

Medication Update

Safety Labeling Changes Approved By FDA
April —June 2004

*Drug products with safety labeling changes to the
CONTRAINDICATIONS, BOXED WARNING, WARNINGS,
PRECAUTIONS, or ADVERSE REACTIONS sections.*

*For more information, go to MedWatch
www.fda.gov/medwatch/safety.htm*

- Wellbutrin (bupropion hydrochloride) Tablets**
- Wellbutrin SR (bupropion hydrochloride)
Sustained-Release Tablets**
- Wellbutrin XL (bupropion hydrochloride)
Extended-Release Tablets**

FDA and GlaxoSmithKline notified healthcare professionals of revisions to the WARNINGS and PRECAUTIONS sections of labeling to alert healthcare professionals that patients with major depressive disorder, both adult and pediatric, may experience *worsening of their depression* and/or the *emergence of suicidal ideation and behavior* (suicidality), whether or not they are taking antidepressant medications. The warning recommends patients being treated with antidepressants be observed closely for clinical worsening and suicidality, especially at the beginning of a course of drug therapy, or at the time of dose changes, either increases or decreases.

Serzone (nefazodone hydrochloride) Tablets
FDA and Bristol-Myers Squibb notified healthcare professionals of revisions to the INDICATIONS AND USAGE, DOSAGE AND ADMINISTRATION, and WARNINGS sections to encourage healthcare providers to engage in a thorough risk-benefit analysis, including consideration of the *risk of hepatic failure* associated with Serzone treatment, when deciding among alternative treatments available for depression. In addition, healthcare providers and consumers are cautioned about the need for close observation of

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A Special NAMI CCNS Fundraising Event

Two new plays by NAMI CCNS board member
and playwright, Todd Logan

Fallout

An honest, hopeful—often funny—play that tells the
story of one man’s journey
to recover from losing his wife to mental illness

and

The Playwright...and All That Crap

The story of a playwright who’s convinced he’s writing
nothing but, well, crap...
and his long-suffering wife

Sunday, July 18
“The Studio” at the Raven Theater
6157 N. Clark Street, Chicago

Reception 6:00 p.m.
Performance 7:00 p.m.
Post-show discussion 9:00 p.m.
Ticket price \$35.00

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Board of Directors

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Visit our web site
www.namiccns.org
Web site maintained by
Tom Maier

President's Letter

Dear NAMI-CCNS Members,

Now that the spring rains have finally lessened, I would like to wish all of you a healthy and pleasant summer season. For many people, the summer months are a time to enjoy relaxed schedules and to take vacations with family members or friends. However, it is also important to recognize that too many changes in routines and schedules can be stressful for people for whom mental illness is a daily fact of life. So, as you go about enjoying these next few months of sunshine, please do keep in mind the need to adhere as much as possible to the routines and schedules that have been developed to help a family member manage the symptoms of his or her mental illness.

At this point, I want to extend a heartfelt thanks to Julie Savastio and her family for their incredible efforts to make our Tag Day event a successful event despite the rainy weather we experienced on the days that it was scheduled. I also want to thank all the NAMI-CCNS members and community volunteers who braved the cold temperature and wet conditions to help our affiliate distribute information about mental illness while collecting donations from the drivers of cars at two major Glenview intersections and people in transit at the Glenview railroad station. The money that was collected will be used to help defray the cost of our affiliate's educational and support programs.

Thanks to our gifted resident playwright and board member, Todd Logan, we are pleased to offer once again a night at the theater on Sunday, July 18th as our second fundraising event for this year. Todd's play, *Fallout*, reflects his keen sensitivity about the impact of mental illness on family life. Todd is a master of using language to depict both poignant and humorous elements of life, both of which I am sure we will experience when we attend this play. A second one-act play, *The Playwright...and All that Crap* will also be performed. Invitations to this event have been mailed to all NAMI-CCNS members and we hope that you can attend.

Finally, I want to alert you to two NAMI conferences that will be taking place this fall. NAMI National will be holding its annual conference in Washington, D.C. from September 8-12th. For those of you who wish to attend a conference closer to home, NAMI Illinois will be holding its annual conference during the weekend of October 15-17th in Lisle, Illinois. It's not too early to start to plan to attend one or both conferences!

