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Winter 2011 VOL. 34 No. 1

SHARE & CARE

THE RECOVERY OF HOPE ~ THE HOPE OF RECOVERY

NO TIME TO LOSE

The best way to deal with a mental health problem? As quickly as possible

Whether it's a teenager showing troubling behavior, an adult heading for a relapse or someone who sees no reason to keep on living, the right sort of intervention can make all the difference to the outcome. And right means the sooner the better.

PEPP at the Douglas Institute, Mental Health First Aid and Suicide Action Montreal are three quite different groups working in totally different ways. But they all agree that time is their best weapon when acting to ward off serious trouble.

No Time to Lose

~1~

MENTAL HEALTH FIRST AID
building awareness from the ground up

If you break a leg, first aid will see you through until you get to a hospital. That's the principle behind Mental Health First Aid (MHFA): it's giving help to a person struggling with a mental health problem or in crisis until a professional caregiver can take over.

Launched in Canada in 2006 by the Alberta Mental Health Board, support for MHFA went national in 2010 when the Mental Health Commission of Canada brought the program under its roof. MHFA originated in Australia in 2001 and now operates in 15 countries. Its primary mandates are to educate people about the importance of recognizing the signs of an individual in distress, to teach them how to provide effective early intervention and to reduce stigma by emphasizing compassion, caring and understanding.

Most family members coping with a loved one's illness know only too well the symptoms of impending trouble. MHFA is focused on broader segments of the population that are generally not as knowledgeable: the business world, education, law enforcement groups (among the program's strongest supporters), even some healthcare institutions.

A five-day training program is offered, after which successful participants become certified trainers. They in turn conduct 12-hour training sessions at their place of work or in their communities-at-large. The trainers are not employees of MHFA, but do receive ongoing support. They set their own schedules and charge a fee to course attendees.

Two courses are currently being given. The basic one is aimed at adults. The youth course focuses on adults who interact with youth ages 12 to 24, but it's also suitable for young people 18 and over. Courses for First Nations people and for seniors are in the discussion stage.

During their course, attendees are taught how to be first responders. They learn what to watch for (unusual or erratic behavior, signs of depression or anxiety), the right way to connect whether the cause of the crisis is anxiety, stress or a psychotic break, and how to be effective should the person be a friend, a loved one or a stranger on the street.

Stigma at the root

Most people are willing to lend a hand when the emergency is a medical one. They shy away when they see someone struggling with what looks like a mental health situation. The resulting sense of isolation only adds to the suffering. Says MHFA master facilitator Keith Turton in Calgary, "A large part of what we want our course to do is break down the stigma by increasing mental health literacy

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How sweet it was!

"Mind, Body & Soul," our fundraising event held last October at Avanti le Spa, was an unqualified success. Pampering spa services, delicious food, music and prizes galore provided a fun-filled evening for close to 100 attendees. Our support and education programs also came up winners, with nearly $13,000 being raised to keep them going strong.

Mental Health First Aid *... continued from page 1*

within the population. That means being able to identify a problem situation, talk about it and refer the person to an available mental health service." But it doesn't always have to come to that. Sometimes a sympathetic ear is enough to calm a situation.

Eventually Turton would like MHFA training to become mandatory at all places of employment and given the same priority as standard first aid or CPR. Human resources professionals and workplace health and safety representatives are two groups that would find it especially beneficial, he says.

There are now more than 355 MHFA instructors in Canada. They have trained more than 30,000 mental health first aiders in eight provinces and all three territories. Courses are given in French and English and are open to the general public. It's not necessary to know someone with a mental illness to participate.

At present MHFA is looking for French-speaking instructors, whom they will train in either official language. For more information on this or any pertinent subject, go to **mentalhealthfirstaid.ca**. ❐

No Time to Lose

~2~

PEPP early start, better finish

"The long-term outcome of a psychosis often depends on what happens in the first two to five years."

So says Vidya Iyer, coordinator of the PEPP program at the Douglas Institute. And there's solid evidence to support her claim.

PEPP, begun in 2003, provides assessment and specialized treatment services for people in the first stages of psychosis. It's a two-year program with a research extension to five years possible for some.

Acceptance is limited to 14-35-year-olds who have had little or no treatment for their illness — less than 30 days, to be exact. For most, it will be their first time. Illnesses treated include affective psychosis (bipolar disorder or major depression with psychotic features) and non-affective psychosis (schizophrenia, schizoaffective disorder and delusional disorder).

