice. I am committed to fighting stigma and unifying all communities to overcome the barriers we face.

In 2006, my local NAMI Latino affiliate invited me to a meeting. I was Director of Casa Primavera, the only US Latino Clubhouse. Never having heard of NAMI, I was greeted with acceptance by Spanish speaking members who gave me a sense of purpose – and my journey began. I served 6 years as Vice-President of my affiliate, participated in 9 NAMIWalks, provided Spanish interpretation at our convention, and currently serve as Director of Advocacy for Massachusetts’ NAMI Latino affiliate. Early on I served as a NAMI Connections Champion supporting 7 clubhouse members, then became a NAMI Connections Facilitator, a state NAMI Connections trainer, and now train nationally in Spanish (NAMI Conexiones). I took IOOV training and participated in Family-to-Family workshops, then co-facilitated family support groups in Spanish and English. I participated in the Sharing Hope Latino Leaders focus group, then secured a Compartiendo Esperanza grant to make it accessible to Latinos locally.

I will devote particular effort to remove barriers within diverse communities to accessing NAMI signature programs as an essential key that increases public awareness. I will advocate leveraging technology to expand capacity at the grassroots level as a game-changing way to connect with many communities and age groups. As an advocate for access in integrated health care reform and parity, these changes need to lead to improved outcomes in particular for people who are difficult to engage: homeless, involved with the criminal justice system, veterans, young people and families. My particular strength lies in helping others overcome the overwhelming fear to voice our opinions, speak up for our rights and create change. Building the NAMI community through national bilingual education efforts, I am dedicated to role modeling how sharing our message also serves to recruit influential allies that will unite and support our work.
Nora Lott Haynes  
Nominated by NAMI Georgia  
Member, NAMI Savannah (GA)

Late 1990’s my family was “awakened” into a dark, secret place. After a heart-wrenching, lonely path one of my dear children was diagnosed with schizophrenia/poly-substance abuse—such things were not discussed in small town USA. From that time, life can be excruciating but hopeful with NAMI love.

Retired, Georgia Department of Education  
Secretary 2004-2005, Past President 2006-2009, Vice President 2015-2016, Public Policy Chair 2010, 2015-2016, Board of Directors, NAMI Georgia Public Policy Chair, Board of Directors, NAMI Savannah (GA), 2012-2014

I have not served on the NAMI Board of Directors previously. Founding Member, Georgia CIT Advisory Board, 2004-present Member, CIT (National) and International, 2007-2012  
Director, Opening Doors to Recovery (ODR) Research Project, 2009-2013

Consultant, NIMH ODR Project, 2015-2016

I am not currently serving in any public/elected office.

After the “awakening” – knowledge that my child had a serious mental illness (SMI) – I realized going to Naranon was not completely the support I needed. My child was in prison and I was lost. Someone suggested I call a NAMI mommy whose SMI child was in prison as well. After numerous conversations, she stated, “You must sign up for a Family-to-Family class.” I did and it changed everything!

I became involved with the local affiliate and learned about CIT. After all our encounters with police, SWAT, etc., I knew from experience that educating and ending the stigma and ignorance about mental illness was key. In 2004 Georgia’s CIT program in partnership with the Georgia Bureau of Investigation (GBI) began training, and Georgia’s CIT Advisory Board was formed.

Another interest is Public Policy perhaps because as a young girl I spent many hours at the Legislature with my Grandfather who was a state senator. I enjoy lobbying during the Georgia Legislative sessions. Successes: removing mental health from a behemoth agency; chairing the Governor’s Mental Health Ombudsman committee; forming a Behavioral Health Coordinating Council; and, obtaining state match funding for ODR.

The Opening Doors to Recovery (ODR) research project is most meaningful to me. In 2013 a successful demonstration grant was completed. Presently we are engaged in an ODR NIMH randomized control trial. Next stop – evidence-based-practice!