In closing, members are welcome to attend our monthly board meetings which, with the exception of August, will take place the first Wednesday of each month at Wilpower, 444 W. Frontage Road, in Northfield. The dates of the meetings for the remainder of this year are July 7, September 1, October 6, November 3, and December 1st. If you wish to contact me about any topic relative to our affiliate, please write to my email address (Chughesnamiccns@aol.com) or call our affiliate telephone number, 847 724-1460.

Best regards,
Candice A. Hughes

Patients taking the antidepressants for *clinical worsening of the symptoms of depression*, for the *emergence of suicidality*, and for the emergence of a variety of other symptoms that may represent a worsening of the patient's condition.

Paxil (paroxetine hydrochloride) Tablets

Paxil CR (paroxetine hydrochloride) Controlled-Release Tablets

FDA and GlaxoSmithKline notified healthcare professionals of revisions to the **WARNINGS** and **PRECAUTIONS** sections of labeling to alert healthcare professionals that patients with major depressive disorder, both adult and pediatric, may experience *worsening of their depression* and/or the *emergence of suicidal ideation and behavior* (suicidality), whether or not they are taking antidepressant medications. The warning recommends patients being treated with antidepressants be observed closely for clinical worsening and suicidality, especially at the beginning of a course of drug therapy, or at the time of dose changes, either increases or decreases.

OTHER PRECAUTIONS

- General
 - Discontinuation of Treatment with Paxil CR
 - Abnormal Bleeding
- Information for Patients
- Drugs that Interfere with Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)
- Drug Interactions
 - Drugs that Interfere with Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)
- Pregnancy
 - Nonteratogenic Effects

Celexa (citalopram hydrobromide) Tablets and Oral Solution

PRECAUTIONS

- General
 - Discontinuation of Treatment with Celexa
 - Abnormal Bleeding
- Information for Patients
- Drugs that Interfere with Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)
- Pregnancy-Nonteratogenic Effects

Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI.

Lexapro (escitalopram oxalate) Tablets and Oral Solution

PRECAUTIONS

- General
 - Discontinuation of Treatment with Lexapro
 - Abnormal Bleeding
- Information for Patients

- Drugs that Interfere with Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)

- Pregnancy-Nonteratogenic Effects

Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid an antibiotic which is a reversible non-selective MAOI.

Effexor (venlafaxine hydrochloride) Immediate Release Tablets

Effexor XR (venlafaxine hydrochloride) Extended Release Capsules

PRECAUTIONS

- Drug Interactions
 - Drugs Metabolized by Cytochrome P450 Isoenzymes
- CYP2C9

Xanax (alprazolam) Tablets

PRECAUTIONS

- Suicide
- Laboratory Tests
- Drug Interactions

ADVERSE REACTIONS

- Treatment-Emergent Adverse Events Reported in Placebo-Controlled Trials of Anxiety Disorders
- Adverse Events Reported as Reasons for Discontinuation in Treatment of Panic Disorder in Placebo-Controlled Trials

Abilify (aripiprazole) Tablets

FDA and Bristol-Myers Squibb notified healthcare professionals of revision to the **WARNINGS** section of labeling, describing the *risk of hyperglycemia and diabetes* in patients taking Abilify. FDA asked all manufacturers of atypical antipsychotic medications, including Bristol-Myers Squibb, to add this Warning statement to labeling. Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics.

Desyrel (trazodone hydrochloride)

FDA and Bristol-Myers Squibb notified healthcare professionals of revisions to the **CLINICAL PHARMACOLOGY** and **PRECAUTIONS** sections of the Desyrel labeling. Desyrel is indicated for the treatment of depression. In vitro drug metabolism studies suggest that there is a *potential for drug interactions when trazodone is given with the CYP3A4 inhibitors ketoconazole, ritonavir, and indinavir*. It is likely that CYP3A4 inhibitors may lead to substantial increases in trazodone plasma concentrations with the potential for adverse effects. If trazodone is used with a potent CYP3A4 inhibitor, a lower dose of trazodone should be considered. Conversely, carbamazepine reduced plasma concentrations of trazodone when coadministered. Patients should be closely monitored to see if there is a need for an increased dose of

trazodone when taken with carbamazepine.