A few other restrictions: clients need to live within a 30-minute drive of the Douglas and they can't be suffering from epilepsy, mental retardation or psychosis brought on by substance abuse.

Not the usual

There are standardized psychiatric services and then there's PEPP with its specialized early-intervention service. The approach is different right from the start, considerate of the sensibilities of their many young clients.

There's an open referral system. No need for a visit to a GP or a psychiatrist. Anyone can refer — a school counselor, a family member or friend, even the clients themselves.

In the interest of saving time and avoiding an untreated psychosis, there's a rapid screening policy: every screening request is filled within 72 hours at the latest; most often it's the same day. For people reluctant to visit the hospital, the screening can be done somewhere more convenient.

"We have what we call a modified assertive case management approach," says Iyer. "Everyone who enters the program is assigned a case manager and a psychiatrist. Both of them follow their clients from start to finish." In other treatment programs, patients can have different people taking care of different things and it's easy for details and information to get lost in the shuffle. PEPP clients can feel secure knowing their case manager does it all for them, accompanying them to their appointments, tracking schedules, keeping everything nicely under control.

Iyer: families are our allies

Family involvement is an important part of PEPP's mandate. "We always try to meet families within the first week so we can reassure them and answer their questions," says Iyer. "They're often important allies in the program and we encourage their support. The case managers are in constant touch with them because they know what's going on and can supply us with important information. Especially early on in the treatment, they're often the ones seeking help, so we make family psycho-education and other interventions available. Their involvement makes a big difference to the outcome. With young clients especially, I'd say it's vital."

Just a little bump

Clients largely set the pace at PEPP. There's no authoritarian "here's what you do, here are your meds" approach. At the beginning, patients see their case manager and psychiatrist a few times a week, much less as recovery progresses. But meetings don't always have to happen at the clinic. Visits can be arranged at home or a favorite coffee shop. Medication is prescribed at the lowest possible level for symptom control. Should a patient want to try doing without, that's possible, too. It's all consistent with PEPP's goal of a quick return to a normal routine. "Everything we do is to prevent or minimize hospitalizations and ER visits and get people back on track," says Iyer. "If they're in CEGEP, we want to see them back there. If they hope to find a job, we'll help them get one — not in a sheltered workshop, but a paying job in the community. We consider the illness just a little bump and then the road smoothes out."

A research program

PEPP has always been a clinical research program. That orientation shows in the many assessments done periodically throughout a treatment. Explains Iyer: "We're not happy saying, 'Oh, the client is doing better.' What does that mean? We

want to have some objective criteria for remission, relapse and our understanding of the client's quality of life."

From the beginning PEPP has undertaken a variety of research projects to understand every aspect of the course and outcome of a first-episode psychosis: who does well and who doesn't; how to prevent relapse; how do people come through the ER; who gets referred by a GP; why do some people take longer than others to get into the program; who takes medication; why do some clients start and then stop; how does self-esteem change over the course of the program. "We've presented our findings and published a lot," says Iyer. "It's not an exaggeration to say that we're considered one of the leading programs in Canada in first-episode psychosis prevention and research."

A new study

In 2008 PEPP began a study on duration. The feeling was growing that some people needed more than just two years of specialized intervention, that they might do much better later on if they were followed longer. But how long? No one had answers.

Now there's a research project to tackle the question. After clients have spent their two years in the program, they're asked to participate in a randomized trial. Some patients will continue to be followed by PEPP for three more years, others will receive regular psychiatric care for the same period of time. By 2012 or 2013 results of the study should provide a good fix on which duration of intervention produces better outcomes and whether PEPP could be more effective by lengthening its program.

Since 2003 PEPP has accepted 352 clients for treatment. Of these, about 20 percent dropped out in the first year, far fewer than the norm in regular psychiatric services. Remission percentages are higher at PEPP and so are those for function and outcome, meaning the number of people who return to their normal life and go back to school or work.

The hope is that, if the research findings justify it, increased funding will allow PEPP to extend its services. For families and their loved ones coping with the frightening development of a first psychosis, that day can't come soon enough. ❐

2010 Low-Beer Lecture

NEW HOPE FOR THE HOMELESS

Finally, those who've lived it are having input on tackling the problem

Côté, centre, with panelists Chris and Billie-Jo

Attendees of this year's Edith and John Hans Low-Beer Lecture were given a wide-angle look at a perennial health and social issue: how best to help the mentally ill population living on the streets.

