The Sandy Hook Elementary School Tragedy; NAMI Statement Includes Trauma Resources

ARLINGTON, Va., Dec. 14, 2012 -- The National Alliance on Mental Illness (NAMI) has issued the following statement which includes recommended links to trauma resources for families:

"Like other Americans, NAMI is horrified and saddened by today's tragedy at Sandy Hook Elementary School. As of Friday at 5:00 p.m. (Eastern), news reports indicated that close to 30 people were shot and killed, most of them children. We extend our sympathy to their families and to all who knew and loved them.

It is extremely important that the Newtown, Conn. community be prepared to provide trauma services and resources to all those affected by the tragedy. Our national community must do so as well. The tragedy will inevitably leave an impression on many children. Parents and caregivers throughout the country will need to reassure them.

American Psychiatric Association recommendations include:

- Create an open and supportive environment where children know they can ask questions.
- Give honest answers and information. Use words and concepts they can understand.
- Help children to find ways to express themselves and to know that people are there to help. Remember also that children learn by watching parents and teachers react and listening to their conversations.
- Don't let children watch too much television with frightening repetitious images.
- Monitor for physical symptoms such as headaches, stomach aches or other pains.

Additional resources are also available from the Center for the Study of Traumatic Stress (CSTS), the University of Maryland Center for School Mental Health (CSMH) and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

NAMI will follow news reports closely as more details become known. At this time, there is no indication that mental illness was a factor in the tragedy. It is important to not make assumptions or speculate in such cases. The overall contribution of mental disorders to the total level of violence in society is exceptionally small.

When tragedies occur, no matter what their nature or cause, national, state and local communities must come together to find out what went wrong and to take steps to ensure it does not happen again. We expect such scrutiny to occur in days and weeks ahead. Today, however, is a time to mourn and pray for the victims of a senseless act and for their survivors. As a nation, we must reassure each other."
Congratulations to the latest graduates of the York County Crisis Intervention Team (CIT) training program! Attendees from the Sanford Police Department, Buxton Police Department, Southern Maine Medical Center, Department of Corrections, and the Maine State Police were recognized at a graduation ceremony on Friday, December 7 at police headquarters in Sanford.

CIT was developed in collaboration with State wide law enforcement, mental health agencies, and NAMI to help improve First Responder interactions and outcomes with persons with mental illness and substance use disorders. York County’s program includes staff from many first responding agencies to ensure that a comprehensive, County-wide approach is in place to assist those with mental illness.

Through their 40 hours of training, CIT members learn skills such as suicide intervention, verbal de-escalation techniques, the role of the family in the care of a person with mental illness, and legal training in mental health and substance abuse issues. CIT members also participate in role playing exercises based on real-life scenarios and spend a day visiting mental health and substance abuse inpatient and outpatient treatment facilities where they have the opportunity to engage in one-on-one dialogue with mental health consumers.

Since the program began in 2002, more than 1300 First Responder State-wide have completed CIT training and are able to use their specialized skills. Many thanks to Sanford Chief Thomas Connolly and Jen Goodwin from Counseling Services Inc for providing the attendees with a great program and a great learning experience.
NAMI SUPPORT GROUPS

You are not alone. NAMI Maine provides support groups for peers (people with mental health conditions) and family members to meet with people experiencing similar issues and learn new strategies to handle daily challenges. Groups are available for veterans and veteran’s family members as well. Call 1-800-464-5767 or check our website at www.namimaine.org for information on a group near you. Come and join us.

ANNOUNCING A NEW PEER SUPPORT GROUP IN PORTLAND BEGINNING JANUARY 14TH

NAMI Portland peer support group
Meets on the second and fourth Monday of the month from 7:00 – 9:00 p.m. at the Dana Health Education Center at Maine Medical located at 22 Bramhall St., Portland. The group will meet in Room 6. Parking is located on back side of the hospital. For more information leave a message for Brian at (207) 651-7803.

IN ADDITION the NAMI Portland family support group is meeting at the same time in Room 3 at the Dana Center. Beginning in January this group will once again be meeting upstairs in a conference room on the main floor of the Dana Center.

