



NAMI CCNS
Box 612
Winnetka, IL 60093

Place
Stamp
Here

NAMI CCNS EDUCATION CLASSES, SUPPORT GROUPS AND OTHER SERVICES

**NAMI CCNS' psychoeducational classes*

***WRAP** A free, 12-week self help and recovery course taught by adults in recovery to adults recovering from brain disorders. WRAP is designed to: decrease and prevent intrusive or troubling feelings and behaviors; increase personal empowerment; improve quality of life; and assist people in achieving their life goals and dreams. For information and registration, call NAMI CCNS at 847-724-1460.

***Visions for Tomorrow** An 8-week course designed for primary care givers of children with mental disorders. The class covers bipolar disorder, schizophrenia, anxiety disorders, eating disorders, ADHD, as well as brain biology, treatments, medications, communication and coping skills. Class is free of charge. Call Barb Maier for information at 847-446-8416.

***Family to Family** A 12-week class designed for family members and close friends of individuals with mental illnesses. The course covers schizophrenia, depression, bipolar disorder, borderline personality disorder, panic disorder, obsessive compulsive disorder, co-occurring addictive disorders, as well as medications, coping skills, and advocacy. Class is free of charge. To register, call Joyce at 847-853-6191.

General Meeting is an educational program featuring speakers with expertise in the mental health field. (See Calendar)

Care and Share is a support group for people with mental disorders, as well as their friends and families. (See Calendar)

Visions for Tomorrow Support and Discussion Group is for parents of children, adolescents, and young adults with mental disorders. Call Barb Maier for information at 847-446-8416. (See Calendar)

Response Team A "warm line" (not a crisis hot line) for anyone looking for resources, referrals (or just a chance to connect to others) about dealing with mental disorders. Call the NAMI CCNS office and leave a message at 847-724-1460.

Sundays at One is a social meeting group for young adults (ages 18 to 35) coping with mental disorders. Run by Alan Carlile, Candice Savastio, and Nathan Maier (who struggle with chemical imbalances). Call Nate at 847-446-8416. (See Calendar)

Other Organizations

Anorexia Nervosa and Associated Disorders offers information on referrals and local support groups for eating disorders. Call Dawn at 847-831-3438.

Child and Adolescent Bipolar Foundation is a national, parent-led organization of families raising children diagnosed with bipolar disorder. For information on support groups, visit www.bpkids.org or call 847-256-8525.

Depression and Bipolar Support Alliance of Greater Chicago meets the second and fourth Monday of each month at the Devon Bank, 6445 N. Western Ave., Chicago. 7:30 pm. Call Chet for details at 773-465-3280.

Depression Support Group meets the fourth Monday of every month at the Kenilworth Union Church, 211 Kenilworth Avenue, Kenilworth, 7:00-9:00 pm. Individuals and families interested in learning more about depression and bipolar disorder are invited to attend. Call 847-251-4272 for information.

Obsessive Compulsive Disorder Support Group meets the first Monday evening of each month at the Anxiety and Agoraphobia Treatment Center in Northbrook. \$20 fee. Call Alana at 847-559-0001, ext. 8.

Obsessive Compulsive Foundation of Metropolitan Chicago has a complete list of area support groups. Call 773-880-1635.

Panic Disorder Support Group meets Wednesday evenings at the Anxiety and Agoraphobia Treatment Center in Northbrook. \$15 fee. Call Marleen Lorenz for information at 847-559-0001, ext. 6.

Recovery, Inc. is a self-help group for people with mental disorders. Call 312-337-5661 for meeting places and times.

TARA Chicago Personality Disorder/Emotion Dysregulation Support Group Professionally-led group for family members of persons with BPD or other emotional dysregulation issues. Meets the third Wednesday of each month at the Northwestern Memorial Hospital conference facility in Chicago. 6:30-9:00 pm. \$5 per session donation. Please email: rh5mail-tara@yahoo.com before attending for information. (See Calendar) ■



Medication Update

Paxil: New Changes in Warnings

GlaxoSmithKline and FDA notified healthcare professionals of changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information for Paxil and Paxil CR. These labeling changes relate to adult patients, particularly those who are younger adults.

A recent meta-analysis conducted of suicidal behavior and ideation in placebo-controlled clinical trials of paroxetine in adult patients with psychiatric disorders including Major Depressive Disorder (MDD), other depression and non-depression disorders. Results of this analysis showed a higher frequency of suicidal behavior in young adults treated with paroxetine compared with placebo. Further, in the analysis of adults with MDD (all ages), the frequency of suicidal behavior was higher in patients treated with paroxetine compared with placebo. This difference was statistically significant; however, as the absolute number and incidence of events are small, these data should be interpreted with caution. All of the reported events of suicidal behavior in the adult patients with MDD were non-fatal suicide attempts, and the majority of these attempts (8 of 11) were in younger adults aged 18-30. These MDD data suggest that the higher frequency observed in the younger adult population across psychiatric disorders may extend beyond the age of 24.

