



Medication Update

FDA Public Health Advisory

Suicidality in Adults Being Treated with Antidepressant Medications

Several recent scientific publications suggest the possibility of an increased risk for suicidal behavior in adults who are being treated with antidepressant medications. Even before these reports became available, the FDA began a complete review of all available data to determine whether there is an increased risk of suicidality (suicidal thinking or behavior) in adults being treated with antidepressant medications. It is expected that this review will take a year or longer to complete. In the meantime, FDA is highlighting that:

- Adults being treated with antidepressant medications, particularly those being treated for depression, should be watched closely for worsening of depression and for increased suicidal thinking or behavior. Close watching may be especially important early in treatment, or when the dose is changed, either increased or decreased.
- Adults whose symptoms worsen while being treated with antidepressant drugs, including an increase in suicidal thinking or behavior, should be evaluated by their health care professional.

These recommendations are consistent with existing warnings for treated adults in the approved labeling (package insert) for antidepressant medications that can be found at: www.fda.gov/cder/drug/antidepressants/PI_template.pdf The Healthcare Professional and Patient Information Sheets for the antidepressant indications will be updated to add this information within the week. A list of drugs to be included in this update can be found at: www.fda.gov/cder/drug/antidepressants/antidepressantList.htm

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NAMI CCNS Annual Fundraiser

Please join us Sunday, October 30 for a special showing of a film about Howard Hughes, chronic sufferer of OCD, by Jane Atlas and Joyce Grant, formerly of the New Trier English department. The film and lecture chronicles Hughes' struggles with obsessive-compulsive disorder as he built his financial empire, created scientific breakthroughs, and had tumultuous relationships with some of Hollywood's most famous women. Atlas and Grant examine Howard Hughes' walk on the razor's edge separating genius from madness.

Tickets are \$40 per person; the money goes to fund NAMI CCNS programs that help educate people with OCD and other mental disorders. Presentation will be held at the Northshore Senior Center, 161 Northfield Road, Northfield, from 2:00-4:00 p.m.

Please call Deb Walsh at 847-784-0446 or Pat Rodbro at 847-945-6402 for tickets and information.

From the Co-Presidents

Dear Members,

When the unimaginable, unthinkable, unanticipated state of psychosis occurs in someone we love, who steps up to the plate? Who has the power to act? In Illinois you cannot hold someone against their will for more than 72 hours unless they are deemed a danger to themselves or others. Precious time can be lost because some of the most effective medications or treatments cannot be administered in a timely manner without the patient's prior authorization. So what can we do to avoid devastating consequences? A Declaration of Mental Health Treatment. [This legal document can be found on the NAMI CCNS website: www.namiccns.org.]

To summarize:

When a person is unable to make good treatment decisions, a good crisis plan should include an advance directive for medical health treatment that details the type of treatment you would like to receive or avoid. This legal document empowers you to make decisions in advance about three types of mental health treatment: psychotropic medications, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. If a judge or physician believes you are incapable of making treatment decisions, the Declaration will be followed (otherwise, you will be considered capable to give or withhold consent for the treatment).

This declaration becomes valid when signed by you and two qualified witnesses (who are personally known to you and present when you sign or acknowledge your signature). You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. This document can be personalized to include things such as what treatment facility you would prefer to be taken to, which family members you would like to be involved, how you want family members to treat you, and what signs they should look for to signal your recovery.

On another note, on August 9th, Judy Graff and Ann George attended the grand opening celebration of Eden Supportive Living. It is Illinois' first community for young adults with physical disabilities. It is privately owned and managed, and along with resident apartments, it has a movie theater, fitness center, an art gallery, and many Smart-Home features. It is located at 140 West Gordon Terrace, Chicago, telephone 773-472-1020.

Board meetings are open to all members. We encourage you to attend. This is a good way to learn about what NAMI CCNS is doing. The next meeting will be held September 7 and October 5 at Wilpower, 444 Frontage Road, Northfield, at 7:30 p.m. If you would like to contact us directly, please do so by email: CHughesNamiCCNS@aol.com or anngeorge@comcast.net, or call the NAMI CCNS telephone number: 847-724-1460.

Sincerely,

Candice Hughes and Ann George

2005 Board of Directors

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Questions, comments?