HELP OTHERS

LEARN HOW TO FACILITATE A NAMI SUPPORT GROUP
Are you a family member or a peer (someone who has a mental health concern) interested in helping others get the support they need? Are you a Veteran or the spouse/partner of a Veteran interested in helping others get the support they need?

Gain the skills you need to co-facilitate a NAMI Support Group. We need your help.

- Learn about group dynamics
- Learn group structure and process
- Practice skills that insure an effective support group meeting

FREE 2-DAY SUPPORT GROUP FACILITATOR TRAINING AVAILABLE

Sign up for the next NAMI Support Group Facilitator Training planned for Portland January 3-4. This training is for both peers and family members to learn how to facilitate a NAMI support group of your choice. Additional trainings are scheduled regionally. If you would like more information about becoming a NAMI support group facilitator, or would like to be put on a waiting list for the next training near you, contact Christine Canty Brooks at 1-800-464-5767, or email ccanty-brooks@namimaine.org.
Family-to-Family is a FREE twelve week education course for family members and friends of people living with mental illness. The course covers information about mood disorders (bipolar disorder and major depression), panic disorder, schizophrenia, borderline personality disorder, PTSD, obsessive compulsive disorder and other major mental illnesses. In addition, coping skills such as handling crisis and relapse; suicide prevention, basic information about medications; listening and communication techniques; problem-solving skills; recovery and rehabilitation; and self-care around worry and stress are included.

Course starting in January in Portland.
To be put on a waiting list for the next Family-to-Family course near you please contact Christine Canty Brooks at 1-800-464-5767, or email ccantybrooks@namimaine.org. We are also looking for family members who are interested in being trained to co-teach the Family-to-Family course. This is a wonderful and rewarding way to give back to others in need.

RESEARCH NEWS

SAMHSA Report Reveals 20 Percent of U.S. Adults Experienced Mental Illness in the Past Year In the past year, 45.6 million people had mental illness according to the 2011 National Survey on Drug Use and Health (NSDUH): Mental Health Findings report.

New on the MedlinePlus Mental Disorders page:
Burden of Mental Illness 11/25/2012 10:32 PM EST  Source: Centers for Disease Control and Prevention

New on the MedlinePlus Child Mental Health page:
Psychiatry Gets Revised Diagnostic Manual

12/03/2012 02:00 PM EST
One of the biggest changes: 'autistic disorder' will now be known as 'autism spectrum disorder'
Source: HealthDay

Experts Call for Mental Illness Screening for Children
11/28/2012 05:00 PM EST Leading mental health experts are calling for school children to be screened for risk of mental illnesses such as depression and have devised a test that reliably identifies those at high risk.
Source: Reuters Health

New on the MedlinePlus Anxiety page:
Anxiety 11/27/2012 01:19 PM EST Source: Mayo Foundation for Medical Education and Research

Anxiety Disorders 11/27/2012 01:19 PM EST Source: NAMI

New on the MedlinePlus Mental Disorders page:
20 Percent of US Adults Experienced Mental Illness in the Past Year
11/29/2012 08:52 PM EST
Source: Substance Abuse and Mental Health Services Administration

New on the MedlinePlus Schizophrenia page:
Long-Term Use of Some Antipsychotics Not Warranted in Older Adults 11/28/2012 09:00 AM EST
**Psychotropic Medications Are Prescribed Appropriately Among U.S. Teens**
12/04/2012 10:52 AM EST
Source: National Institute of Mental Health - NIH

**Most Teens with Mental Disorders Not on Meds**
12/03/2012 04:02 PM EST
Despite concerns that too many U.S. youth use prescription psychiatric drugs, a new study suggests just one in seven teens with a mental disorder has been prescribed medication, and far fewer without a diagnosis are on treatment.
Source: Reuters Health

**New on the MedlinePlus Depression page:**
Experimental Agent Briefly Eases Depression Rapidly in Test
12/10/2012 08:13 PM EST
Source: National Institute of Mental Health - NIH

**When Antidepressants Don't Work, Give Counseling a Try**
12/06/2012 07:00 PM EST
Study found that patients were three times likelier to benefit from the addition of cognitive behavioral therapy
Source: HealthDay