Seroquel (quetiapine fumarate)

FDA and AstraZeneca notified healthcare professionals of revision to the WARNINGS section of labeling, describing the increased *risk of hyperglycemia and diabetes* in patients taking Seroquel. FDA has asked all manufacturers of atypical antipsychotic medications, including AstraZeneca, to add this Warning statement to labeling.

Clozaril (clozapine)

FDA and Novartis notified healthcare professionals of revision to the WARNINGS section of labeling, describing the increased *risk of hyperglycemia and diabetes* in patients taking Clozaril. FDA has asked all manufacturers of atypical antipsychotic medications, including Novartis, to add this Warning statement to labeling.

Zyprexa (olanzapine)

FDA and Lilly notified healthcare professionals of revision to the WARNINGS section of labeling, describing the increased *risk of hyperglycemia and diabetes* in patients taking Zyprexa. FDA has asked all manufacturers of atypical antipsychotic medications, including Lilly, to add this Warning statement to labeling. □

A TAG DAY THANK YOU

By Julie Savastio
Tag Day Coordinator

A chance to give back to NAMI-CCNS. A chance to show support for a loved one, a friend, a family member. A chance to be visible in the community, to advocate for those who suffer from mental illness and to provide information. We came as families, with friends and as family representatives. We made phone calls and sent in donations. We offered our support and gave encouragement. And on May 14 and 15, rain and shine and road construction in Glenview, we made Tag Day a memorable event. As of the last report presented by our Treasurer, collections and donations are approximately \$7,000. Donations continue to arrive.

Thank you to the members who volunteered to make phone calls and assist with correspondence, especially, Lenore Bernstein, Maun Dee, Chris Dee, Jim Brodnicki, Ellen Roth, Deb Walsh, Candice Savastio, Judy Graff, Ray Savastio, Barb Maier, Nate Maier and Jim Walsh.

Thank you to the organizations and groups that have continued to support our event including Wilpower, Thresholds and New Trier High School and student volunteers Katie Kahn, Elles Coster, Erika Diaz, Gina Traeger. Special thanks to Amanda Wall for working with her Advisor Andrea Levin to enlist taggers.

Great participation from members of "Sundays at One" social group for young adults.

A very huge thanks to our tagger volunteers Dora Barichello, James Brodnicki, Bonnie Schein, Vickie Newman, Judy Graff, Barb Maier, Ann George, Carol Gail, Dolores B. Parker, Lexie Parker, Eileen Starkey, Nate Maier, Laura Phillips, Adam

Anderson, Gail Helfner, Agnes Byrne, Michael Brandt, Bonnie Hinkler,

Marilyn Applebaum, Jim Gullery, Pat Gullery, Coleen Gullery, Dan Gullery, Fariba Samouhi, Nancy Hug, Theresa Hutchins, Tom Maier, Candice Hughes, Donna Swanson, Gay Geary, Lai Kwok, Maureen Byrne, Marian Chase, Tina Nelson, Alexandra Nelson, Bill Nash, Rita Nash, Huelene Chadwick, Rose Hamon, Larry Hamon, Bridget Gillen, Liz Winkowski, John Tompson, Joyce Friedman, Charlene Floreani, Javier, Candice Savastio, Lauren Savastio, Linda Savastio and Ray Savastio. Extra special thanks to John, Charlene, Javier, Lauren & Pat G. who made this a Tag Day Marathon.