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Website maintained by Tom Maier

September October 2005



Medication Update/ *continued*

FDA is working closely with the manufacturers of all marketed antidepressants to fully evaluate the risk of suicidality in adults treated with these drugs. The FDA has asked these manufacturers to identify all placebo-controlled trials conducted in adults in their development programs for their antidepressant products, regardless of the indication studied, and to provide information from these trials to FDA. Manufacturers are being asked to use a similar approach to assembling this information as was used in evaluating the risk of suicidality in placebo-controlled trials in pediatric patients treated with antidepressant medications. The method used to analyze the data for risk of suicidality in children using antidepressant medications is described in more detail at the following web page: www.fda.gov/cder/drug/antidepressants/default.htm. A similar approach will be used for adults.

FDA's comprehensive review will involve many hundreds of individual clinical trials and many thousands of adult patients. It is expected that this review will require a year or more to complete because of the large number of trials and the thousands of adverse events that must be checked for possible evidence of suicidality. The FDA will make the results of its review available to the public once its analyses are complete, and will update this advisory in the meantime if more definitive information becomes available.

Source: FDA/Center for Drug Evaluation and Research

FDA Safety Labeling Change: Clozapine and Granulopoietic Suppression

The FDA approved revisions in the safety label for Novartis Pharmaceuticals Corporation's clozapine tablets used in the treatment of schizophrenia. Baseline white blood cell (WBC) and absolute neutrophil counts (ANC) should be established prior to starting the medication. Subsequent evaluations must be made on a regular basis, including at least four weeks following discontinuation.

Source: FDA/Center for Drug Evaluation and Research

VNS Given Final Go-Ahead

The FDA has approved Cyberonics' VNS (vagus nerve stimulator) device for adjunctive long-term treatment of depressed patients who have failed to respond to four or more antidepressant treatments. The device is a pacemaker-like implant that sends electrical pulses from the chest to the vagus nerve in the base of the brain. The implant was approved for epilepsy in 1997.

Following a failure in their phase III study, Cyberonics tracked the patients on the device for two years, finding a response of 21 and 30 percent based on two different measures after one year, about double the response in a comparison treatment-as-usual group. As part of the conditions for approval, Cyberonics must conduct new trials.

The device plus the surgery (in and out the same day or overnight) costs in the neighborhood of \$30,000 or more, though one's health plan may foot the bill.

Source: *McMan's Depression and Bipolar Weekly*

Venlafaxine Reduction/Discontinuation Can Lead to Impaired Driving

Medscape General Medicine's review of the widely used SNRI (serotonin- and noradrenaline-reuptake inhibitor) antidepressant, venlafaxine hydrochloride (Effexor, Dobupal), found that serious withdrawal symptoms may occur within hours of cessation or reduction of the patient's usual dosage. Withdrawal symptoms include confusion, impaired coordination, sensory disturbances, vertigo, delirium, stroke-like symptoms, and depersonalization. The author, Daniel Campagne, concludes, "Patients should be explicitly urged either to adhere to a strict medication routine or do not drive a car (during withdrawal)." Withdrawal symptoms may occur irrespective of dosage. Tapering (the recommended tapering period for venlafaxine is two weeks) may not necessarily be sufficient to prevent these symptoms. Patients should be aware of the possibilities of severe withdrawal symptoms and avoid driving or operating hazardous machinery.

Source: Daniel Campagne, "Venlafaxine and Serious Withdrawal Symptoms: Warning to Drivers," *Medscape General Medicine*, 2005; 7 (3)

FDA Approves Adderall XR for Adolescents with ADHD

The FDA has approved an expanded indication for Shire Pharmaceuticals Group's Adderall XR as a once-daily treatment for ADHD among adolescents aged 13 to 17 years. Previous approval for use in children aged 6 to 12 years and for adults aged 18 and over was granted in 2001 and 2004, respectively. ■

A Guide to...

“Understanding” Suicide

By Linda Logan

Last month I attended the funeral of a 42 year-old woman who committed suicide. She left behind a husband and two young children. Those closest to her tried desperately to help her. But in the end their efforts and intentions were defeated by an insidious and lethal disease: depression. Depression killed Kate* as surely as if she had been felled by cancer.

(*Not her real name)

At the service, friends and family members expressed a range of emotions: shock, disbelief, sadness, anger, and numbness—common reactions to many deaths. But running through their reactions was a struggle to “make sense” of Kate’s death, a desperate need to “understand” what propelled her to do this heinous and irrational act. Over and over I saw people shaking their heads in disbelief, asking each other why—*how*—could she have killed herself.