It is important that all patients, especially young adults and those who are improving, receive careful monitoring during paroxetine therapy regardless of the condition being treated.

New Warnings in Labeling for Clozaril

Novartis has notified healthcare professionals about new warnings and drug information in the labeling for the antipsychotic drug Clozaril (clozapine). Patients taking clozapine are at increased risk of potentially life-threatening agranulocytosis. The labeling has required white blood cell monitoring for these patients. The new labeling provides for a number of changes regarding the WBC monitoring program. The frequency of monitoring may be reduced to once every four weeks after the first year of clozapine treatment in patients who have maintained satisfactory white blood cell (WBC) counts. Monitoring instructions for the first year of therapy remain the same: weekly for the first six months, and every two weeks for the second six months. A new requirement to determine and report the absolute neutrophil count has been added. Previously, only the total white blood cell count was required. There are new WBC requirements for initiating clozapine therapy: the total WBC count must be at least 3500 per mm³ and the absolute neutrophil count must be at least 2000 per mm³. If a patient experiences a moderate decrease in either total white blood cell count or absolute neutrophil count, evaluate the risks and benefits of continuing clozapine treatment. If clozapine is continued, white blood cell counts must be monitored weekly for the next 12 months. The new labeling also warns of increased mortality in elderly patients with dementia that have received clozapine to treat behavioral symptoms, and it reminds physicians that this drug is not approved for use in dementia-related psychosis. There is also a new contraindication in patients who have paralytic ileus.

Continued on page 5

From the Co-Presidents

Dear Members,

I was reading the papers the other day, when the following headline caught my eye: "Ill Spouses Take Toll on Partners." Was this surprising? Hardly. The finding is the result of a Harvard University Medical School study published in the February 16 issue of the *New England Journal of Medicine*. Dr. Nicholas Christakis, lead investigator of the study, said, "People are interconnected, and their health is, too."

What particularly struck me was the finding that brain disorders, such as dementia and other psychiatric disorders, had a far greater impact on caregivers' health than physical illnesses like cancer and chronic heart failure.

For family members caring for people with mental disorders, this is a daily fact. It is important for each of us to remember that while caring for those we love, we need to take the time to care for our own physical and emotional health, as well. I hope, too, that this article will remind health care providers of the importance of caring for the caregivers as well as the patients.

On another note, congratulations to Julie Savastio, Tag Day chairman, and to everyone else who worked so tirelessly to make Tag Day a success. NAMI CCNS is truly grateful to all who participated (*for more on Tag Day, please see page 4*).

Finally, NAMI Illinois is looking for a volunteer to design a PowerPoint presentation about NAMI Illinois. The program would run continuously at the NAMI Illinois State Conference in Northbrook, October 20-22. If you are interested, call Barb Maier at 847-446-8416.

Please join us at our next Board meeting June 7 (*see Calendar for details*). Board meetings are open to all NAMI CCNS members and are a great way to find out more about us and what we do. If you'd like to reach Candice or me directly, please e-mail us at (Candice) CHughesNAMICCNS@aol.com or me at anngeorge@comcast.net, or call the NAMI CCNS office at 847-724-1460.

Respectfully yours,

Candice Hughes and Ann George

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Editor: Linda Logan, Ph.D.

Questions, comments?

Please e-mail:

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Visit our website: www.namiccns.org

Website maintained by Tom Maier

June July 2006



Calendar

June 7 Board of Directors meeting at Wilpower, Inc. 444 Frontage Road, Northfield, 7:30 pm. Meetings are open to all NAMI CCNS members.

June 13 “Care and Share” is a support group for caregivers, friends and family, and individuals with mental disorders. New participants welcome; registration not required. Rush North Shore Medical Center (Sharfstein 2 East room), 9600 Gross Point Road, Skokie, 7:30 pm.

June 8 “Visions for Tomorrow” support and discussion group for parents of children, adolescents, and young adults with mental disorders. Kenilworth Union Church, 211 Kenilworth Ave., Kenilworth, 7:30 pm. Call Barb Maier for information 847-446-8416.

June 23-25 TARA Weekend Family Educational Workshop on Dialectical Behavioral Therapy Coping Skills. Contact rh5mail-tara@yahoo.com

June 25 “Sundays at One” is a support group for young adults with mental disorders who’d like to get together. Borders Bookstore, 49 S. Waukegan Road, Northbrook, 1:00-3:00 pm. For information and registration, call Nate Maier 847-446-8416 or Alan Carlile 847-736-4587.

