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Winter 2008 VOL. 31 No. 1

SHARE & CARE

THE RECOVERY OF HOPE ~ THE HOPE OF RECOVERY

The fear of relapse and how families can make a positive difference

Relapse, recovery, remission: they're the 3 Rs of serious mental illness, a trio all too familiar to families and their ill relatives. Less known is the fact that, contrary to what was once believed, relapse does not strike out of the blue. It is now the accepted wisdom that there are warnings. Relapses can often be predicted and most of them can be prevented (as many as 80 percent is one estimate).

Dr. Christopher S. Amenson, a California-based psychologist, has developed a stages-of-relapse model. As his table below indicates, each of the five stages has its own characteristics. Overall, family members can reduce the risk of relapse by being supportive of their relative and providing a low-stress environment. If and when relapse occurs, they can also play an important role throughout the crisis to minimize its impact and hasten recovery.

Stage 1: Stability

- Encourage your relative to keep up a healthy lifestyle and develop good coping and interpersonal skills.
- Help her to manage medication symptoms and side effects.

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WHEN MEDICATIONS CLASH

Drug-drug interaction is a fact of treatment life — and a problem that often goes unreported

Really lucky people take no medications at all. Most of us take some. Those with mental illness generally take more than the norm, which makes them especially vulnerable to the possibility of drug-drug interaction.

Dr. Howard Margolese, associate professor at McGill and a psychiatrist at the McGill University Health Centre, specializes in treating patients with schizophrenia. He's also a specialist in clinical psychopharmacology, a field that includes drug-drug interaction.

"This is a common problem among psychiatric patients, but we can all relate to it," he says. "It can happen to anybody taking two or more different medications — psychiatric drugs, non-psychiatric drugs or a combination of the two."

Interaction brings on unwanted side effects, such as constant fatigue. The more drugs involved, the greater the possibility of a problem occurring.

It starts in the liver, where most medications are metabolized. Some psychiatric meds have a blocking effect on the liver's metabolizing enzymes. This produces a seesaw reaction, reducing the effects of one medication while increasing those of the other or others.

The offenders

Antidepressants, mainly the selective serotonin reuptake inhibitors (SSRIs), are well known for their blocking ability. Among medications in general use, some antibiotics and some antifungal drugs are also strong inhibitors.

"Interaction can sometimes also occur between two drugs of the same sort, such as two different anticonvulsants," says Margolese. "Physicians have to be aware of that overlap when they're switching a patient from one drug to another."

Margolese: be aware, not alarmed

Some interactions are well within a patient's ability to avoid. Drugs and food, for instance. Grapefruit juice is a known blocker of one of the liver's enzymes.

Caffeine has an effect, albeit a minimal one. Alcohol is slightly different. Its main effect is not on metabolism, but because it's a depressant it interferes with the ability of psychiatric medications to work properly. "It's always better not to drink alcohol if you're on psychiatric medication," advises Margolese. "But a glass of wine with dinner occasionally shouldn't be a problem. Just remember that one drink will be equal to the effect of two or three."

Tobacco is a major no-no in more ways than one. Smoking speeds up an enzyme that plays a major role in metabolizing psychiatric drugs. If people on antipsy-

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INVEGA offers new hope for treating schizophrenia

Last October Janssen-Ortho introduced a new medication the company sees as providing schizophrenia patients a significant improvement in the quality of their daily lives.

It's called INVEGA. Taken orally once a day, it's formulated to deliver a controlled flow of medication that keeps schizophrenia symptoms in check over 24 hours. In clinical trials INVEGA was shown to significantly improve both the symptoms of the illness and its allover severity.

INVEGA is not extensively metabolized in the liver, meaning patients can look forward to the prospect of fewer drug interactions and the side effects that commonly occur, notably the dreaded weight gain.

If you suffer from schizophrenia, INVEGA broadens your choice of medication options. It could help you stay compliant and make treatments for your illness less of a burden. Speak to your doctor about it.

VOLUNTEERS NEEDED

Volunteers are the backbone of AMI-Québec. Without their active participation in many of our endeavors, we would not be able to continue offering our present wide variety of programs. If you're willing to help out by committing some time, you'll be trained by us so you'll be all set to handle the work.