According to the research, suicide’s apparent inexplicability is one of the salient features of survivors’ (the friends and family left behind) grief. Unlike a death from cancer, a death committed at the behest of a mental disorder frequently haunts survivors who may replay every event, every conversation they had with the deceased, berating themselves with a litany of “coulda, woulda, shoulda’s,” and beating their heads against the wall searching for a reasonable explanation.

Yet, I would argue that there is no way they could “understand” suicide. Why not? Because they don’t speak the language. Picture this: you enter a room where everybody in it is speaking, say, Norwegian. You struggle to comprehend a sentence, a single word, anything—but you can’t. So it is with suicide and suicidal ideation (suicidal thoughts). Entering the mind of a suicidally depressed person is like crossing into the Twilight Zone: it is an alternate reality with its own dark logic. If you are a severely depressed person contemplating suicide, you may appear—to the outside world—as a loving parent and spouse, a capable and well-liked worker. You may or may not seem depressed (more about that later). But your internal reality tells you otherwise: you are a pathetic excuse for a human being, unworthy of the space you occupy on the planet. In your work life, you are a failure and a fraud, never living up

to your (and/or others’) expectations. You are a failure as a parent, a disappointment as a spouse. Though you love your children with an intensity bordering on ferocity, you believe it is better that they should grieve for you and move on than be saddled with you for the rest of their lives. Well-meaning friends and family members who tell you this will pass, that you are ill and can get better, simply don’t get it: it is hopeless. No one has *ever* felt like this before. Each day your psychic pain grows greater. Life assaults you with the violence of a knife wound. It hurts to even breathe. Suicide promises a release from this inarable pain. You are caught in a rip tide, being carried far from shore. Some of you will make it safely back; others will not. *That’s* the language of suicide.

Every year, 30,000 people kill themselves in the U.S. An estimated one million die by suicide worldwide. Yet for all the time and money being funneled into suicide research and prevention, we have, as Robert Frost said, “Miles to go before we rest.”

Suicide and mental disorders

According to the NIMH, “90% of people who kill themselves have depression, substance abuse, or other diagnosable mental disorder.” The important thing to note here is that of these 90%, most (again, according to NIMH) were undiagnosed, untreated, or both. How can this be? Wouldn’t the person’s illness be so evident that anyone could recognize it? The answer is no.

Depression is an illness with many masks. It is not simply about sitting in a corner all day, crying (although it could be). In some cases, depression is not about sadness at all. In younger people, for example, depression may manifest itself as school truancy and substance abuse. For other people, it may be present as irritability and rage. Some people are highly anxious and agitated.

It is important to understand which disorders and characteristics place a person at risk for suicide:

- **Depression**

The NIMH estimates that 60% of the people who kill themselves had a mood disorder. According to American Association of Suicidology, a depressed person is at a 20 times greater risk for committing suicide than the general population.

- **Schizophrenia**

Suicide is a serious danger in people who have schizophrenia. People with schizophrenia have a higher

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“Understanding” Suicide/ *continued*

rate of suicide than the general population. Approximately 10% of people with schizophrenia (especially younger adult males) commit suicide. Unfortunately, the prediction of suicide in people with schizophrenia can be especially difficult.

- **Impulsivity**

Impulsiveness is the tendency to act without thinking through an action or its consequences. Impulsiveness is a symptom of several mental disorders. The mental disorders with impulsiveness most linked to suicide are: Borderline personality disorder among young females; conduct disorder among young males; antisocial behavior in adult males; and alcohol and substance abuse among young and middle-aged males.

- **Anxiety and agitation**

Severe anxiety and agitation are risk factors for suicide. A recent Swedish study found that acute anxiety increases the chances of suicide by nine times in men and three times in women.

- **Alcohol and drug abuse**

Alcohol and drug use, when co-occurring with a disorder such as depression, puts an individual at a 50% to 70% higher risk of suicide than the general population.

- **Parasuicide**

A history of parasuicide (or suicide attempts) increases the risk for a successful, or completed, suicide tremendously. According to NIMH, “A single previous attempt multiplies suicide risk by 38 to 40 times.” 10% of patients who make suicide attempts die of a suicide within ten years. Unfortunately, although parasuicide can be a useful indicator for suicide risk, approximately 50% of completed suicides are first attempts.

Gauging a person’s mental state and suicidal ideation

- **Does the person seem...**

Unable to make decisions? Unable to concentrate, remember, or think clearly? To have lost interest in the things they used to like to do? To be withdrawing from friends and family? To be having more problems at work, school, or home?