June 28-July 2 NAMI National Annual Convention, Washington, D.C. For information and registration, visit nami.org and click on NAMI 2006 Convention or email convention@nami.org

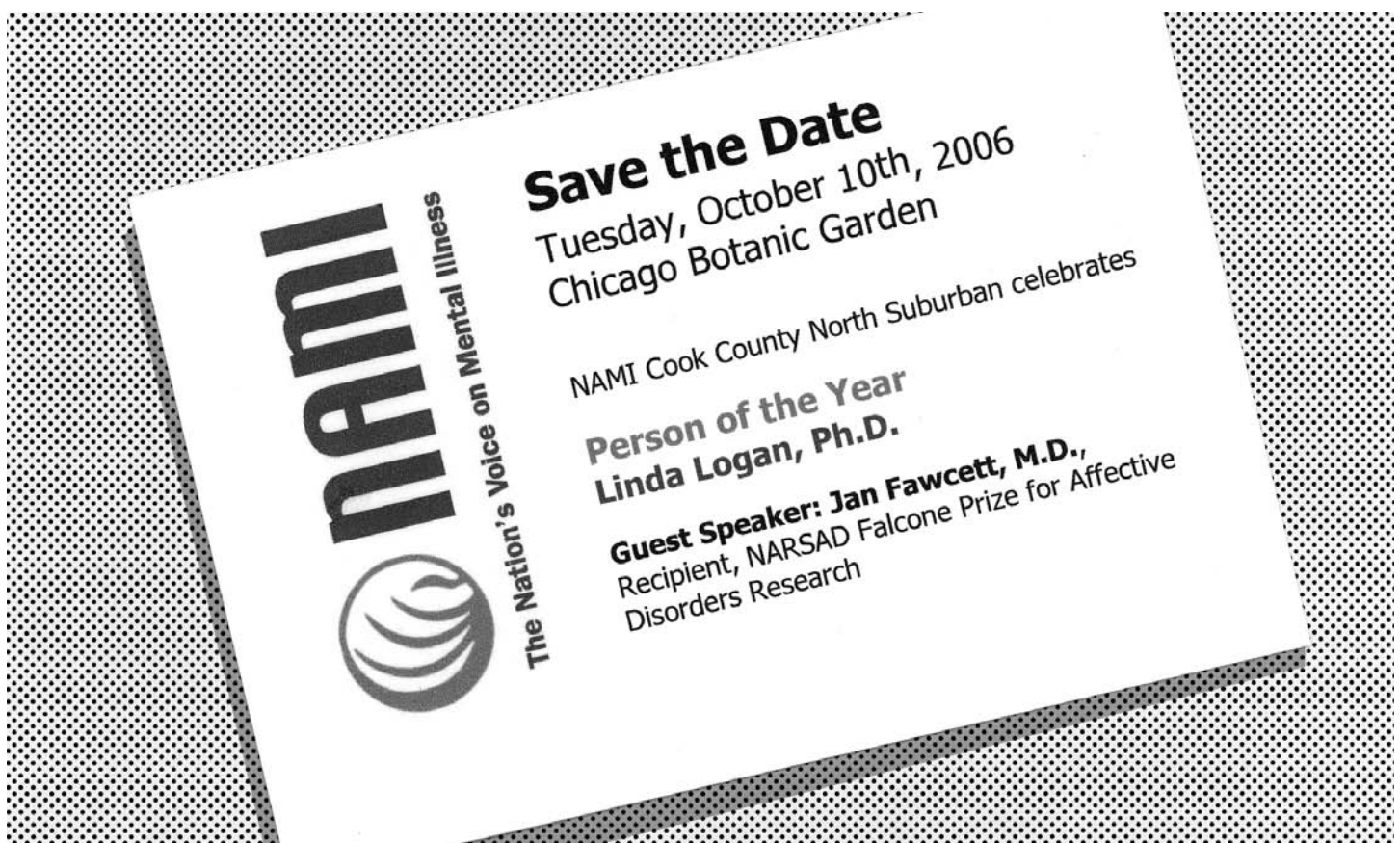
July 7 Board of Directors meeting *(See June 7 listing)*

July 11 “Care and Share” *(See June 13 listing)*

July 13 “Visions for Tomorrow” *(See June 8 listing)*

July 13 TARA meeting on borderline personality disorder and emotion dysregulation *(See June 23-25 listing)*

July 30 “Sundays at One” *(See June 25 listing)* ■



A Guide to...

Atypical Antipsychotics and the Metabolic Syndrome

By Linda Logan

What is metabolic syndrome?