Unless you've been there, your experience of street life can only be second-hand. Jijian Voronka was there, and recounted her existence as a self-described young, angry street kid with mental health issues. Her brother, who died at age 21 in a wretched transitional house, led a tragic life. But Voronka escaped. Now a PhD student in sociology at the University of Toronto, she's also heavily involved with the Mental Health Commission of Canada's At Home/Chez-Soi project as a consumer research consultant and a founder of their national consumer panel.

Voronka is just one consumer — there are 80, she estimates —tapped by the Commission to be consultants, peer support workers, research interviewers and organizers. They're working for real, viable change based on real understanding. Many of their suggestions have become policy procedures.

Sonia Côté, Montreal's site coordinator of At Home/Chez-Soi, provided an overview of the project and the consumer-inclusive approach that sets it apart.

At Home/Chez-Soi is a five-year, $110 million national research study now underway in Vancouver, Winnipeg, Toronto, Montreal and Moncton. The largest study of its kind anywhere, it seeks to learn more about the experiences of mentally ill people living homeless so as to better understand which services and housing practices would be most helpful to them.

The project drew inspiration from the highly successful "Housing First" program now in place in New York City. Its long-term goal is nothing less than

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No Time to Lose

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SUICIDE ACTION MONTREAL
help when it's needed most

You could walk by the building daily and have no idea what's happening inside. On purpose there's no name plaque, nothing to attract the eye.

Suicide Action is a telephone crisis intervention service whose clients are people edging dangerously close to self-destruction. Opened in 1984, it's free, confidential and anonymous, the only service of its kind in Montreal.

About 30 staff members and an army of 250 volunteers are dedicated to one goal: preventing suicide. Their hotline is the nerve centre of the operation. It's open all day, all night, all year and is run primarily by the volunteers. Thoroughly trained and supervised, they field some 20,000 calls a year, most of them from people in distress.

Beyond its core service, Suicide Action also trains healthcare professionals to be effective interveners when working with people who are suicide-intent. CLSCs, school systems and other community groups regularly refer clients. Worried or grieving family members call for advice and information sessions can be arranged for concerned relatives and friends.

We must be doing something right.
Last year, and now this year again, substantial funding from the Canada Post Foundation for Mental Health has come our way. The foundation, established in 2008, distributes grants to frontline community groups helping families and individuals cope with mental illness. Here, foundation representatives and executive director Ella Amir, right, at the presentation.

Encouraging news in Quebec

Sharon Casey is one of three trainer/consultants. She says that while Quebec still ranks first in suicides in Canada, the numbers are decreasing. "The rate today is the lowest it's been in 25 years. The numbers for youth have been declining steadily since 1998 and nobody knows exactly why. Today it's the 30-50 year old population that's most at risk."

And it's a male profile. Eighty percent of deaths by suicide are males. Ironically they're the ones least likely to ask for help. The traditional male role (be stoic, suck it up) still applies. "It's one of the reasons our mandate includes family members," says Casey. "If a wife calls who's worried about her husband, but he won't go near the phone, we'll help her so she can get help for him." Finding ways to reach men more effectively has been a goal in recent years.

The heart of the matter

Suicide is the absence of hope, the feeling that the suffering will never change and ending it all is the only solution. Everyone who's suicidal shares those same feelings and effective telephone intervention requires skill.

"These aren't cases or problems to be solved, they're people," explains Casey. "The communication must be human, not a diagnostic checklist. People have resources, abilities and competencies, something that's brought them this far. We need to identify it, because that's what will protect them. Once we put people in contact with their strengths, then we've got a basis to work from. At the same time, we have to read the situation. Is there time to talk? Is a detox service or crisis centre the next step or should an ambulance be called? Very often, people have second thoughts at the last minute. If we're there at that point we can make a huge difference."

Casey: find the strength and work with it

Even better is to be there at the start, when the black thoughts are growing but there's no plan in place yet and the thought of suicide can be frightening. Those are the cases that are quickest to resolve.

What families can do

Families can play a huge role in preventing the suicide of a loved one. It's human nature to want to avoid grappling with the possibility of such a tragedy, but knowing what to look for and how to react is critical.

1. Look for changes. Changes in behavior and attitude can be warning signs. Sleeping all the time or not enough. Not eating. Letting health or appearances go. Deviating from a normal routine isn't always an omen, but it should be cause for suspicion.