- **Does the person complain about...**

Aches and pains, such as headaches, stomachaches, or backaches? Feeling sad or empty? Feeling hopeless, helpless, or worthless? Having a decreased or increased appetite? Being unable to sleep (and stay asleep) or have trouble waking up in the morning?

- **Is the person...**

More restless? Irritable? Crying? Isolated or secluded? Drinking or doing drugs more than usual? Displaying rage

and uncontrollable anger? Engaging in uncharacteristically risky behavior?

- **Has the person talked about...**

Death, dying, committing suicide? Wanting a way to stop the pain? Seeing no hope of change for the future?

If someone is talking about suicide

Be your brother’s keeper. Get help and get it fast. Call 911. Hospitalize the person if they appear to be in immediate danger. Otherwise, set up an appointment with a mental health professional and *take* your friend or loved one there. *Do not leave the person alone.* You may also call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). Look around your house and eliminate things such as guns, pills, or other potentially lethal objects (this is called means reduction). Studies have shown that suicidal people do not automatically substitute means of killing themselves if the desired method is removed. This means if they were planning on using a gun and the gun is removed, they will not necessarily look for another means of killing themselves. Firearms are the most common method of committing suicide among both men and women. The NIMH states, “The presence of firearms in the house has been found to be an independent, additional risk factor for suicide.”

Talk to them:

- Be willing to listen. Find a block of quiet time when you and your friend can talk.
- Ask if he or she is thinking about suicide. Yes, ask! Asking doesn’t make people commit suicide.
- Be direct; talk opening and freely about suicide.
- Allow the person to express his or her feeling and accept them. Don’t try to argue point by point or “solve” each of their problems. Let them talk.
- Don’t be judgmental.
- Don’t debate whether suicide is right or wrong.
- Tell them treatment (and hope) is available, but don’t offer glib reassurances, which only prove you don’t understand.
- Don’t allow yourself to be sworn to secrecy.
- Don’t force the person to promise he or she won’t commit suicide. It won’t do any good.

Treat the underlying psychopathology

Studies show the most effective means of treating severe depression is through a combination of psychotherapy *and* psychopharmacology (medications). According to the NIMH, “Not only does treatment lessen the severity of

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“Understanding” Suicide/ *continued*

depression, it may also reduce the length of time a person is depressed and may prevent additional bouts of depression.” Suicide research has shown that continued care with a psychotherapist is critical. As the Institute of Medicine argues, “Medication alone is not sufficient treatment for suicidality. Psychotherapy provides a necessary therapeutic relationship that reduces the risk of suicide.” In terms of medications, there is, unfortunately, no magic anti-suicide pill. Moreover, the relatively long lead-time of many antidepressants makes waiting for the meds to kick in a frustrating and dangerous time for the suicidal patient. The absence of an immediate effect may confirm the patient’s sense of futility about treatment and the possibility of getting better. Medication takes time and requires patience from the patient and reassurance from the therapist. However, once a regimen has been established, studies indicate, “Medications will reduce suicide risk if maintained for at least 6 months in bipolar and unipolar patients.” Recent research has established that cognitive therapy reduces repeat suicide attempts by 50%. Cognitive therapy teaches the suicidal person new ways to handle negative thoughts and feelings of hopelessness. By learning adaptive ways to handle stress and resolve their problems, they are reducing the likelihood that they will resort to suicidal behavior as a solution. Also, while antidepressants have been shown to be no more effective than placebo in the first eight weeks of treatment, the drug, clozapine, is the first FDA-approved drug shown to be effective in preventing suicide attempts among persons with schizophrenia. In bipolar disorder, preliminary studies are showing similar results for lithium carbonate.

Is suicide preventable?

To be preventable, suicide must be predictable. And, despite the plethora of research coming out of NIMH and other organizations, predicting suicide is more of an art than a science. Mental health professionals have no less than 30 instruments to assess suicidal ideation. These instruments consider dimensions such as hopelessness, hostility, negative self-evaluation, irrational beliefs, psychological pain, external pressures (stressors), agitation, history of parasuicidal behavior, reasons for living, and angry impulsivity. With names like the Lethality Scale, the Brief Reasons for Living Scale, SADS Persons Scale, Paykel Suicide Scale, and Self-Monitoring Suicide Ideation Scale, the instruments vary widely in their reliability and predictive value, and false positive and false negative results. The low base rate of suicide (suicide is a relatively rare occurrence) makes prospective studies especially difficult.