According to the American Heart Association, metabolic syndrome (sometimes called Syndrome X) is a group of metabolic risk factors characterized by:

- Abdominal obesity (waistline > 35" in women; > 40" in men)
- Hyperglycemia or glucose intolerance (fasting glucose 100 mg/dL or higher)
- Dyslipidemia or elevated triglycerides (150 mg/dL or higher); low levels HDL ["good" cholesterol] (< 40 mg/dL in men; < 50 mg/dL in men)
- Hypertension or elevated blood pressure (130/85 mmHg or higher)
- Prothrombotic state (high fibrinogen or plasminogen activator inhibitor-1 in the blood)
- Proinflammatory state (elevated C-reactive protein in the blood)

Fueled by the obesity epidemic, metabolic syndrome is growing rapidly in this country. The American Heart Association estimates that over 50 million Americans have metabolic syndrome. People with metabolic syndrome are at a greater risk of developing type 2 diabetes and cardiovascular disease. Unfortunately, for reasons not completely understood, people with schizophrenia and mood disorders are at an increased risk of metabolic syndrome, with some estimating an up to four-fold increase. Worse, many of these same people require atypical antipsychotics that can cause metabolic syndrome.

What's the relationship between metabolic syndrome and atypical antipsychotics?

Atypical antipsychotics can increase the risk for developing metabolic syndrome. One study found nearly 30% of acutely admitted inpatients receiving one (or more) atypical antipsychotics meets the criteria for metabolic syndrome, especially weight gain (often considerable). For a patient struggling with schizophrenia or other mental disorders, weight gain is an additional problem. Aside from these dangerous health effects, weight gain is often a personally

troublesome side effect. One researcher found weight gain was "the most distressing" side effect cited among patients taking atypical antipsychotics. Indeed, weight gain is so troubling that one study found 50% of those who had gained weight on an atypical antipsychotic resulted in nonadherence.

What exactly is an atypical antipsychotic?

The first generation of antipsychotics was developed in the 1950s. Older, conventional antipsychotics, such as Thorazine (chlorpromazine), Haldol (haloperidol), Prolixin (fluphenazine), and Trilafon (perphenazine), while effective in treating many of the symptoms of schizophrenia, were frequently accompanied by disconcerting side effects, such as tardive dyskinesia (a disorder that can cause lip smacking, tics and other involuntary movements), akathisia, and Parkinsonism. In the 1990s, atypical antipsychotics — often referred to as second-generation antipsychotics (SGAs) — were developed and approved for use in schizophrenia and acute mania in bipolar disorder by the FDA (although they are used off-label for other disorders).

Atypical antipsychotics currently in use in the U.S. are:

- Zyprexa (olanzapine)
- Clozaril (clozapine)
- Risperdal (risperidone)
- Seroquel (quetiapine)
- Geodon (ziprasidone)
- Abilify (aripiprazole)

Do all atypical antipsychotics cause the same metabolic effects?

No. In 2004, the American Diabetic Association/American Psychiatric Association 2004 *Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes* established that some atypical antipsychotics produce greater metabolic dysfunction than others. That is, the atypicals are not a homogeneous class, but one characterized by marked diversity in metabolic effects. In brief, the study showed Zyprexa (olanzapine) and Clozaril (clozapine) increase a person's chances of incurring weight gain, diabetes, and dyslipidemia. Risperdal (risperidone) and Seroquel (quetiapine) show slightly fewer metabolic effects, while Geodon (ziprasidone) and Abilify (aripiprazole) have the best side effect profile in terms of metabolic syndrome.

Drug	Weight gain	Diabetes risk	Worsening lipid profile
Zyprexa (olanzapine)	+++	+	+
Clozaril (clozapine)	+++	+	+
Risperdal (risperidone)	++	D	D
Seroquel (quetiapine)	++	D	D
Geodon (ziprasidone)*	+/-	-	-
Abilify (Aripiprazole)*	+/-	-	-

+ Increase effect

- No effect

D Discrepant results

* New drugs with limited data on long term results

Aren't the newer antipsychotics better than the older drugs?

In order to address just that question, the NIMH conducted the CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) study, a 1500 patient study designed to answer:

- Are the newer, atypical antipsychotics better and safer than older ones?
- How do the atypical antipsychotics compare with each other?
- Are atypical antipsychotics cost-effective?

A summary of the first two phases of the CATIE study found:

- Three-quarters of the nearly 1500 patients involved in the study switched from their initial treatments to a different drug.
- Zyprexa (olanzapine) appeared to work best at controlling schizophrenic symptoms, but also had the highest rate of side effects (such as weight gain). Interestingly, many patients preferred to stay on Zyprexa despite the weight gain because the drug was so effective that the weight gain was preferable to extrapyramidal side effects (such as Parkinsonism, akathism, tardive dyskinesia, and dystonia) associated with older, conventional drugs.
- Contrary to the assumptions of many practitioners, newer atypical antipsychotics do not offer significantly better effects than the older drugs. That is, differences *between* conventional antipsychotics (such as Trilafon

[perphenazine]) and the newer ones were “not substantial.”