I have learned much and feel honored to have served NAMI Georgia as President, Vice President, Secretary, Public Policy and Nominating Chair, Director of the ODR Project, chair and cofounder of CIT Advisory Board, CIT International Board member and others. As a Board Member there is much to share with NAMI about these experiences and lessons learned. They line up perfectly with the strategic plan – I am ready to roll.

Gary Mihelish  
Nominated by NAMI Helena (Montana)  
Member, NAMI Helena (MT)

I am the parent of a son who has lived with schizophrenia for 31 years.

Retired  
NAMI Helena, President  
NAMI Montana, Board of Directors

I am currently in my first term on the NAMI Board of Directors which spans 2013-2016.  
CIT Montana, Board of Directors, 2016 thru 2019

I am not currently serving in any public/elected office.

Our family was made aware of serious mental illness 31 years ago when our teenage son developed the prodromal symptoms of schizophrenia. In 1996 we were trained to teach the Family to Family Education Program. My wife and I have subsequently taught F2F over 35 times and we continue to teach. We are also trained as NAMI Support Group Facilitators and NAMI Provider Education Teachers. I have worked on the NAMI Montana WALK for 12 years, been president of NAMI Montana for 8 years and been a member of the NAMI National Board of Directors for 3 years during which I have served 2 years as Treasurer. I participated in the strategic planning for the 2015 - 2017 NAMI Strategic Plan and support its Drivers and Goals.
Leslie El-Sayad  
Nominated by Tennessee  
Member, NAMI Oak Ridge (TN)  

The threads of mental illness have been woven throughout the fabric of my entire family. Depression, anxiety, alcoholism and eventually a brief personal bout with agoraphobia. In 1992 my son was diagnosed with schizoaffective disorder and addictions to alcohol and drugs. He courageously strives daily to stay in recovery.

Family Nurse Practitioner, Morgan County Medical Center  
President, Board of Directors, NAMI Tennessee  
Past President, Board of Directors, NAMI Oak Ridge (TN)  
I have not previously served on the NAMI Board of Directors.  
I am not currently serving in any public/elected office.

Despite being a mental health provider and family nurse practitioner, I was unprepared for the affect my son’s first psychotic break would have on our family. The family experience was never emphasized in my medical education. Fortunately I found NAMI Oak Ridge within two months of his first hospitalization. I was among the first classes of trainers of Journey of Hope, a pioneering peer-to-peer series of classes for families. Teaching other family members and training new teachers has been a rewarding experience and continues to provide a message of hope in my own life.

Over the past 24 years, I have held local NAMI Oak Ridge offices, most recently the immediate Past President. At the state level I am currently the NAMI Tennessee President following several terms as Vice President for East Tennessee. I’m old and I know it. I am endeavoring to become more conversant with the younger generations, their challenges, their needs, their aspirations, and their technology. After all, the youth and their parents are the very ones who have an opportunity to embrace earlier recovery and not lose their lives to the effects of mental illness. My NAMI Tennessee presidency has been concentrating on bringing our outreach and communications up to a level of speaking to all those who could benefit from engagement with NAMI.

Just as we are not solely defined by mental illness, NAMI and its members must think of their cause as part of the vast body of societal experiences including family life, education, law enforcement, workplace and social interaction. We need partners to help extend the reach of our “time, talent and treasure”. We are not alone and should not expect to improve the general mental health of the community without the help of others.

Barbara A. Ricci  
Nominated by NAMI New York City Metro (New York State)  
Member, New York City Metro (NY)  

I have a sibling diagnosed with schizoaffective disorder.

Managing Director, Deutsche Bank  
Co-President, Board of Directors, NAMI New York City Metro (NY), 2016-2018  
I have not previously served on the NAMI Board of Directors.  
NYC’s Department of Health and Mental Hygiene’s Executive Council Regional Planning Consortium

When my brother was diagnosed with schizoaffective disorder my family was abruptly launched into a fragmented mental health system in a culture that generally fears and misunderstands mental illness. NAMI educated my family, introduced us to community and, importantly, provided us with hope. Thanks to NAMI, we improved our coping skills which resulted in reduced stress levels, improved family communication and better long term outcomes for my brother and his family caregivers.