As one noted suicide researcher has stated, “It is well established that suicide is unpredictable in an individual.” All we can do is study the aggregate and look for patterns of suicide risk. Likewise, the NIMH asserts, “At the current time there is no definitive measure to predict suicide or suicidal behavior. Researchers have identified factors (mental illness, substance abuse, family history of suicide, history of sexual abuse, impulsive or aggressive tendencies), but very few persons with these risk factors will actually commit suicide.” Finally, the suicidal person himself is often mute on the subject. While many suicidal people send out signals of their distress, a person intent on committing suicide will often deny their intent to loved ones and, especially, mental health professionals. “A number of studies have shown...that the patient’s denial of suicidal ideation is common before a suicide.” A Note to Suicide Survivors: If the best minds and research institutions in the country cannot predict—let alone prevent—suicide, how is the average family struggling to keep a suicidal person afloat supposed to? Apart from keeping them safe, hospitalizing them, or enlisting treatment and medication, there is only so much that can be done. The burden of grief for suicide survivors is heavy enough without the unnecessary weight of guilt and recrimination. ■

Sources: National Institute of Mental Health (NIMH), Gregory Brown, “A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults”; Jan Fawcett, “Suicidal and Bipolar Disorder,” *Medscape Psychiatry and Mental Health*, 2005; 8 (2); NIMH, “Reporting on Suicide: Recommendations for the Media”; NIMH, “In Harm’s Way: Suicide in America”; NIMH, “Frequently Asked Questions About Suicide”; NIMH, “What to do When a Friend is Depressed”; NIMH Press Release, “Cognitive Therapy Reduces Repeat Suicide Attempts by 50%”; *British Medical Journal Specialist Journals*, news release August 11, 2005 cited in Robert Predict, “High Anxiety Can Be Deadly,” *HealthDay*, August 22, 2005; Centers for Disease Control and Prevention, “Youth Suicide Prevention Programs: A Resource Guide”; Institute of Medicine, “Reducing Suicide: A National Imperative”; American Association of Suicidology, “Understanding and Helping the Suicidal Individual.”

For More Information

For nearly fifty articles on suicide—from screening and prevention, at risk populations, to coping for survivors, and research, go to the Suicide web page at MedlinePlus:
www.nlm.nih.gov/medlineplus/suicide.html

Calendar

September 7 Board of Directors meeting at Wilpower, Inc., 444 Frontage Road, Northfield, 7:30 pm.

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

September 13 “Care and Share” is a support group for people with mental disorders and their families and friends. Rush North Shore Hospital, 9600 Gross Point Road, Skokie, 7:30-9:00 pm. (Sharfstein Auditorium). No charge; no registration required. Call Maun Dee for information at NAMI CCNS 847-724-1460.

September 21 “Treatment and Research Advancements in Personality Disorders,” Sponsored by National Association for Personality Disorders. Newcomers & introduction - 6:30 to 7:00 pm; Structured program - 7:00 to 8:30 pm; Mindfulness exercise & closing - 8:30 to 9:00 pm. Northwestern Memorial Hospital, Feinberg Pavilion, 3rd Floor, Conference Room E, 251 East Huron Street, Chicago. Email rh5mail-tara@yahoo.com for information. Parking available for \$8.00 after 3 pm at NW corner of N Fairbanks and E Ohio (2 1/2 blocks from NMH). Suggested donation: \$5.00.

September 23-24 “Visions for Tomorrow Teacher Training” at the Doubletree Oakbrook (formerly the Oakbrook Hyatt). Call Barb Maier for information at 847-446-8416.

September 25 “Sundays at One” is a support group for young adults with mental disorders who want to do things together. 1:00-3:00 pm. Borders Bookstore, 49 S. Waukegan Road, Northbrook (corner of Waukegan and Lake Cook Roads). For information and registration, call Nate Maier 847-446-8416.

October 4 “The Medicare Prescription Drug Benefit - Part D: Impact on Medicare Enrollees,” is an educational seminar by health and disability advocates, including Stephanie Altman, attorney, Health and Disability Advocate and the co-author of *Medical Assistance*

Programs in Illinois and the *Illinois Medical Assistance Action Plan*. Topics covered: issues concerning eligibility and enrollment for extra help; how the Illinois Pharmaceutical programs will coordinate with Part D; the Prescription Drug Plan (PDP) formularies; the exception and appeal procedures. Sponsored by NAMI of Greater Chicago, 1536 West Chicago Avenue, Chicago. 4:00-6:00 pm. For free registration call 312-563-0445.