Thank you to members and friends who send in donations, especially, Melissa Rooks, George and Katharina Sloboda, Johanna Daubitz, Bea Canchester, Jim Schantz, Mary Lawlor, Bernice Faintuch, Jim and Shirley Weber, Peggy and Grant Wonders, Carol Towne, James and Mary McGrath, Mary Sergesketter, Bob and Barbara Spencer, Boyd and Lois Metzger, Patricia Blumen, Jill Smith, Dr. Earl N. Solon, Kathleen O'Donovan Clevon, Rick and Deane Borgeson, Carolyn Orsi, Mr. and Mrs. Herbert Kwok, Ann George, Jim Jennings and Jennings Chevrolet, Inc., Gloria DeSimone, James and Laura Brodnicki, Mary Barber, Charlotte and Dick Donat, Lois Savastio-Van Ryan, Ann George, Jim Brodnicki and Bridget Gillen, and Jim and Maureen Carroll.

A final thanks to the City of Glenview and drivers in the community that offered donations and displayed our tags. □

Viewpoint

Psychopathology, Pharmacology and the Crisis of Self: An Open Letter to My Doctor

By Linda Logan

I have been treated for bipolar disorder for over 15 years. About twelve years ago, I entered a bad period that resulted in 17 months of intermittent hospitalizations over a two-year period. I've been treated with more than 40 different medications (and various combinations thereof), and will remain on meds the rest of my life. The following letter reflects some of the philosophical issues raised by severe mental illness and its pharmacologic treatment.

Dear Doctor,

A friend of mine just marked the fifth anniversary of her diagnosis with breast cancer. Cancer-free for five years, she has been returned to her life, restored and recovered. She is radiant, even buoyant, in her recovery and, while I am happy for her, I am jealous. My return to life after a severe mental illness has not been marked by such joyousness. While I have been relieved of the desire for self-annihilation, I have, more accurately, been *rescued*, not restored. I am nowhere near the person I used to be. My old self has disappeared, leaving a shadow of who she was in her place.

I have raised the issues of authenticity and the crisis of self with you a number of times over the years. I suppose, from your viewpoint, such philosophical questions on my part must seem an indulgence, no different than adolescent navel-gazing. I sense you think that I should be grateful I'm not dead and move on. Yet every hour of the day, I feel and watch myself go through such dramatic changes in mood, cognition, energy that I am unsure as to whether there is any sustaining self underlying these beings. I'm troubled by the inconstancy, by fact that there seems to be no transcendent "me."

I don't think you understand how pervasive--and disturbing--this problem is for me. I don't think it is unique to my experience of mental illness; I believe that it is something that you, as a doctor, need to understand.

I've been monitoring my moods, energy, cognition and behavior for decades. (A closetful of journals can attest to that.) Many of my entries concern the chasm

between my robust former self (my premorbid personality, as you would call it) and its pale survivor. I suspect that the crisis of self results from a combination of three factors: the biochemical consequences of the illness itself, residual symptoms, and psychopharmacological effects.

The effect of mental illness on the brain

If mental disorders are caused (at least in part) by some type of dysfunctioning and/or dysregulation of the brain's neurochemical systems, couldn't the *illness itself* further alter the brain's chemistry and structure? Depression, for instance, may have a neurochemical "signature," as it were, that may wreck the same degree of havoc on the brain as the blows a boxer sustains to his head.

Animal studies suggest this is a possibility: cortisol flooding the brain can disturb neurochemical pathways, hippocampal neuronal degeneration of rats has been induced by chronic stress. If mental disorders not only reflect a disturbance in the brain, but in turn, go on to *cause* brain disturbances, could this damage be reversed? (Remember, until very recently, scientists scoffed at the notion that brain cells are capable of regeneration.)

It's as though the depression and despair I felt when I was sick was a conflagration, a firestorm that raged through the affective landscape until there was nothing left but seared soil and charred stumps. As a result, my affective repertory is limited to fear and anger. Empathy, sadness, despair, etc. are affective states I *have*, but do not feel. I have learned to navigate the affective world by compensating with my intellect. Like the blind person who "sees" with his fingertips, I feel by *telling* myself, "I am sad," rather than *feeling* sad. On a bad day, being emotionally decathected makes me feel like a robot. But most of the time, like W.C. Fields, I comfort myself by "considering the alternative."

Residual symptoms

Over the years, our conversations have veered away from recovery to those other "R" words: response, remission, and residual symptoms. As you and your colleagues treat us as we move through the harrowing course of the illness' acute phase toward stabilization, your presumptive goal is to match, as closely as possible, the selves of the persons we were before.