I joined the NAMI New York City Metro board eleven years ago and have been board president for over three years. I am also a benefactor to NAMI Lancaster County Pennsylvania. Highlights from my board presidency include:

• Launching #IWILLLISTEN on social media which inspired #IWILLLISTEN advocacy days in schools including Northwest Missouri State University, workplaces like American Express, and cities such as Philadelphia. The campaign has won eleven national and global advertising awards.
• Conceiving of and leading the Inaugural CEO Summit on Mental Health in the Workplace at the NYSE. Deutsche Bank will host the 2nd CEO Summit this June.
• Starting a Young Professionals Advisory Board of Millennials and Gen X’ers.
• Analyzing how to provide NAMI services in a Medicaid funded environment. Currently beta testing with provider partners who welcome NAMI family support at their treatment hubs.
• Upgrading NAMI-New York City Metro’s Charity Navigator rating to the coveted four stars.
• Offering the first Spanish Basics facilitator training in the country.
• Making 16,000 individual contacts in 2015 via our programs and services.

I am fortunate to work with incredibly talented Staff members, Board Directors and Volunteers at NAMI New York City Metro. Our successes result from a true team effort.

I want to support NAMI’s Strategic Plan by transforming local affiliate achievements to the national level.
Charma D. Dudley, Ph.D., FPPR
Nominated by NAMI Southwestern Pennsylvania (Pennsylvania)
Member, NAMI Southwestern Pennsylvania (PA)

As a licensed psychologist I have worked to help families understand and cope with a loved one struggling with mental illness. It became personal when my niece at 14 years of age was diagnosed with depression and anxiety. As a family member I am energized to work on eradicating stigma.

Pennsylvania
President, Board of Directors, NAMI Southwestern Pennsylvania (PA)
I have not previously served on the NAMI Board of Directors. I am not currently serving in any public/elected office.

As the previous Clinical Director for an agency that provided services for families affected by trauma, I focused on the need to educate our staff and families about the relationship between mental health issues and trauma. A family support worker, Linda Thornhill, and NAMI board member approached me after a workshop I conducted for parents on recognizing the signs and symptoms of mental health concerns in children and adolescents. She stated NAMI’s board “needs someone like you…you can be a voice for all of us…you explained things …you spoke the truth…and we understood”. She disclosed that her son was diagnosed with ADHD…she explained how I could be an asset to the community. She wanted me to tell the truth…to help those understand that disparities and stigma about mental illness must be stomped out in disadvantaged children and communities of color. I knew little about NAMI. A year later, an esteemed NAMI board member, Dick Jevon, talked to me about joining the board… Dick educated me about NAMI’s mission and what it meant to be a board member … he was passionate and engaging. At that time I had no one in my family with a mental illness but I knew as a psychologist that mental illness was common. I had friends whose children were struggling with mental health issues. I knew that it was important to educate and help parents, teachers and caretakers of children to recognize the symptoms of mental illness in the same way we recognize asthma and diabetes…and only through advocacy, education, intervention, understanding and support would stigma be eliminated.

With Linda’s encouragement, Dick Jevon’s passion, their personal stories and my desire to be a part of a strong grassroots organization…I started the path to becoming a board member and now a family member.

Lacey Berumen, Ph.D., MNM
Nominated by NAMI Colorado Springs (Colorado)
Member, NAMI Jeffco (CO), NAMI Colorado Springs (CO)

I am a multi-generational family member who has been honored to be identified as part of the recovery team for my loved ones. At times this has meant being the advocate, at other times the negotiator but always being present and always remaining optimistic.

Clinical Crisis Assessment, Centura Health-St. Anthony Hospital-Psychiatric ER
Member, NAMI Jeffco (CO)
Member, NAMI Colorado Springs (CO)
I am currently in my first term on the NAMI Board of Directors which spans 2013-2016.
I am not currently serving in any public/elected office.