2. Listen for verbal messages. They can be direct, as in "I want to kill myself, I want to end it all." Or indirect, "My problems will soon be over." "You won't have to worry about me much longer."

3. Don't automatically assume the worst. Instead, put the question frankly: "Are you thinking of killing yourself?" If you can't bring yourself to be so blunt, get help. "Call us," says Casey, "and together we'll work it out so you can get an answer."

True or false?

Misinformation about suicide abounds and some myths can be toxic. The most dangerous ones are also among the most common:

1. Don't ask because you'll give them ideas. "You can't push someone to begin thinking about suicide by asking a question," Casey says. "What you can do is give them a huge sense of relief that the subject is up for discussion. We have clinical research that backs me up 100 percent on this."

2. Those who talk about it never do it. Not true. Most people who commit suicide did talk about it one way or another beforehand.

3. They're just trying to manipulate you or get attention. Casey: "People talk about suicide because they're suffering, not because they crave attention. But really, if their need to be taken care of is so strong that they're willing to pay the ultimate price, surely that's enough to provide them with the attention they crave."

4. Suicide rates spike at Christmas. Actually, no. But they do soar whenever news of a suicide, particularly when it's a well-known person, hits the media. That makes the vulnerable feel even more so.

Life is hope

Suicide is a balance: as suffering increases, hope diminishes. That's why Suicide Action considers time so vital. The sooner a problem is identified, the easier it is to reinstate hope. "But even at the worst moment, people are ambivalent about ending their life," Casey notes. "As long as they're alive, a small grain in them wants to live. We can work with that. We can intervene right up to the very last minute."

Suicide Action Montreal can be reached 24/7 at **514-723-4000**. Their web address is **www.suicideactionmontreal.org**. To talk to someone in suicide prevention in other regions of Quebec, call toll-free **1-866-277-3553**. ❐

TANYA GUALTIERI
and her generous students

CDI College is a community college offering training for careers in business, technology and healthcare. Instructor Tanya Gualtieri teaches a healthcare course, which includes a module on mental health. To deepen her students' understanding and empathy, Gualtieri goes far beyond textbook information and explanation: she has her class assume the role of people in the grip of various mental illness and disorders.

We were pleased to learn that Gualtieri has cited AMI and the important work we do in support of families. Doubly pleased, in fact. We recently received a donation from her students so that, in her words, "the hope might continue to develop without end." ❐

HOW SKA AND REGGAE MUSICIANS
became our new best friends

With his talents as a saxophonist, singer and arranger, John Jordan was one of the masterminds behind the skyrocket-success of the Me Mom and Morgentaler band during the '90s.

His world came crashing down in 2001 when he was diagnosed with bipolar disorder. Through a time of turmoil marked by hospital stays, the loss of his home and abandonment by many friends and colleagues, AMI support groups provided the haven Jordan so desperately needed.

As therapy for regaining control over his life and emotions, Jordan and two friends began working on a new music project called Osmosis Unlimited. They produced demos, assembled a band and now, seven years later, have released their first CD. "The One For You" features 12 tracks of reggae, ska and rock. It's sold at their concerts and is available worldwide on iTunes, Amazon and other e-tailers.

And here's the beauty part: for every CD sold, Osmosis Unlimited is donating $5 to AMI. Explains Jordan: "AMI was an invaluable resource for me. Their support groups taught me the importance of peer support and the value of being part of the mental health community. We hope that by spreading the word about this important community resource we can help both those diagnosed and their families find the help and support they need."

For more information visit **www.osmosisunlimited.com**. ❐

John Jordan (r) with reggae singer Hayes "Kali" Thurton

WINTER 2011

SUPPORT GROUPS
Mondays 7:30pm 4333 Côte Ste-Catherine Road
unless otherwise indicated. No registration necessary.