We presently need volunteers at the reception desk. The way callers or visitors are welcomed may determine their future relationship with AMI: whether they call back, become members or decide to participate in a program. Because we attach such importance to this first contact, the desk is staffed throughout the week. Qualified candidates are patient, sensitive individuals who enjoy working with people.

We are also looking for volunteers to join the Political Action committee. Political attention to mental health issues needs improving on both federal and provincial levels. The efforts of this committee can help change things for the better.

If you're interested in these or other volunteer opportunities, call Kimberley at 514-486-1448.

***Medications** ... continued from page 1*

chotics such as clozapine or olanzepine stop smoking, drug levels in the blood might increase, meaning the dose could be reduced. That's one good reason for quitting, never mind the well-known health benefits of being tobacco-free.

Unfortunately drug-drug interaction plays favorites. People can either be slow, regular or rapid metabolizers of medication. It's genetic. Slow metabolizers are more likely to experience drug-drug interactions. They're also apt to be more sensitive to side effects and very low doses of their meds may be prescribed. Rapid metabolizers may need higher doses, but they're less likely to have interaction problems.

Other factors that contribute to interaction differentials are body weight, absorption rates, gender (women generally metabolize more slowly) and age. Metabolism of most medications decreases as we grow older.

Medications often clash when a GP writes a prescription without knowing the patient is already taking a psychiatric drug. That's where an alert pharmacist can spot potential trouble and why it's wise to have all your prescriptions filled at the same pharmacy.

Margolese differentiates between an interaction and a clinically meaningful interaction. Clinically meaningful he defines as being substantially affected by side effects. He estimates that occurs less than 30 percent of the time. As he explains: "If you have an interaction and it increases one drug a bit and decreases the other drug a bit, the allover effectiveness will very likely stay the same and you won't notice a significant difference. You just need to remember that if you're taking one drug, then adding a second, there could be a reaction. But that's no cause for alarm. Our bodies are pretty good at metabolizing." ❐

BECOME A SAVVY PATIENT

1. Don't rush to get through your sessions with your psychiatrist. Side effects such as tiredness and dizziness are not inevitable reactions to drugs. Speak up about these and any other reactions you have, especially if you're starting a new medication.
2. Keep in mind that drug-drug interaction is a possibility if you're taking more than one medication. Be alert to your body signals.
3. Make sure your pharmacist, an important member of your care team, is aware of every medication you're taking. It's wise to fill all your prescriptions at one pharmacy.
4. Your GP should also know of all your medications and the doses. Bring your vials with you to your appointments.
5. Smoking — both the legal and illegal kind — plays havoc with medication. Try your hardest to break the habit. Use alcohol seldom if at all. The caffeine in coffee, tea and colas has less of an effect, but the possibility is there. Avoid grapefruit and grapefruit juice — there are plenty of tasty alternatives.
6. If you want to learn more, pharmacists can usually give you a list of side effects. In the "Dummies" series of how-to books, *Understanding Prescription Drugs for Canadian Dummies* (Ian Blumer & Heather McDonald-Blumer) offers practical, readable information.

2007 LOW-BEER MEMORIAL LECTURE

THE FIGHT AGAINST STIGMA

Why it's so tough, what works best and how consumers hold the key to success

If anyone doubted the enormity of the stigma problem concerning mental illness, listening to Dr. Patrick Corrigan at the Low-Beer Lecture last October was a reality check.

What drives stigma? Mass communication must shoulder a large part of the blame. Cliché messages that turn up in movies, advertising, tabloid newspapers and even cartoons perpetuate the myths: brain disorders bring on weakness, incompetence and that old bugaboo, the homicidal maniac.

Stigma is part of the social fabric. People laugh when a comedian jokes about a solution: "Can't we all just lighten up?"

Well, no, we can't. Because stigma ruins lives. "Wiping it out is a matter of social justice," remarked Corrigan, a professor at the Institute of Psychology in Chicago, part of that city's Illinois Institute of Technology.

Three approaches

Corrigan identified three methods of combating public stigma: education, protest and contact. Education counters the fictions with facts. But for Corrigan it's an over-rated approach that results in only a small, temporary improvement.