October 5 Mental Health Recovery Fair, “Recovery and Beyond,” presented by the Illinois Department of Human Services, Division of Mental Health Region II, Community Partners in Recovery Planning Committee, with keynote speaker, Carol Simontacchi, CCN, MS, author of *The Crazy Makers*, at the Elgin Mental Health Center, Routes 20 and 31 South, Elgin, 10:00 am-3:30 pm.

October 5 Board of Directors meeting at Wilpower, Inc. 444 Frontage Road, Northfield, 7:30 pm.

October 11 In conjunction with Mental Illness Awareness Week, NAMI CCNS will be hosting a program at 7:30 pm in the Sharfstein Center at Rush North Shore Medical Center, 9600 Gross Point Road in Skokie. Program details to be announced in a separate mailing to members.

October 13 “Visions for Tomorrow Parent Support Group” (See *September 8*)

October 30 NAMI CCNS Annual Fundraiser, Northshore Senior Center, 161 Northfield Road, Northfield from 2:00-4:00 pm. A film on Howard Hughes by former New Trier English teachers, Jane Atlas and Joyce Grant, will be presented. Hughes suffered from obsessive-compulsive disorder, a devastating, but treatable, mental disorder that affects one in every 50 adults and one in every 100 children. NAMI CCNS gives people with OCD and other disorders the resources they need to be educated. Your support of this program will help fund our work. Tickets are \$40 per person. Please call Deb Walsh at 847-784-0447 or Pat Rodbro at 847-945-6402 for tickets and information.

October 30 “Sundays at One” (see *September 25*) ■

Legislative Update

By Sally Mann

National

Medicaid Reform Commission Endorses Higher Co-Payments for Prescription Drugs, Medication Access Restrictions, Rejects Bid to Narrow Definition of Rehabilitation and Case Management Services

On August 18, a federal Commission charged with developing changes to the Medicaid program endorsed a series of recommendations to Congress for trimming future spending by \$10 billion over the next 5 years. These changes included a number of recommendations that would have an enormous impact on beneficiaries with severe mental illness including higher co-payments for prescription drugs and diminished access to specific medications through prior authorization, therapeutic substitution and other administrative barriers.

This Commission – authorized by Congress and selected by HHS Secretary Mike Leavitt – will now shift to developing long-term reforms for Medicaid by late 2006. In the meantime, Congress will be finalizing legislation cutting Medicaid by \$10 billion over the next five years in September. While the recommendations of this Commission are not binding on Congress, they will carry significant weight. Likewise, a separate set of proposals from the Bush Administration will also be considered by both the House Energy & Commerce and Senate Finance Committees early next month.

Advocates are strongly encouraged to urge members of Congress to:

- Oppose increases in co-payments for prescription drugs covered under Medicaid.
- Oppose restrictions to the definition of rehabilitation and case management services recommended by the Bush Administration.
- Oppose efforts to restrict access to medications to treat mental illness through increases in supplemental rebates.

Medicare Modernization Act Fact Sheets

www.cms.hhs.gov/medicarereform/factsheets.asp

- “Quick Facts about Medicare’s New Coverage for Prescription Drugs for People with Limited Income and Resources”

www.cms.hhs.gov/medicarereform/limitedincomeresources11105.pdf

- “Quick Facts about Medicare’s New Coverage for Prescription Drug If You Applied for Extra Help” www.cms.hhs.gov/medicarereform/11130ifyouappliedforextrahelp.pdf
- “Quick Facts about Medicare’s New Coverage for Prescription Drugs” www.cms.hhs.gov/medicarereform/newcovpresdrug.pdf
- “Quick Facts about Medicare’s New Coverage for Prescription Drugs” (en Espanol) www.cms.hhs.gov/medicarereform/elnewcovpresdrug.pdf
- “Quick Facts about Medicare’s New Coverage for Prescription Drugs for People who Get Supplemental Security Income Benefits or Help from Their State Medicaid Program Paying Their Medicare Premiums” www.cms.hhs.gov/medicarereform/ssi.pdf
- “Quick Facts about Medicare’s New Coverage for Prescription Drugs for People with Medicare and Medicaid, and Medicaid Now Pays for Their Prescription Drugs” www.cms.hhs.gov/medicarereform/medicaid.pdf
- “Quick Facts about Medicare’s New Coverage for Prescription Drugs for People who Get Help from Their State Pharmacy Program to Pay for Their Prescriptions” www.cms.hhs.gov/medicarereform/statepharmacy.pdf