- There are “meaningful differences,” however, *among* the atypicals. CATIE established that the atypical antipsychotics differ in their efficacy, safety, and tolerability profiles, sometimes dramatically. Zyprexa (olanzapine), like Clozaril (clozapine), was found to alleviate symptoms of schizophrenia better than others.
- In terms of cost-effectiveness, the CATIE study found that the newer atypical antipsychotics offer few (if any) benefits over conventional medications, which cost a fraction of what the newer ones cost. According to the *New York Times*, atypical antipsychotics, which comprise 90% of the national market for antipsychotics, generate \$10 billion in annual sales.

What should my doctor do if I'm on an atypical antipsychotic?

According to one study, doctors are doing only a “modest” job of monitoring their patients on atypical antipsychotics. “Many of the metabolic complications that go unnoticed by psychiatrists are associated with serious adverse health effects,” one researcher states. “In some cases, these complications can increase the risk of cardiovascular disease and even death...”

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lead to their altered expression and to disruptions in brain and nervous system development, initiating a cascade of events that leads to psychotic disorder, the study suggests.

Law and colleagues hypothesized that alterations in the expression of certain types of neuregulin 1 in the brain may explain the genetic association with schizophrenia. They compared post-mortem tissue from the hippocampi of patients with schizophrenia and those without the disease, looking at four types of the neuregulin 1 gene. They tested whether the expression of these four gene products was abnormal in the brain in schizophrenia and whether genetic variants within the neuregulin 1 gene, previously associated with the disease, were linked to their abnormal expression. The NIMH researchers found that the expression of one product of neuregulin 1 (called type I) was increased in patients with schizophrenia and that altered expression of this gene product may contribute to increased risk of schizophrenia. Furthermore, expression of a novel type of neuregulin 1 in the brain that was first discovered in Iceland (called type IV) was also increased and found to significantly contribute to increased risk of schizophrenia. The study suggests that these genetic variants of neuregulin 1 potentially interfere with proteins involved in the gene's regulation. The researchers propose that in patients with schizophrenia, altered regulation of neuregulin 1 expression likely disrupts the gene's signaling, which affects brain development and plasticity, thus contributing to the development of the disease. ■

Depression Rates Are Lower In Children Whose Mothers Are Successfully Treated

From the National Institute of Mental Health

When women treated for depression become symptom-free, their children are less likely to be diagnosed with depression, according to a study published in the March 22/29 issue of the *Journal of the American Medical Association*. The study showed that children of mothers who achieved remission of symptoms had an 11 percent drop in diagnosis of depression. There was an 8 percent increase in diagnosis of depression among children whose mothers did not become symptom-free. The study alerts health professionals and patients of the need to vigorously treat depressed mothers and to evaluate their children for symptoms.

The study, STAR*D-Child, examined 151 mother-child pairs, including children 7-to-17 years old, in 19 clinical settings across the country. STAR*D-Child is an ongoing part of a larger clinical trial called Sequenced Treatment

Alternatives to Relieve Depression (STAR*D), also funded by NIMH. The trial was conducted in real-world healthcare settings to determine how to successfully treat depression in adults who didn't become symptom-free after their first treatment or in whom the first treatment caused side effects.

Other studies have produced strong evidence that children of depressed parents are two to three times more likely than others to have major depression or other anxiety or disruptive disorders. Genes play a major role in depression that starts young, but environmental factors — the presence of a parent with depression, for example — may influence whether or not a child develops symptoms. This study included a mix of children who were depressed and children who were not depressed at the outset of the trial.

In children who were depressed when the study began, 33 percent of those whose mothers went into remission over the three-month period went into remission themselves. Their symptoms improved only after their mothers' symptoms improved by at least 50 percent. Only 12 percent of children with depression at the outset of the study achieved remission when their mothers did not become symptom free.

Of the children who entered the study free of depression, none whose mothers went into remission were diagnosed with depression during the three months. In contrast, 17 percent of those whose mothers did not go into remission were diagnosed with depression at the three-month mark.

All of the mothers began by taking the antidepressant citalopram, a selective serotonin reuptake inhibitor. Those for whom citalopram was not successful were switched to other drugs randomly assigned.

Researchers who evaluated the children after three months of the study did not know which treatments the mothers had been taking. Thirty-three percent of the mothers went into remission before the three-month assessment, and, of these, 92 percent had been taking citalopram; two had been switched to extended release venlafaxine-XR, and one to a combination of citalopram and bupropion.

The researchers will continue to follow the children for a year after their mothers go into remission during the study, or for two years if their mothers do not go into remission. ■

Advocacy Update

Lack of Police Training Leads to Two Tragedies

By Sally Mann

Legislative and Advocacy Chairperson

Recent police mishandling of two mental health emergencies have had disastrous consequences, one resulting in a death in Wisconsin and another where a woman lies in critical condition in the hospital here in Illinois.