Continued on page 6

Zoloft commercials notwithstanding, I'm not sure severe mental disorders are curable illnesses. Treatable, yes, but not necessarily curable. No amount of pills or therapy can return me to the person I was before I got sick. That competent, confident person has, like Elvis, "left the building."

The literature on psychosocial impairments following a mental illness does not address the *experience* of mental illness, the *phenomenology* of the disorder. Instead, researchers measure degrees of therapeutic responses by monitoring eye contact, facial expressiveness, social and vocational statuses, etc.). *They have measured everything but the state of our selves and the nature, and consequences, of their alterations.*

Paradoxically, on the eve of my first hospitalization, I was at the height of my career and experiencing some of the best moments of my life. I had completed my Ph.D. a few years before and had begun teaching as a lecturer at MIT. My short stories were getting positive feedback from one of the country's top editors, I had three achingly beautiful children whom I loved ferociously, a great husband and a small group of close friends. Life truly could not have been better. Except, of course, that I was suicidally depressed.

Eleven years later, I am not affiliated with a university, cannot write short stories or poetry, and, since moving to Chicago, have not duplicated the social world I had before I was sick. Moreover, I can easily go three days without leaving the house or talking to anyone other than my immediate family. Fortunately, my children have grown into wonderful young adults and, unlike many of the women I met in the hospital, my husband and I are still married (twenty-nine years last week). But many of my days are still colored by dread, fear and worry---residual symptoms that persist like stubborn laundry stains.

The paradox of psychopharmacology

The psychopharmacologic armamentarium marshaled to combat my mental disorder has, in fact, wrecked their own kind of mental havoc. While I have no doubt that these medications played a key role in my ability to go home---and stay home---they come with some profound psychological consequences. For instance, before Elavil (the first medication I was put on for depression), my daily mood ranged from bad to worse, each accompanied by extreme depth of feeling. Elavil

successfully curbed the depth and range of my despair, but it blunted everything else, as well. Now I couldn't feel *anything*. My therapist explained that Elavil helped steady the wide amplitude of emotions I was experiencing, but in so doing, also affected the experience and intensity of normal feelings. The logic of this escaped me. It seemed like hacking off a leg to treat a stubbed toe. So there I was: in a Mephistophelean exchange of psychic pain for nothingness, I became the affective equivalent of someone with a C-3 spinal cord injury. It was like going from satellite TV to one lousy channel.

Drugs similarly affected my cognition. Lithium, while successfully reigning in my mood swings, turned my formerly agile mind into mush, leaving me so cognitively stupefied that if my brain could drool, it would have. My creative writing was stopped dead in its tracks. Where I used to write short stories and poetry as easily as if someone were whispering them in my ear and I only had to write them down, now nothing I did could summon the muse. Even talking became difficult; word retrieval was painful and slow. Finding the right word was like being a child at a carnival trying to manipulate a claw-and arm machine to pick up a toy. How could I write when I couldn't even think?

Me, my self and my dopamine

As you know, paralyzing fatigue was the presenting symptom of my depression. Central nervous system stimulants have been an integral part of my regimen just to keep me awake. On a bad day, I could sleep right through them. The inconstant self is only exacerbated by my medication regimen. Watch what happens: At breakfast, I take my handful of pills (Wellbutrin, Abilify, lithium, Provigil, Zoloft, synthroid and Ritalin) and flip through the newspaper. Genocide, tornadoes, celebrity shoplifting---none of the articles compel me. The columns appear endless, the font, impenetrable. Then, out of what William James called the "bloomin' confusion," come the first signs of alertness. Dawn is breaking in the prefrontal cortex.

Now articles do not just seem interesting, they are *fascinating*. I want to know everything about the subject I'm reading about: its historical context, antecedent events, implications and ramifications, underlying socio-political ideologies. Physically, my body, which was being propped up by the counter, suddenly snaps to attention, as though a spinal column has been retrofitted in my back. Once energized, I am eager to start my day and go to my study where various writing projects await me.