FAMILY for relatives
January 10, 17, 24; February 7, 14, 21; March 7, 14, 21

SIBLINGS AND ADULT CHILDREN
January 17; February 14; March 14

BIPOLAR DISORDER for consumers and relatives
January 24; February 21; March 21

DEPRESSION for consumers and relatives
January 24, February 21; March 21

OBSESSIVE COMPULSIVE DISORDER for consumers and relatives
January 17; February 14; March 14

HOARDING GROUP (in collaboration with Quebec OCD Foundation)
January 10; February 7; March 7

ANXIETY for consumers and relatives
January 10; February 7; March 7

PAC Parents of Adult Children
7:00pm at AMI
January 18; February 17; March 15

KALEIDOSCOPE for consumers
January 17; February 14; March 14

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

SOUTH SHORE for relatives
Wednesdays 6:30pm
Greenfield Park Baptist Church, 598 Bellevue North, Greenfield Park
January 12, 26; February 9, 23; March 9, 23

REGISTRATION REQUIRED for programs below
Call AMI for details or to register

Mood and Thought Disorders
6-session program begins February 1

Roundtable Discussions
March 21, April 25

Teleworkshops
January 19; February 16; March 16

Telesupport Groups
January 25; February 22; March 22

BOARD MEETINGS
Tuesdays 7:00pm at AMI
January 11; February 8; March 8

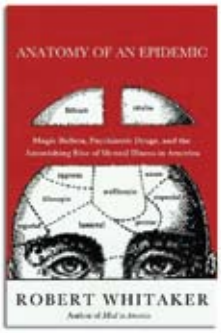
BOOK REVIEW

Robert Whitaker

Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America

(Crown Publishers, New York, 2010; 396 pages; $32.)

Reviewed by Robyn Belkin



Award-winning journalist Robert Whitaker (author of *Mad in America*) has written a new book that raises a pointed question: Why have the numbers of mentally ill on government disability rolls tripled during the very years when, supposedly, effective treatments have been found for these illnesses?

Anatomy of an Epidemic challenges what we have come to accept as true about the biological causes of mental disorders and the advances made in psychopharmacology in the past twenty years. Systematically researched, persuasively argued, lucidly written and immensely readable, it presents a wealth of evidence suggesting that psychiatric drugs may not be all they are cracked up to be: that their effectiveness is belied by long-term outcomes, and that when taken on an ongoing basis, they may do more harm than good.

If this book had been written by a psychiatrist, it might now be spearheading a revolution within the profession, or at least a long-overdue reassessment of the current paradigm of care. But coming from a journalist, it is less likely to be considered required reading by the psychiatric community. This is a shame. Whitaker cites study after study reporting that long-term outcomes for mental illness are worsened, not improved, by extended use of psychiatric medications — indeed, that long-term prognoses are better when the drugs are taken for a shorter time, and best when there has been no exposure to them at all. These are studies we do not see in the media, where the focus naturally is on promising new developments as reflected in short-term studies.

Whitaker describes a familiar pattern: while the drugs appear initially to work, they lose their effectiveness over time, yet patients cannot stop taking them because when they do, symptoms return and are exacerbated in a rebound effect. This necessitates increased doses and/or additional drugs, with attendant complications and often deleterious side effects. His search of the literature did not unearth any scientifically-based evidence that mental illnesses are caused by brain imbalances — but he did find documented evidence that the drugs cause changes in the brain.

Whitaker's premise is that the ongoing use of psychiatric drugs may actually *create* chronicity of the illness — besides triggering a host of physical problems. He is particularly concerned that the drugs are prescribed to adolescents, and, increasingly, even to very young children. In his last

continued on page 8

Low-Beer *... continued from page 3*

ending homelessness among the mentally ill by providing housing first of all, along with the support and treatment necessary to promote recovery and integration into the community. The difference is, At Home/Chez-Soi seeks to do this not by prescribing, but by asking: "What do you think would work best for you? The choice is yours."

The fundamental question to be answered is whether people who can choose where they live and which services they receive fare better than those who receive standard services and housing options. Researchers will also want to learn what works for whom, how it works and at what cost. Across Canada, 2,285 people are participating in the project, 500 of them in Montreal. The project's challenge becomes clear when you understand that, in this city alone, there are 15,000-20,000 homeless people, many suffering from both mental illness and addiction problems.

Since the launch of At Home/Chez-Soi in 2009, hundreds have been housed and are receiving support. The Low-Beer evening concluded with the introduction of four participating Montrealers. Each one had a sadly familiar story to tell, but they were all in the past tense. The group credited At Home/Chez-Soi with giving them better dreams to plan for. Getting back to society, helping teens make good choices and building a family life were high on their wish lists.