Protest has a moral overtone that makes headlines, but there's an attitude rebound that may actually increase stigma.

Contact — repeated person-to-person contact — works. It affects behavior and improves attitudes, and the improvements seem to stick. The catch is, it depends on consumers going public about their illness. To borrow a term from the gays(whom Corrigan much admires for their courage and determination to conquer their own stigma), consumers need to come out.

Self-stigma

Self-stigma is what happens when consumers silently endorse the public's negative attitudes about mental illness and turn them against themselves. Its roots are fear, shame, anger and low self-esteem. Self-stigma is contagious, easily transmitted to families, friends and others. It's also the greatest obstacle to beating the public stigma problem.

Corrigan's decade-long battle continues

There are costs to coming out: disapproval and gossip; social and work exclusion; rejection by some friends and family members. But the benefits, says Corrigan, are worth it: relief and truth without fear or hiding; joining peer groups with similar experiences; new-found pride and self-worth; repudiation of stigma stereotypes.

Corrigan talks from personal experience. He's suffered from depression for 25 years and has been working to counter stigma for the past decade. "I'm passionate about the subject," he says. "Consumers need their own voice and control over their lives." ❐

Straight from the heart

From time to time, AMI receives intensely personal mail from consumers and family members. Their writing usually reflects emotions and observations that have accrued from their experiences with mental illness. We like these accounts for their insights as well as for the therapeutic benefits that committing thought to paper can provide. We're sharing a few of these selections now (some have been edited for space) and there may be more to come. Our future mail will tell us whether the idea has legs.

RACHEL HOFFMAN

Illness of the Brain

The descent to madness started slowly.
A voice, an unbidden voice.
A thought became an irrational command.
I lost husband, home, children, mother, father.
Then amongst the voices
I lost me.

SABA MALIK

My Recovery

As I sit here, I wonder what helped me get through the bumpy ride of dealing with bipolar. I firmly believe that accepting God is the first step to recovery. If He has willed me to have bipolar, then there is goodness in it. For that reason I have vowed to use my illness for the betterment of mankind.

In the sea of recovery, I cannot expect no storms. One that hit full-force was the negative notions surrounding mental illness. Believing the lies others spread and even surrendering to my own biases hindered my progress. First I lied to myself by

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BIPOLAR DISORDER, TYPE II

To quote comedian Rodney Dangerfield, it "don't get no respect"

Mention bipolar disorder and most people think of type I. That's because type I's characteristic mania phase is notorious for the dysfunction, hospitalization and even psychotic behavior that it causes. It's so flashy and dramatic, people take notice. When a celebrity happens to get caught in its grip, the media have a field day.

By comparison, type II bipolar is a shy and quiet relative. Its high point is hypomania, not mania, so it gives the impression of being a less serious form of the disorder. It gets nowhere near the attention lavished on type I and little or no respect as an illness. But don't you be fooled.

Depression is the chief characteristic of type II bipolar. Its hypomania is more like a "can do" mood of energy, expansiveness and irritability that can result in highly productive activity. It doesn't cause a marked impairment in functioning and may go unnoticed by those suffering from it. When hypomania is seen for what it is, it's often welcomed as a relief from the more dominant depressed state. Unfortunately those same characteristics mean that hypomania can easily fly under the radar screen of clinicians and diagnosis can be missed.

Those with type II usually seek help during their depressive episodes. Because the symptoms of bipolar depression can be severe and certainly are recurrent, too frequently a diagnosis of major depression is made without the realization that the true illness is a member of the bipolar family.

The dangers of type II

Since it's powered by depression, this is a serious illness that can cause an extreme amount of partial and total disability. Recognizing its potential pitfalls is a vital part of gaining wellness skills.

Type II can cause frequent and persistent suicidal thinking, even at a young age. Those thoughts of suicide can result in intense and distracting psychological pain. They can seem rational and sometimes persist even when no attempt at suicide is made. It's easy to mistake them for a normal part of life.

Once a person is diagnosed with type II, it's difficult for those without healthcare training to understand why that diagnosis was made, since the flashy mania of type I isn't part of the illness.