In Madison, Wisconsin, Victor Montero-Diaz, fearing someone was trying to kidnap him, locked himself in the restroom of a gas station and called 911 and his parole officer. The parole officer, who knew Mr. Diaz suffered from mental illness and drug abuse and had a good relationship with him, called police dispatch and informed them that he was on his way. Unfortunately, the police did not wait for the parole officer's arrival.

The police waited no more than two minutes before knocking the door down and shooting him to death. The police claimed that they had to kill Mr. Diaz because he had a steak knife and when he was rushed an officer was cut. They claimed that the officer who fired the shot was a trained hostage negotiator, but this was not a hostage situation and no one was in danger. This was truly a mental health crisis and one wonders why the police did not wait for the parole officer.

In Chicago, a young former UCLA student was arrested after creating a disturbance while having a heated cell phone conversation with a family member and arguing with a

person who tried to intervene. After she was arrested her father called the police and informed them that she suffered from bipolar disorder and was not taking her medication. He begged the police to hold her until a family member arrived from California to take her home. Instead the police released her into an unfamiliar high crime neighborhood on the South Side where she was lured into an apartment at the Robert Taylor Homes, sexually assaulted, and then fell (or was thrown) from the seventh floor clad only in her underwear. As of this printing, she remains unconscious on life support in critical condition at Stroger Hospital. A man has been arrested and charged with aggravated criminal sexual assault and unlawful restraint. He has been denied bail.

The Chicago Police Department has guidelines for dealing with the mentally ill; in 2004 it began to provide training for its officers in recognizing and dealing with mental illness. However, only about 150 of the more than 13,000 officers have been through the 40 hour training program. None of the officers involved in this incident had received the training. Under the police guidelines, she should have been sent to a hospital for treatment.

Because of the shortage of affordable mental health and psychiatric services, our nation's jails and prisons have become "The New Asylums." Many prisoners are drug addicts who self-medicate because of the lack of adequate services. Police are not trained mental health providers, but they are frequently called to handle mental health crises, often with the disastrous results that occurred in Madison and Chicago. We at NAMI CCNS should make sure that the police in our communities receive training in recognizing and dealing with persons who are mentally ill. ■

Legislative Update

By Sally Mann

Illinois

Two bills have passed the Illinois legislature and are awaiting Governor Blagojevich's signature:

- HB 4125 Amends the Illinois Insurance Code. Provides that certain mental health coverages include pervasive developmental disorders including autism. Applies to health maintenance organizations and individual policies of accident and health insurance.

- HB 4202 Amends the Illinois Insurance Code. Provides that a group health benefit plan shall provide coverage for 60 (now 35) visits for outpatient treatment of mental illness. Effective immediately.

Contact Governor Blagojevich and urge him to sign these important bills. WWW.Illinois.Gov

Doctors are encouraged to oversee carefully their patients taking atypical antipsychotics. This involves:

1. Screening

Before prescribing an atypical antipsychotic, doctors should screen the person being considered for such treatment. Screening patients can help identify which patients are more at risk for metabolic syndrome than others. Factors to consider include:

- Personal and family health history
- Baseline data on height and weight
- Waist circumference and blood pressure
- Fasting blood glucose levels and lipid levels

Any patient who has insulin resistance and obesity *prior* to treatment with an atypical antipsychotic must be watched vigilantly.

2. Monitoring

Once treatment with an atypical antipsychotic has commenced, the patient must be monitored regularly. It is advised that the doctor:

- Assess weight at 4-, 8-, and 12-weeks after initiating therapy
- Assess fasting glucose at three months
- Assess blood pressure during each appointment

3. Treating

Studies have found that treatment strategies can help mitigate the risk of metabolic syndrome. Doctors should:

- Treat obesity
- Treat glucose intolerance and diabetes with nutrition therapy and self-monitoring of blood glucose
- Treat dyslipidemia
- Treat hypertension
- Treat prothrombotic stroke
- Encourage the patient to stop smoking

3. Providing interventions

Doctors are urged to provide counseling and nutritional education, as well as educate the patient as to the importance of physical activity in reducing weight gain. Apart from diet and exercise, some studies indicate the

drugs metformin and topiramate may be helpful in weight reduction.

4. Switch medications

The ADA/APA Consensus Development Panel recommends that any increase of 5% or more from baseline weight “warrant consideration of changing to a different agent.” While switching to a new medication, doctors should inform patients of the possibility of relapse during the period of cross tapering (the process of weaning off one drug while slowly introducing a new one).

Is there any up side to taking an atypical antipsychotic?