Family-to-Family brought my family to NAMI. I later was fortunate to be hired to serve as the Colorado State ED for six years. During this time NAMI Colorado grew education, support and recovery programs and began our NAMIWalks. As an ED I believed that I could not grow programs not knowing them myself, so I too started teaching Family-to-Family at the VA. As a Gulf War Air Force Veteran, I knew firsthand how military service impacted families, and they too needed access to this lifesaving education. During this time, I made the decision to enter my doctoral program hoping to better understand the intersection of health literacy and medical decision making. Not being one to give less than 100% it became evident I could not focus on both my courses and NAMI full time.

Over the last three years, I was fortunate again to represent NAMI on the Board during that time I have worked with: Governance on re-affiliations; policy; strategic planning chairing the committee to develop the current strategic plan; fundraising – identifying potential funders to include helping to build the relationship that led to financial donations, as well as the in-kind video production from University of Phoenix for our education programs (Peer-to-Peer and Homefront); personnel and convention helping with the convention in my home State of Colorado.

In the next three years, I hope to help NAMI diversify our financial resources; diversify the outreach of our NAMI programs especially into our military families and to continue to elevate the discussion of mental health into public policy. As I firmly believe this is the last civil rights battle left to be addressed where we must hold our leadership in all political parties accountable for upholding the law and being the voice for those who at times can’t.
Shirley J. Holloway, Ph.D.
Nominated by NAMI Alaska
Member, NAMI Anchorage (AK)

I was the mother of a beautiful, smart young woman who lived with mental illness until she took her life six years ago. We saw several professionals, but no one referred us to NAMI. I want other families to find NAMI support and services before they lose their loved one.

Owner, Leadership for Excellence
Past President, Board of Directors, NAMI Alaska
Vice-President, Board of Directors, NAMI Anchorage (AK)
I have not previously served on the NAMI Board of Directors.
Blood Bank of Alaska, Board of Directors, 3 year term, ending 2/2019
CIRI, Board of Directors, 03 year term, ending 4/2019
Charter College, Board of Trustees
I am not currently serving in any public/elected office.

In 2010, my daughter took her own life after living with mental illness. Rather than give flowers, I looked for an organization that people could donate to in her memory. One of the organizations I discovered was NAMI Anchorage. Their response was wonderful. They came to our home, met with our family and helped us to move forward. As a result of their thoughtful and caring support, I offered to help in any way possible. The next thing I knew I was on the NAMI Anchorage Board.

For the past five years, I have served on the NAMI Anchorage Board as Vice President. As my involvement grew with NAMI, I learned that our state NAMI was in serious trouble. Consequently, I took the President’s role and lead NAMI Alaska, with the help of others, to be successfully re-chartered.

Because of the many leadership opportunities I have been afforded; principal and superintendent of schools, college president, commissioner of education for the State of Alaska and founder of a nonprofit, I bring experience in developing and implementing strategic plans and measuring results of the stated goals.

The NAMI strategic framework clearly articulates the priorities and goals. I believe, I can continue to build on the engagement on which the plan was built. Advocacy is a strength I bring to the NAMI Board. I am particularly passionate about focusing on youth, underserved populations and broadening public awareness and inclusion.

If only, we had found NAMI years ago I might be telling a different story. I want to be a part of helping others to learn about the NAMI voice of hope, empowerment, advocacy and support.

I would be honored to bring my skills, knowledge and attributes to the national NAMI Board of Directors.
NAMI National Convention
Denver. July 6-9, 2016

Attend the NAMI National Convention to:

- Learn how to spearhead advocacy efforts for mental health reform
- Be inspired by top researchers sharing exciting new research and tools
- Network with experts in the mental health field
- Earn CEU credits as a licensed counselor, social worker or registered nurse

REGISTER NOW & SAVE!
Early Bird rates end May 31

For more information on the convention, visit www.nami.org/convention