The depression of type II stews and simmers beneath the surface. It frequently becomes so much a way of life that the person who experiences it long-term fails to get treatment until it's boiling over.

Type II is frequently misdiagnosed and treated with antidepressants alone (without a mood stabilizer). This can worsen the symptoms.

***Relapse** ... continued from page 1*

- Remind her of the importance of monitoring symptom triggers, symptoms and warning signs.

Stage 2: Early warning signs

- Recognize the signs of impending trouble.
- See that your relative charts his symptoms, takes the warning signs seriously and doesn't delay in contacting his case manager or therapist if necessary.
- Urge him to act quickly — most relapses take 2 or more weeks.

Stage 3: Relapse

- Ensure that your relative gets the right treatment and follows it.
- Have hope, take heart — and be sure to communicate your optimism.

Stage 4: Symptom remission

- See that the treatment regime is followed.
- During the next 2-6 weeks your relative is at high risk for another relapse — be supportive and patient.

Stage 5: Recovery

- Continue being patient, supportive and positive.
- Watch for the return of symptoms, symptom triggers and risk factors.
- Encourage your relative to develop realistic plans for the present and the future.

A relapse-prevention plan specifically for consumers will be included in the spring issue of *Share&Care.* ❐

Information taken from *Preventing Relapse* by Diane T. Marsh in *A Family-Focused Approach to Serious Mental Illness — Empirically Supported Intervention*, 2001.

STAGES OF RELAPSE

Stages	Characteristics
Stage 1: Stability	• Symptoms controlled • Mental illness in background • Satisfactory quality of life
Stage 2: Early Warning Signs	• Return or increase of symptoms • Anxious and overwhelmed • Changes in behavior • Changes in biological rhythms • Concern of others
Stage 3: Relapse	• Runs its course • Severe symptoms • Loss of control
Stage 4: Symptom Remission	• Quiet, passive and dazed • Aftermath of trauma
Stage 5: Recovery	• Skill recovery (often 6-9 months) • Healing and reintegration • High risk for relapse

Hypomania is frequently not recognized as part of the illness. When it occurs, it may be seen as a sign of improvement rather than as a part of the overall illness.

Now the good news

Until recently, most bipolar disorder research focused on type I, so less information was available about type II. That's changing now and more attention is being paid to type II. While it may never be the headline-grabber that its noisy relative is, type II is being recognized for its place in the family of bipolar disorders. Appropriate treatment and the use of wellness skills can usher in a life without the constant drama of overwhelming depression.

Clinicians are recognizing that type II requires a different approach from that used for type I. The medical community is getting better at looking for the red flags that distinguish it from major depression. Researchers are recognizing the distinctive role it plays among mood disorders. Finally type II is beginning to get more respect. ❒

Adapted from *Bipolar Disorder, Type II — How is it like Rodney Dangerfield?* by Dr. Jane Mountain in *Beyond Bipolar Newsletter*, July, 2007.

Dr. Mountain's latest book, *Beyond Bipolar — 7 Steps to Wellness,* is on order for the Monty Berger Library. For other reading on bipolar, visit **www.beyondbipolar.com/**

Tips for dealing with bipolar disorder, type II

1. Take your illness seriously.
2. Ask questions to understand the reasons for your diagnosis.
3. Learn what a normal mood is so you don't confuse it with hypomania. Keeping a mood chart or graph will help you.
4. Recognize hypomania as being part of the illness and pay as much attention to its treatment as that of depression.
5. Counteract suicidal thoughts by carrying a card or note stating "I need help. I am feeling suicidal. Please stay with me and help me call (your doctor, family member, friend)." Include the phone number.
6. Stay in treatment even when you feel well.
7. Develop a network of family and friends who can help you maintain a healthy lifestyle.

The facts on Borderline Personality Disorder

An eight-session information program on Borderline Personality Disorder (BPD) is being offered in January by Friends for Mental Health.

The family-oriented series, one given in English, one in French, is being called "To love and help someone suffering from BPD: a challenge that can be achieved." It will cover the nature of the disorder, its symptoms, behavior and challenges, and what changes families can make to improve the quality of life for everyone affected by it.