**New on the MedlinePlus Mental Disorders page:**
Mental Health in the Hispanic / Latino Community
12/07/2012 01:04 PM EST
Source: American Psychiatric Association

**Kids with Autism Common Users of ERs, Study Says**
12/07/2012 12:00 PM EST
Findings suggest need for better outpatient psychiatric care
Source: HealthDay

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**OTHER NEWS**

**Reintegration Awards**
Since 1997, the Reintegration Awards, supported by Eli Lilly and Company, have celebrated the achievements of those in the community who dedicate themselves to improving the lives of individuals with serious mental illnesses, and the achievements of those living with schizophrenia or bipolar disorder who battle tremendous odds to improve their own lives and the lives of their peers. In 2013, the National Council for Community Behavioral Healthcare is proud to partner with Lilly to offer the Reintegration Awards.

Honorees of the Reintegration Awards receive cash prizes of $5,000 to $10,000, to be donated to a non-profit organization of the honoree’s choice. Categories include Achievement, Advocacy, Artistic Contribution, Clinical Medicine, Education, Employment, Housing and Mentorship.

**All applications are due no later than December 31, 2012.**
Click on this link for the application and more information:
http://www.thenationalcouncil.org/cs/awards_of_excellence/reintegration_awards
Defining Trauma: Give Us Your Feedback

SAMHSA is now seeking input from the public on the concept paper, SAMHSA's Working Definition of Trauma and Principles and Guidance for a Trauma-Informed Approach.

For ease of review, the paper is divided into three sections:

- Definition of Trauma
- A Trauma-Informed Approach
- Guidelines for Implementing a Trauma-Informed Approach

Each section has a separate link and unique forum to provide comments and, if you wish, to vote on comment offered by others. You have up to 10 votes to endorse other comments, and you may revise your votes throughout the comment period.

The feedback forum will be open beginning Monday, December 10, 2012, and ending at midnight eastern time on Friday, December 21, 2012. This forum will provide an open and transparent process for stakeholders to offer their comments about the definitions, principles, and guidelines, and also make suggestions for improvement.

Feedback on the forum is an important part of the public dialogue on this issue. Your feedback will be carefully considered in the shaping of the definitions of trauma and trauma-informed approach, and the principles and guidelines of a trauma-informed approach.

Learn More About How SAMHSA Developed the Working Definition of Trauma
Information for Families, Respite Providers, Case Managers and The Community

NAMI Maine coordinates the delivery of respite services for families with children and youth under the age of 18 who have been diagnosed with developmental, emotional or behavioral disabilities. The Family Respite program is available for families from all parts of the state of Maine and if you, or someone you know can benefit from a coordinated, planned break from raising children with special needs, please call NAMI Maine today. Families may qualify for up to 16 hours of respite care per month and are encouraged to utilize friends, family members and others (who know their children) as respite providers. Or, they may choose to utilize a qualified respite worker from NAMI Maine’s growing list of approved providers.

All application and permission forms for families and providers are available for downloading on the NAMI Maine website (www.namimaine.org) as well the Family Respite website, www.respiteforME.com.

There are some important changes for families & providers to take note of;

- Children who qualify for respite care must under age 18. No exceptions.
- Unused respite hours now carry over from quarter to quarter until the end of the fiscal year
- Families must provide diagnosis documentation less than a year old
- Providers must become employees of NAMI Maine

Providers must be certified by 12/31/2012

If you would like to know more about the NAMI Maine Family Respite program, please contact Pete or Karen at NAMI Maine for more information or to find out how to receive an application.

NAMI Maine is currently recruiting respite providers in all regions of the state to work with families who have need of services. Providers are hired as employees of NAMI Maine and are paid at either $9 or $11 per hour, depending on their background, training and education. Remember – uncles, aunts, grandparents, neighbors and other friends & relatives are encouraged to become providers by applying on line, by fax, or calling NAMI Maine to receive application materials. We will conduct a criminal background, driver’s license & child protective check on all applicants and all providers must become certified between now and December 31, 2012.