Given the size and complexity of the homeless problem here and across Canada, it's easy to despair of solutions emerging any time soon. Yet self-esteem and happiness to someone without a bed to curl up in at night can be quite simple. Asked what he craved when living on the street, one of the panelists answered, "Four walls, a roof and a key of my own." ❐

DOWNLOAD IT NOW:

the information you need to protect your ill relative's future

Sharing The Care is a document laying out the financial and legal facts every family should know in order to plan for their ill relative's security in the future. Written and recently updated by lawyer Marilyn Piccini Roy, a member of our advisory committee, *Sharing The Care* is available in our library for reading at the office. Or you can download it from our website. Go to **www.amiquebec.org**. ❐

TRIBUTES & MEMORIALS

In honor of Pat and Paul Rubin
Norma and Leonard Newman

In honor of Harold Bricks
Marylin and Jeffrey Block

In honor of a special birthday for Sandra Moss
Nancy Katz
Eva and Harvey Kuper

In honor of Abe and Barbara Weiss
Michael, Fran and Howard Brenhouse

In honor of Dr. Daniel Frank
Michael, Fran and Howard Brenhouse

In honor of friends made at Chez-Doris
Elizabeth Tremain

In honor of Dr. Janique Harvey and Marie-Louise Snowboy
Saul Friedman

In honour of Paul Rubin and family
Edward Schachter

In honor of Mr. and Mrs. William Klein's wedding anniversary
Sonia Weinzweig

In honor of Anita Miller
Frank Kagan and Elsa Kisber

In honor of Riva and Carl Gelber's birthdays
Doris Evin

In honor of Nancy Taub
Dora Gesser

In honor of Steven Cummings
Sherry Ellen

In memory of Pieter Boudens
Beppie Boudens
Mr. and Mrs. Ching Suen

In memory of Saul Cohen
Barbara and Leonard Freedman
Claudia and Jerry Ikeman

In memory of Manuel Whitzman
Delores Breitman

In memory of John Simpson
Kay Simpson

In memory of Debbie Richardson
Kay Simpson

In memory of Gus Boudens
Kay Simpson
Beppie Boudens

In memory of Noll Lederman
Jacqueline Gerols
Jeannette Sayegh

In loving memory of Liz Kane
Sally McNamara

In memory of Morris Kerbel
Marylin and Jeffrey Block

In memory of Florence Pripstein
Pat and Paul Rubin

In memory of David Lazarus
Lynn and Andy Nulman

In memory of Vincenza D'Iorio
Debbie Toth and family

In memory of Nicolas Busch
Erica Cavallini
Debbie Toth and family

In memory of Marion Verrall
Sally and David Verrall

In memory of Bonnie Henke
Kay Simpson

In memory of Patricia Mullins
Kelly Morel

In memory of Doug Richardson
Kay Simpson

In memory of Dr. Samarthji Lal
Kay Simpson

In memory of Brendan Dixon
Arlene and Danny Berg and Manon Covell and Dr. Gendron

In memory of Murray Marmor
Claudia and Jerry Ikeman

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

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Book Review *... continued from page 6*

chapter, he looks at initiatives in the United States and Europe that are producing good long-term outcomes for both adults and children by using meds very cautiously or not at all, in conjunction with humane and supportive cognitive therapies.

The criticism most often voiced about his book is that Whitaker mistakes correlation for cause. The rise in disability rates during the years when drug treatment became standard may say more about changing definitions of disability than about the impact of meds. But Whitaker says that, so far, no critic has come up with studies he failed to cite, showing that drugs improve long-term outcomes.

Possibly we are all addicted to the "chemical imbalance" paradigm. Doctors, patients, and families all want to believe that a pill can restore "normality" to the mentally ill, just as insulin does for diabetics. Besides holding out hope, the biological paradigm has brought relief to parents and families who, on the Freudian model, used to be blamed as having caused their loved ones' illnesses (this is a subject Whitaker does not adequately address.) But if the "brain disease" theory is, as Whitaker claims, still only a theory, and one with no conclusive evidence to support it, we may need to be willing — no pun intended — to change our minds.

Whatever else, this is not a book to ignore. ❐

JANSSEN-ORTHO

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.

SHARE&CARE

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

Ella Amir, *Managing Editor*
Bryna Feingold, *Associate Editor*
Liane Keightley, *Designer*

Articles and comments are invited. Anonymity will be respected if requested. Guest articles reflect the opinions of the authors and do not necessarily reflect the views of AMI-Québec.
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Member of La Fédération des familles et amis de la personne atteinte de maladie mentale (Québec)