The program starts mid-January. Friends for Mental Health is located in the West Island. To register, call Francine at the AMI office, 514-486-1448.

WINTER 2008

GUEST SPEAKER EVENINGS
Mondays 7:30pm 4333 Côte Ste-Catherine Road

March 17: *Housing Choices: What there is and what we need: how these options promote recovery.* Lynn Hewitt, Douglas Institute, and two speakers representing *L'Abri en ville*

EDUCATION
7:00-9:00pm at AMI

Mood and Thought Disorders
6-session program begins March 11

Recovery Workshop
Mental illness: learning to live a better life.
Rachel Hoffman and Kimberley Jackson
6-session program begins February 27

Roundtable Discussions
The Recovery Process. Abe Weiss
January 31

Effective Communication with someone with a mental illness. Dr. Camillo Zacchia
February 20

SUPPORT GROUPS
Mondays 7:30pm 4333 Côte Ste-Catherine Road unless otherwise indicated

FAMILY for relatives
January 7, 14, 21; February 4, 11, 18; March 3, 10

PAC Parents of Adult Children
7:00pm at AMI
January 15; February 12; March 13

SOUTH SHORE for relatives
Wednesdays 6:30pm
2499 rue St-Georges, room 200, LeMoyne
January 9, 23; February 6, 20; March 5, 19

SIBLINGS AND ADULT CHILDREN
January 14; February 11; March 10

DEPRESSION/BIPOLAR DISORDER for consumers and relatives
January 7; February 4; March 3

DEPRESSION for consumers and relatives
January 21; February 18; March 10

OBSESSIVE COMPULSIVE DISORDER for consumers and relatives
January 21; February 18; March 10

KALEIDOSCOPE for consumers
January 14; February 11; March 3

LIFELINE for consumers
Thursdays 1:00-3:00pm
Alternative Centregens, 5770 Auteuil, Brossard

BOARD MEETINGS
Tuesdays 7:00pm at AMI
January 8; February 5; March 4

Heart *... continued from page 3*

saying I did not have a mental illness. Then I believed that I could not be intelligent, could not have a family, that I was dangerous.

The turning point came when I saw the truth: I was running away from the fact that I had a mental illness. I also saw the truth as holding many doors of contentment, one of which was my vow to use my illness to help others in the same situation through moral support and education.

The biggest surprise along the road to recovery was the infinite love I received (and still do) from places and people I never imagined. Recovery has taught me we are stronger and more beautiful than we think. It has taught me to focus on the life in my years rather than the years in my life. Now life is boring if I don't use my illness. I have fun with it. I talk about it. I have learned that my work in recovering from bipolar is nil compared to the endless time and effort of my family to help me. I thank God, my mother, my family, my friends and, of course, my doctors. May God grant you the highest abode in paradise.

YVES BOURASSA

My first permanent, professional job was with a small firm. A year later I joined a big company. Within a week I experienced a strange anxiety crisis and began seeing a psychotherapist. I was soon fired and my anxiety turned to a depressive state. Thinking I no longer needed it, I stopped the therapy.

I would go to job interviews even though I did not feel like meeting people. I couldn't smile or remember names and was evasive about my last work. I left the impression of having a troubled mind. After more than two years of limited activity, I asked a friend for help. "Forget job hunting," he advised. "Instead, tell me about your life."

Discussing matters that had troubled me for years gave me energy. I also became more aware of my mind's impairment. For example, I noticed it was challenging for me to go to a shopping centre bathroom to wash my hands. I would go home thinking, "My next challenge will be to buy a few bananas and exchange greetings with the cashier."

A paranoid crisis hospitalized me. I was put on Haldol and remained in the hospital for a month. I actually enjoyed the activities, the food and the socialization. After my release, I found a professional job and was soon asked to travel to France. I got worse there, could hardly sleep and felt isolated from people I could trust. I was back in a week. The job lasted 30 months, but after the incident I needed something less stressful.

I took some courses, tried different jobs, participated in activities at the Centre *Espoir*. Now I am a factory worker and I have accepted the situation. ❐

FIRST CHOICE OR LAST RESORT?