Illinois

Your Efforts Do Count

Governor Blagojevich has signed the following bills dealing with mental health into law:

- House Bill 59 now becomes Public Act 94-0402. This bill repeals the sunset provision in the current parity law, allowing Illinois’ parity law to continue in effect indefinitely.
- House Bill 2190 now becomes Public Act 94-0584. This bill adds Post Traumatic Stress Disorder to the list of illnesses that are covered by the Illinois mental health insurance parity law.

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- Senate Bill 283 now becomes Public Act 94-0574. This bill makes it somewhat more difficult to transfer juveniles to adult jurisdiction. Since a substantial percentage of persons in the juvenile justice system have a mental disorder, this legislation represents some progress in dealing with juveniles who run into trouble with the law.
- House Bill 3812 now becomes Public Act 94-0521. This bill allows persons facing involuntary commitment to agree to outpatient care. It also sets standards for voluntary admission.
- HB808 now becomes Public Act 94-0182 and permits record sharing (subject to fairly elaborate protections) between the Illinois Department of Corrections and the mental health system. This is intended to facilitate identification of persons with mental disorders in prisons and continuity of care upon discharge from prison.
- SB559 is now Public Act 94-0202 and permits police officers to transport persons to mental hospitals without personally observing the behavior that is the basis for commitment and without completing a commitment petition. The police officer must have reasonable grounds to believe that the person is committable; the person transported cannot be kept at the hospital against her or his will unless someone else completes a petition (and 2 certificates).
- Senate Bill 75 now becomes Public Act 94-0118. This bill authorizes a \$10 filing fee on all real estate documents with the proceeds to be used to support affordable rental housing. This bill, sponsored by Senator Martinez and Representative Hamos, will benefit persons with mental disorders.

Active support and advocacy from the mental health community have made these acts possible. Thanks to all who wrote letters, sent emails, or made phone calls to your legislators and the governor.

In further action, the Illinois legislature has created a new Subcommittee on Residential Services for Persons with Mental Illness as a subcommittee of the House Fee For Services Initiatives committee. This new subcommittee is chaired by our long time supporter and friend Rep. Julie Hamos.

Cook County Mental Health Court A Success

Last year a mental health court was established in Cook County as an alternative to jail or prison for people with mental disorders charged with non-violent crimes. People in the program are placed on probation and then linked to resources including counseling and medications that can help them break the cycle of repeat crimes. Not only does the program help these defendants, but it also relieves overcrowding of jails and prisons, which are not desirable settings for those with mental disorders.

According to a report in the *Chicago Tribune*, of the 35 men and women who entered the program, only one man has been convicted of a new felony. Before moving to the Mental Health Court, the same group averaged four arrests and two convictions each and spent 4000 days in custody in the year. Now under probation and supervision by the Mental Health Court, participants spent a total of 72 days in custody (spent by one man who was charged with a new drug offense).

Even more encouraging is the fact that statistics indicate participants are staying connected to services and staying out of jails and hospitals. Assistant States Attorney Mark Kammerer, one of the organizers of the program says, "They are psychologically stabilized... We are surprised how smoothly it's going and we're just really pleased."

Because of the resounding success of the program, planners are seeking federal grant money to increase the capacity of the court to around 300 defendants. ■



NAMI CCNS
Box 612
Winnetka, IL 60093

NAMI CCNS EDUCATION CLASSES, SUPPORT GROUPS AND OTHER SERVICES

**NAMI CCNS' two psychoeducational classes*

***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 for details)*

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

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

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 for details)*

Other Organizations

Anorexia Nervosa and Associated Disorders offers information on referrals, information, 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 p.m. 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 p.m. 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 Thursday evenings at Resurrection Hospital, 7435 W. Talcott, Chicago. 7:30-9:00 p.m. Call Carol Miller for information at 773-774-3019.

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 Mona Berman for information at 847-559-0001, ext. 4.

Obsessive Compulsive Foundation of Metropolitan Chicago Call for information 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 p.m. \$5 per session donation. Please email: rh5mail-tara@yahoo.com before attending for information. Web: www.tara4bpd.org *(See Calendar for details)* ■