Absolutely. There is no doubt that some people will benefit by Zyprexa more than they would any other drug. Moreover, proponents of the newer drugs argue that they show improvement over conventional drugs in the treatment of:

- Mood (dysphoria and mania)
- Cognitive symptoms (attention; memory)
- Negative symptoms (amotivation)
- Positive symptoms (hallucinations and delusions)

The true efficacy of medications, however, comes down to the individual. As one drug industry analyst said, “...There is no one-size-fits-all treatment for schizophrenia.” Having an array of medications to choose from is an advantage for all patients. The more arrows in our quiver, the more likely we are to target and eliminate symptoms of disabling mental disorders. Remember, studies like CATIE are designed to measure broad differences, not individual responses. *Talk to your doctor. Only he or she can help you make an informed decision about which type of drug may be best suited to your condition.* ■

Sources: American Heart Association, Metabolic Syndrome, available at: www.americanheart.org/presenter.jhtml?identifier=534; Beaser, R. et al., New Standards of Care for Treating Schizophrenia and Bipolar Disorder: Achieving Efficacy and Metabolic Health with Atypical Antipsychotics, *Medscape*, June 30, 2005; The Metabolic Syndrome, *Brit J Med* 2003; 327:61-62 (12 July); Carey, B., Little Difference Found in Schizophrenia Drugs, *New York Times*, September 20, 2005; Citrome, L. et al., Metabolic Issues in Patients with Severe Mental Illness, *Medscape*, posted August 11, 2005; The Significance of CATIE: An Expert Interview with Jeffrey A. Lieberman, MD, *Medscape Psychiatry & Mental Health*, 2006; 11 (1);

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FDA Approves Methylphenidate Patch to Treat Attention Deficit Hyperactivity Disorder in Children

The Food and Drug Administration approved Daytrana, the first transdermal (skin) patch, for treating Attention Deficit Hyperactivity Disorder (ADHD) in children six to 12 years of age. Daytrana is a once daily treatment containing the drug methylphenidate, a central nervous system (CNS) stimulant. “Daytrana provides an alternative route of administration for methylphenidate in children with ADHD,” said Dr. Galson, FDA’s, Director of the Center for Drug Evaluation and Research.

Daytrana should be applied each morning to the alternating hip, and worn for nine hours. Parents and caregivers will be provided a chart to track the application and removal of the patch. The prescriber may change the amount of time the patch is worn to help manage how long the medication works each day and some of the side effects that may be caused by methylphenidate. If the patch is worn for longer than the recommended nine hours, methylphenidate-induced side effects such as insomnia may occur with greater frequency in some children. Other possible side effects include blurred vision, mild skin irritation or an allergic skin rash and slower weight gain and height growth. Stimulant products generally should not be used

in children with known structural cardiac abnormalities because of a concern that stimulants may further increase the risk of sudden death above the risk that is already present with such abnormalities.

Daytrana should not be used if the child:

- Has significant anxiety, tension, or agitation, since methylphenidate may make these conditions worse.
- Has allergies to methylphenidate or other ingredients in Daytrana.
- Has glaucoma, an eye disease.
- Is currently taking a monoamine oxidase inhibitor (MAOI) for depression, or has discontinued a MAOI in the last 14 days.
- Has motion or verbal tics or Tourette’s syndrome, or a family history of Tourette’s syndrome.

Daytrana has been shown to be safe and effective in two placebo controlled studies in children six to 12 years of age with ADHD. Daytrana is indicated as an integral part of a total treatment program for ADHD that may include other measures such as psychological, education and social, for patients with ADHD. Daytrana is manufactured for Shire US. Inc., by Noven Pharmaceuticals Inc. ■

Source: Food and Drug Administration, Medwatch, and Center for Drug Evaluation and Research

NAMI CCNS would like to thank the members and staff at Wilpower for their help in stamping and labeling our bimonthly newsletter. Without their patience and diligence, *Newsline* would not get out.

The Editor

Tag Day Thank You

By Julie Savastio

Each year NAMI CCNS members and friends hold an annual Tag Day weekend. Tag Day is an opportunity to introduce the community to NAMI CCNS through an informational “tag” describing our mission and listing the many NAMI CCNS programs and resources. On Friday, May 5 and Saturday, May 6, we met in Glenview to hand out tags and Tootsie pops. Outfitted in our green NAMI vests and with collection cans in hand, we heard many heartfelt comments from the people we met, such as : “My mother suffers from depression,” “My brother has bipolar disorder,” “I struggle with anxiety,” and “Thank you for doing this.” Each year the number of people proclaiming, “I know NAMI,” seems to grow.