How do you see physical restraints? As Advocacy committee chair ELVA CRAWFORD reports, the issue is not as simple as it appears

It seems so obvious. Should not the care for psychiatric patients in hospital always be directed towards the least possible use of restraints unless absolutely necessary and only if based on clinical considerations?

Why then do we find ourselves with a new law? *Des mesures de contrôle prévues à l'article 118.1 de la loi sur les services de santé et les services sociaux* calls for the use of physical restraining procedures and seclusion in care only as a last resort. The legislation is aimed at healthcare institutions and requires them to re-examine their protocols to ensure the law's implementation.

AMI's Advocacy committee, comprising family members, care providers, professionals and consumers, discussed the topic. Our starting point was our shared and committed belief that persons suffering from mental illness deserve good quality care.

But what is good quality care when the physical restraint of patients is involved? Varying opinions were expressed, all with a valid point of view. We came to realize that the law was timely and warranted thorough scrutiny. Neither obvious nor simple, the subject is, in fact, very complex.

That complexity became obvious as emotions surfaced during our discussions and we gained a clear picture of both the benefits and the harm using physical restraints can cause. On the negative side, the consumer feels humiliated, the staff may feel a sense of failure, family or friends witnessing the event feel helpless and bewildered as they wonder what might happen next.

Over several meetings, two important themes emerged. First, quality care when restraints are used can be defined in part by clarifying the intent. Second, the quality of life could be enhanced for everyone involved by seeing the restraints as ensuring safety rather than controlling behavior. Our committee concluded that both issues would be addressed in answering the question "What can be learned from this particular experience?"

The positive aspects

As advocates of quality care, we envision at least two positive outcomes if this question is addressed in a serious way. A dialogue

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MAKE AMI THE BEST IT CAN BE

The right board of directors is a powerful asset to an organization. It's important to have the very best people in place.

You probably know someone who could make a valuable contribution to AMI. Give him or her the chance to shine. Send in your nomination, along with a written rationale for your choice, to the office no later than March 1, 2008.

Board elections are held every June during the annual general meeting.

Nominations now open for annual awards and recognition

Every year at the annual general meeting AMI honors those whose exceptional efforts are helping us achieve our goals. Know someone deserving? Submit your nomination — or nominations — accompanied by a short written rationale to the selection committee by March 1, 2008. The board of directors makes the final choice. For more information or help, call us at 514-486-1448.

Monty Berger Award for Exemplary Service

Presented to an individual, usually an AMI member, who has made a significant voluntary contribution to AMI or its mandate over a long period of time.

AMI-Québec Award for Exemplary Service

Presented to someone working in the field of mental illness. Selection criteria include extraordinary care to those with mental illness, guidance and support to families struggling to cope and active participation in support of our goals.

Exemplary Psychiatrist Award

Presented to psychiatrists who endorse our agenda by guiding and supporting families, sensitizing health professionals to the pain and difficulties families face, promoting the inclusion of family members in treatment teams and increasing public awareness of mental illness.

AMI-Québec Volunteer of the Year

Presented to an AMI volunteer for service during the previous twelve months that far exceeded the norm as well as for outstanding and inspiring dedication to our objectives.

The Extra Mile Award

Presented to an individual or an organization for special efforts to promote the understanding of mental illness.

TRIBUTES & MEMORIALS

In honor of Barbara and Abe Weiss
Fran and Howard Brenhouse

In honor of Dr. Daniel Frank
Fran and Howard Brenhouse

In honor of Elaine and Ted Matthews
Pat and Paul Rubin

In honor of Paul Rubin
David Asch

In honor of Sylvia Klein
Sonia Weinzweig

In honor of Ella Amir's appointment to chair the family advisory committee, Mental Health Commission of Canada
Marylin Block
Nancy Grayson