If you are a NAMI Maine respite provider awaiting the next available orientation, please click on the November Schedule button on the left.
Increase in state suicide rates in the USA during economic recession

Aaron Reeves a, David Stuckler a b, Martin McKee b, David Gunnell c, Shu-Sen Chang c d, Sanjay Basu b e

Evidence from European countries indicates a significant rise in suicides from the economic recession, totaling more than 1000 excess deaths in the UK alone.1—3 Among the worst affected economies in Europe, such as Greece, suicides have risen by more than 60% since 2007.2 Thus far, there has been little or no analysis of US mental health data, mostly owing to delays in data availability.

Here, we extend our previous analyses of recessions and suicides in Europe1, 3, 4 to assess trends in all 50 US states. We use data on suicide mortality rates from 1999 to 2010 from the Centers for Disease Control and Prevention. Unemployment data come from the Bureau of Labor Statistics. Time-trend regression models were used to assess excess suicides occurring during the economic crisis—i.e., deaths over and above the level that would be expected if historical trends continued (see appendix for methodological details). Although there are concerns that suicide data are under-reported in the USA, these biases are likely to have been consistent over this relatively short period, although they might lead to a conservative estimate of the mental health effects of the crisis.

In the years before the onset of the crisis (from 1999 to 2007), the suicide mortality rate in the USA was rising on average at a rate of 0·12 per 100 000 per year (95% CI 0·09—0·14; figure). Coinciding with the onset of the recession, the suicide rate accelerated. There were an additional 0·51 deaths per 100 000 per year (95% CI 0·28—0·75) in 2008—10. This acceleration corresponds to an additional 1580 suicides per year (95% CI 860—2300). Thus, during the recessionary period after 2007, there were an estimated 4750 excess suicide deaths (95% CI 2570-6920).

Figure: Time trend analysis of suicide rate in 50 US states and District of Columbia between 1999 and 2010
70—6920).
Vertical line shows onset of recession.

Next we investigated the association between rising unemployment and suicide mortality rates. In Europe, we previously noted that a one percentage point rise in unemployment was associated with a rise in the suicide rate of 0.79% (95% CI 0.16—1.42; p=0.016). Our findings in the USA are slightly higher: a one percentage point rise in unemployment is associated with a 0.99% increase in the suicide rate (95% CI 0.60—1.38, p<0.0001), which is closer to the association estimated when there were no labour market protections (1.06%). The magnitude of these effects is slightly larger than for those estimated previously in the USA, which might indicate that previous studies have not investigated periods of high unemployment or that this recession might be exerting more negative effects on mental health than previous downturns.

Since the rate of unemployment between 2007 and 2010 in the USA increased from 5.8% to 9.6%, our model indicates that the rise in US unemployment during the recession is associated with a 3.8% increase in the suicide rate, corresponding to about 1330 suicides. In other words, rising unemployment could account for about a quarter of the excess suicides noted in the USA during this time.

Looking across US states between 1999 and 2010, we found that the strongest correlation between unemployment and suicides was in Texas (r=0.91), but overall the correlations were statistically indistinguishable between the north, south, east, and west, or when disaggregating states by Democrat and Republican governors (appendix). Small numbers of suicides in small populations limit a state-by-state comparison for all 50 states. Similar patterns were seen if absolute numbers of suicides were used instead of overall rates.

Suicide is a rare outcome of mental illness; these data are likely to be the most visible indicator of major depression and anxiety disorders, as seen in primary-care settings in Spain and in the Greek population. The pattern of accelerating suicides noted in the USA mirrors that recorded for economic reasons in Italy.

Future research should explore other risk factors such as foreclosures and job and income losses, and modifying factors such as gun control policies, access to the means of self-harm, and vulnerable groups, which could explain the remaining portion of the suicide rise observed during the recession.

Our findings have immediate implications for policy. Given that some countries have avoided increases in suicides despite significant economic downturns, there is a clear need to implement policy initiatives that promote the resilience of populations during the ongoing recession. Active labor market programs—projects that immediately help the unemployed find social support and new work opportunities (even part time)—and mental health prevention programs seem to mitigate significantly the negative mental health effects of recessions. The fact that countries such as Sweden have been able to prevent suicide rises despite major recessions reveals opportunities to protect Americans from further risks of suicide during the continued economic downturn.

We declare that we have no conflicts of interest.

**Supplementary Material**

Supplementary appendix

[PDF (267K)]
References

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