John Dewey called desires "the moving springs of action." I would argue that desire *needs* energy, it does not *produce* energy. For example, even if I really want to write about something, I can't do it without energy. Desire alone cannot propel me toward action. Desire without energy is like an airplane sitting on a runway without Jet A. Once my Ritalin kicks in, I have the energy to fuel desire. Yet energy alone is not sufficient to propel desire into action. Desire needs an engine, and that engine is motivation. Desire without motivation is like a psychic dust devil: my ideas would just swirl around unproductively in my head, banging against the inside of my skull.

Properly equipped with energy, desire, and motivation (and concomitantly mental alertness and concentration), I attack my writing project with an optimism veering on the familiar (not to say, wonderful) "can do" feeling of mania.

Energy also affords me the opportunity to get things done that most people take for granted. Errands, for instance. With energy and motivation, I am able to go grocery shopping, buy stamps, etc. After having wallowed in a state of inertia for years, incompetent to fulfill even the most mundane tasks of the housewife, being able to do errands is a blessing.

But Ritalin's incursions into my brain are not limited to the physical realm (energy), the cognitive realm (desire, motivation, concentration), they affect my social behavior, too. As you know, I've always been an introvert, a person who's not particularly interested in interacting with the outside world. Fueled by Ritalin, however, I become socially gregarious--voluble and perky as a talk-show guest, effortlessly chatting up the woman at the dry cleaners for a good ten minutes. To my horror, I've been accused (during one of these moments) of having "a delightful personality."

The afternoon antipodes

While my morning is characterized by the stimulant going through my bloodstream, the afternoon is colored by its absence. By 1:00 p.m., I am back in the grip of frontal lobe syndrome. In a matter of a few hours, I've gone from energy to fatigue, from interest to apathy, from confidence to despair, from sociability to avoidance. When the Ritalin runs out, the show is over: Cinderella's carriage reverts to a mouse-driven pumpkin. I am struck by a fatigue so overwhelming, it feels like paralysis. It is motoric retardation writ large. I see in the literature your colleagues struggle to differentiate

between "physical fatigue" and "mental fatigue." That is beside the point; phenomenologically, they are identical. When I've complained to you of my neurovegetation, you've assured me I could get off the sofa if the house were on fire. I'm not so sure. Without energy, interest flags, motivation stalls. Subjects that seemed so interesting in the morning are met in the afternoon with apathy. How insightful John Dewey was when he wrote: "All of us have desires, all at least who have not become so pathological that they are completely apathetic." Nothing interests me. I don't want to go anywhere or do anything. The indecisiveness that is characteristic of depression results, I think, from an absolute lack of desire. Apathy and anhedonia are a consequence of depletion of energy. I'm too *tired* to do anything. Even breathing seems like work.

The work I was doing in the morning, by afternoon seems like crap: pointless, worthless and meaningless. The telephone calls I easily answered in the morning go unanswered in the afternoon. By 3:00, my day is effectively over. And then, the next morning, it begins anew.

So I ask myself: Do I have a "core" self? Which elements can be removed from this self and have the essential self remain intact? Am I now my "real" self, only minus the depressive symptomatology? Or am I a new self comprised of the effects of the illness and the medications used to treat it? Why do some people make complete recoveries from mental disorders, while others make only partial ones? Does each person have a maximum level—a ceiling—of therapeutic response? Are some people stuck with residual symptoms no matter what the psychotherapeutic and pharmacologic treatments? How probable, really, is recovery from depression or any other serious mental illness?

We can discuss this next time we meet. In the meantime, be mindful that each patient that comes through your door is more than an illness with some vague premordbid personality hovering in the background, they come in with a premordbid *life*. They may never approximate who they once were, may never recapture a range of affective response, may never come close to fulfilling their potential. Their issues go beyond the psychological: they are ontological, striking at the very core of our beings.