In honor of Kay Simpson
Elsie and Doug Richardson

In honor of Annabelle Ship and John Sanders
Meta Fitch

In honor of Riva and Carl Gerlber
Doris Evin

In honor of AMI-Québec's staff and members
Elizabeth Tremain

In honor of Anita Miller
Frank Kagan

In honor of Amedeo Melucci
Luciana Melucci

In honor of Bernadetta Melucci
Luciana Melucci

In honor of Claudia and Jerry Ikeman
Doreen Green

In honor of Jeremy Morcos
Elizabeth Johnston

In honor of Angela Bober
Jean M. Brown

In honor of Mervin Blostein
Judith Arna

In honor of Jeffrey Ariel Finkelstein
Queenie Grosz

In honor of Sherry Ellen
Richard L. Cummings

In honor of Rachel Pnina Frankel
Queenie Grosz

In honor of Dorothy and Bruce McCullogh's special anniversary
Ella Amir

In memory of Max Silver
Heartfelt condolences to Sylvia Silver and family from the AMI board

In memory of Max Silver
Shirley and Bob Smith
Joanne Smith

In memory of Hester Katz
Margie Golick

In memory of Ted Outram
Heather Geary

In memory of Gertrude Rosenberg Silver and Louis Silver
Debby Mayman and family

In memory of Irving Ungar
Brenda Wahl

In memory of Joseph Gyori
Gabrielle Gyori

In memory of Monty Berger
Alvin J. Guttman
Miriam Berger

In memory of Freida Bluma Polter
Claudia and Jerry Ikeman
Lorna Moscovitch

In memory of Marie and Claude DesRosiers
Lucie and Raymond DesRosiers

In memory of Daniel Rosenberg
Rachel Hoffman

In memory of Deborah Richardson
Elsie and Doug Richardson

In memory of Naomi Fitch
Meta Fitch and family

In memory of Susan Leger
Sheila Leger

In memory of Anna Fortin
Francis Fortin

In memory of Lily Cassidy
Muriel Bérubé

In memory of Lois and Philip Berman
Herb Beiles

In memory of Rosa and Paul Baatz
Paul Baatz

AMI-Québec extends sympathy to the bereaved and appreciation to all donors for their generosity. For information, please phone 514-486-1448.

AMI-Québec Membership & Donation Form

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Membership

Membership includes the quarterly *Share&Care*, other mailings and lecture announcements, access to support groups and education programs and all other activities. Complimentary membership is available for people with limited incomes.

- ☐ **I wish to renew my membership**
- ☐ **I wish to become a member**
- ☐ I have a family member with a mental illness
- ☐ I have a mental illness
- ☐ I am a mental health professional

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***Choice** … continued from page 6*

between hospital staff, consumers and families would promote an understanding of the complexities involved and a realization that restraints are meant to assist recovery, not to control. By extension, this could make a major contribution to reducing the stigma attached to being mentally ill.

The goal of recovery-oriented treatment and care is less about behavior control and more about establishing working relationships with the person who is ill. This approach provides an opportunity for consumers to learn ways of gaining greater autonomy over their own lives and behavior with less reliance on external controls.

Stigma remains a major factor for anyone confronting mental illness. Restraints, as a means of control, perpetuate the stereotype of the "insane person" so wild that society needs to be protected. They recall the frightening sight of the straitjacket so often portrayed in movies or comedy sketches.

As a committee that advocates in the care and treatment of the mentally ill, we strongly suggest that everyone, — hospital staff, consumers and families — when faced with a situation where a patient is physically restrained, pause and seek an answer to this question: Was it really the **first choice** or the **last resort** to manage the circumstances at hand? ❐

This issue of *Share&Care* has been made possible by an educational grant from Janssen-Ortho.

amiquébec

Agir contre la maladie mentale
Action on mental illness

AMI-Québec, a grassroots organization, is committed to helping families manage the effects of mental illness through support, education, guidance and advocacy. By promoting understanding, we work to dispel the stigma still surrounding mental illness, thereby helping to create communities that offer new hope for meaningful lives.

Mental illnesses, known to be biologically-based brain disorders, can profoundly disrupt a person's ability to think, feel and relate to others. Mental illness affects not only individuals, but also their families, friends and everyone around them.

Lorna Moscovitch, *President*
Renée Griffiths, *Vice President*
Annie Young, *Vice President*
Joseph Lalla, *Secretary*
Claudia Ikeman, *Treasurer*
Paul Rubin, *Immediate Past President*
Ella Amir, *Executive Director*

SHARE & CARE

Share&Care is published quarterly for members of AMI-Québec and mental health professionals.

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