So far, we have raised \$5,600 with more donations in the mail. Many thanks to the following members and friends, who volunteered time to organize the event, made phone calls, volunteered to tag, and supported the event through mailing in donations:

Alan Carlile, Marilyn Applebaum, Agnes Byrne & family, Bill & Rita Nash, Candice Savastio, Ray Savastio, Tina & Leonard Nelson, Jim Schantz, Chris and Maun Dee, Maureen Byrne, Gary Shovers, Marybeth Hand, Lenore Bernstein, Nancy Hug, Jim and Laura Brodnicki, Nancy Tudor, Frieda Ankin, Peggy Wonders, Christy

Walter, Jim and Pat Gullery, Sandra Shovers, Judy Graff, Barb and Tom Maier, Mike and Pat Rodbro, Bob & Diane Peel, Ann George & Annie, Tiffany George, Rose Nudo, Charlotte Donat, Stan Rothbardt, Patricia Blumen, Marian Chase, Kevin Lawlor, Linda and Tom Green, Phyllis Lisk, Theresa Hutchins, Ricky Sullivan, Billy, Helen Larsen, Ken Budzik, Lois Savastio Van Ryan, Brad Schantz, Mary Lawlor, Gloria DeSimone, John and Roberta Malloy, Patricia Ernhart and Kevin Breslin in memory of Jack Breslin, Elenor Anstaett, Robert and Barbara Spencer. ■



Co-President Ann George with her granddaughter, Annie



Ray Savastio handing out tags to Jim (left) and Brad Schantz

Science Update

Studies Identify Molecular Accomplices Of Suspect Schizophrenia Genes

From the National Institute of Mental Health

NIMH-funded researchers have discovered how certain genes work at the molecular level to increase the risk of schizophrenia. Their findings are among the first to suggest a biological basis for two of the most compelling schizophrenia risk genes. Study authors Barbara Lipska, Ph.D., Amanda J. Law, Ph.D., Daniel R. Weinberger, M.D., Joel E. Kleinman, M.D. and colleagues at NIMH revealed these findings in two papers published in the March 1, 2006 advanced online issue of *Human Molecular Genetics* (Lipska et al.) and the April 25 issue of the *Proceedings of the National Academies of Science* (Law et al.).

Previous genetic studies have identified two genes as schizophrenia risk genes—Disrupted-in-Schizophrenia 1 (DISC1) and neuregulin 1—but the way in which they work has been unclear. DISC1 is important for brain development, particularly, the development of the limbic

system, the brain's memory and emotion hub. Neuregulin 1 controls the construction and wiring of the brain during development, communication between nerve cells, and adaptations to new situations.

Lipska and colleagues examined post-mortem tissue from human hippocampi and prefrontal cortices, brain regions strongly implicated in schizophrenia, to determine how DISC1 is expressed during human brain development and whether DISC1 and several molecules it interacts with are abnormally expressed in schizophrenia. They also tested whether certain high-risk variants of DISC1 were more likely to be abnormally expressed. They found that DISC1 expression peaks in infancy, suggesting that DISC1 plays an important role in human brain development. Although altered expression of DISC1 was not found to significantly contribute to schizophrenia risk, the expression of three molecules (NUDEL, FEZ1 and LIS1) that work in concert with DISC1 was reduced in people with the illness. This reduction was associated with high risk variants of the DISC1 gene. Failure of DISC1 to bind to these partners may

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Grundy, et al., Clinical Management of Metabolic Syndrome: Report of the American Heart Association...Related to Management, *Circulation*, 109 (4): 551; Kaplan, A., Consensus Panel Urges Monitoring for Metabolic Effects of Atypical Antipsychotics, *Psychiatric Times*, April 2004, vol. 31, no. 4; Fleischhacker W. and C. Widschwendter, Treatment of Schizophrenic Patients: Comparing New Generation Antipsychotics to Each Other, *Curr Opin Psychiatry*, 2006: 19 (2): 128-134; Lieberman J. III, Metabolic Changes Associated with Antipsychotic Use, *Primary Care Companion J Clin Psych* 2004;6 [suppl 2]: 8-13; Lieberman, J. III et al., Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia, *New Eng J of Medicine*, 2005; 353:1209-1223; Meyer, J., Schizophrenia and the Metabolic Syndrome, *Medscape Psychiatry & Mental Health* 2005, 295:8 (1); Naasrallah, N. and M. Korn, Metabolic Issues in the Management of Bipolar Disorder: Focus on Weight Gain, *Medscape*, September 8, 2005; Narasimhan, M. et al., Management of Antipsychotic-Induced Weight Gain, *Psychiatric Times*, August 2005, vol. 22, no. 9; Newcomer, J., Metabolic Risk During Antipsychotic Treatment, *Clin Therapeutics*, vol. 26, no. 12, 2004: 1936-1946; NIMH, Studies Offer New Information About Treatment Choices for Schizophrenia; Straker, D. et al., Cost-Effective Screening for the Metabolic Syndrome in Patients Treated with Second-Generation Antipsychotic Medications, *A J Psychiatry* 162 1217-1221 June 2005; Werneke U. et al., Options for

Pharmacological Management of Obesity in Patients Treated with Atypical Antipsychotics, *International Clin Psychopharm* 17 (4): 145-160, July 2002.

For more information on the CATIE Studies

National Institute of Mental Health
"Science Update"

http://nimh.nih.gov/press/catie_phase2.cfm

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