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Legislative Update

By Sally Mann

National

Big Advocacy Push Needed to Pass The Mentally Ill Offender Treatment and Crime Reduction Act

After passing the Senate in 2003, "The Mentally Ill Offender Treatment and Crime Reduction Act" (S. 1194) has, until recently, languished in the House of Representatives. Now, it appears that the bill is beginning to move in the House. S. 1194 and H.R.2387 will provide communities with "opportunities to implement services to break the endless cycle of deterioration and arrests for people who are not criminals but desperately need treatment!" The bill will provide communities with "opportunities to implement services to break the endless cycle of deterioration and arrests for people who are not criminals but desperately need treatment!"

Witnesses at the hearing in the House of Representatives included a representative from NAMI and The Honorable Cheri Nolen, Deputy Assistant Attorney General, Office of Justice Programs, U.S. Department of Justice; Sheriff Ted Sexton of Tuscaloosa, Alabama (incoming president of the National Sheriffs Association); and John Monahan, Ph.D., University of Virginia School of Law, a nationally recognized expert on law and psychiatry.

Despite the recent progress, more support is needed in the House, particularly from House Republicans. Please continue contacting your U.S. Representatives (whether Republican or Democrat) to urge their support for S.1194/HR 2387. Go to www.nami.org/enews4-29 for a letter you can write your legislator.

Illinois

The Medicaid Mental Health Trust Fund

Governor Blagojevich announced in his budget address that he wants to use \$60 million in Medicaid funds to solve the state's budget problems. The Medicaid Mental Health Trust Fund established by legislators and signed into law several years ago has been identified by the Governor as one of these special Medicaid funds he plans to raid. It is possible that he may take as much as \$50,000,000 from this fund in FY 2005.

The funds in question support mental health care for children and adults. A diversion of this size from the Medicaid Mental Health Trust Fund will bankrupt the Mental Health system and adversely affect communities throughout Illinois. Thus, fewer services will be provided to disabled children and adults in Illinois.

A change in the fund would require approval from the Illinois legislature. The legislators and the Governor may benefit from a better understanding of the Medicaid Mental Health Trust Fund and the Medicaid services that you provide in your communities. If you want your voices to be heard, contact your state legislators and the Governor today.

Tell your legislators: No Change to The Medicaid Mental Health Trust Fund

The funds in question support mental health care for disabled children and adults in their communities. Act Today.

To find the legislators for your area, go to <http://www.firstgov.gov/Contact/Elected.shtml> □

Medical Device Update

FDA Approves Vagus Nerve Stimulator for Treatment of Depression

Summary From the Neurological Devices Panel Meeting

(June 15, 2004) The Neurological Devices Panel (the Panel) met on Tuesday, June 15, 2004 in Gaithersburg, MD to discuss and make a recommendation to the Food and Drug Administration (FDA) on the approvability of the Cyberonics, Inc. PMA, P970003/S50 for the Vagus Nerve Stimulator (VNS) Therapy System intended for the adjunctive long-term treatment of chronic or recurrent depression for patients over the age of 18 who are experiencing a major depressive episode that has not had an adequate response to two or more antidepressant treatments. The Panel membership for this meeting consisted of four psychiatrists, one interventional neuroradiologist, two neurologists, a statistician, a consumer representative, and an industry representative.

The sponsor presented its information on the safety and effectiveness of the device, and FDA reviewers summarized the data in the PMA. After deliberations on the information in the submission, the Panel considered FDA's questions.

The Panel then voted five to two to recommend that FDA approve the PMA with conditions. The recommended conditions of approval are as follows:

1. Patients should have failed four or more trials of traditional treatment modalities for treatment-resistant depression (medications and electroconvulsive therapy) prior to use of the device.
2. The device be implanted by surgeons with appropriate training.
3. Training regarding device electronic programming be provided for primary care providers.
4. Additional patient labeling for use of the device and identification card be provided.
5. A patient registry to collect clinical data be established.
6. The physician labeling be revised regarding the following: 12 month open label follow-up, the variable effect of treatment, patient selection, and deletion of imaging claims.

The Panel members who voted against conditional approval believed a new study was necessary to

establish a reasonable assurance of safety and effectiveness of the device.

[Source:
<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfAdvisory/search.cfm> □

Calendar

July 7 Board of Directors meeting
All NAMI CCNS members welcome. 7:30 at Wilpower, Inc., 444 W. Frontage Road, Northfield.

July 8 Visions of Tomorrow Support Group
A support group for parents of children, adolescents, and young adults with mental disorders. Meets at Kenilworth Union Church, 211 Kenilworth Avenue, Kenilworth, 7:30-p.m.-9:00 p.m. Call Barb Maier for details 847 446-8416 *NOTE: No Visions of Tomorrow Support Group in August*

July 25 Sundays at One
A social group for young adults coping with mental disorders, run by young adults also struggling with mental illness. 1:00 p.m.-3:00 p. m. at Borders Bookstore, 49 S. Waukegan Road, Northbrook (corner of Waukegan and Lake Cook Roads). For information and registration, call Nate Maier 847 446-8416 or Alan Carlile 847 736-4587 *NOTE: No Sundays at One in August*

September 9 Visions of Tomorrow Support Group (*see July 8*)

September 26 Sundays at One (*see July 25*) □

NAMI CCNS Education Classes, Support Groups and Other Services

***NAMI CCNS offers two psychoeducational classes each year in the fall and winter**

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

***Family to Family** A 12-week class designed for family members and close friends of individuals with brain disorders (mental illnesses). The course presents comprehensive information on schizophrenia, major 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 Monthly Meeting is an educational program featuring speakers with expertise in mental-health related topics.

Visions for Tomorrow Support Group This group, which meets the second Thursday of each month, is for parents of children adolescents and young adults with mental disorders. Call Barb Maier, facilitator, for information. 847 446-8416

Response Team A "warm line" (not a crisis hot line) for anyone looking for resources, referrals (or just a chance to connect with others) about dealing with mental disorders. Call the NAMI CCNS office and leave a message, 847 724-1460 (messages are picked up three times a week by our response team members)

"Sundays at One" is a new, monthly social meeting group for young adults (ages 18-35) coping with mental disorders (such as depression, bipolar disorder, anxiety, schizophrenia, eating disorders, OCD). Run by Alan Carlile and Nathan Maier, who also struggle with chemical imbalances, the group will emphasize good mental health and offer activities for young adults who want to do things together. Group meets last Sunday of the month, 1:00 p.m.-3:00 p.m. at Borders Bookstore, 49 S. Waukegan Road, Northbrook (corner of Waukegan and Lake Cook Roads). For information and registration, call Alan at 847 736-4587 or Nathan at 847 446-8416

Other Organizations

Anorexia Nervosa and Associated Disorders (ANAD) invites interested parties to call for referrals, information and local support groups. Call Dawn (847) 831-3438

The Depression Support Group meets the fourth Monday of every month at the Kenilworth Union Church, 211 Kenilworth Avenue, Kenilworth at 7:30 p.m. Group invites individuals and families interested in learning more about depression and manic depression (bipolar disorder) to attend. Call (847) 251-4272 for more information

The Child and Adolescent Bipolar Foundation (CABF) is a national, parent-led organization of families raising children diagnosed with (or at risk for) bipolar disorder. For information on support groups, on-line library and other activities visit www.bpkids.org or call (847) 256-8525

Depression and Bipolar Support Alliance of Metropolitan Chicago (DBSA) offers support for persons affected by depressive or manic-depressive disorders. Call (773) 275-3230

Depression and Bipolar Support Alliance (DBSA) meets the second and fourth Mondays of each month at the Devon Bank, 6445 N. Western Ave., Chicago, at 7:30 p.m. Call Chet for details (773) 465-3280

Obsessive Compulsive Disorder Support Group meets weekly Thursday evenings at Resurrection Hospital, 7435 W. Talcott, Chicago. 7:30-9:00 p.m. Call Carol Miller, facilitator, for information 773-774-3019

Obsessive-Compulsive support group Professionally-led group for adults (and their support persons) with OCD per session. Meets the first Monday of each month at Anxiety and Agoraphobia Treatment Center, Frontage Road, Northbrook, 7:30-9 pm. \$25 per session. Call Alona Ramati, M.S. 847-559-0001 ext. 8 before attending first meeting for information