

the challenger

A Publication of the NATIONAL ALLIANCE on MENTAL ILLNESS in Buffalo & Erie County

vol. 21, no. 5
July-August 2006

Mark Your Calendar

July

NAMI Family Meeting, Thursday July 13th, St. Paul's Lutheran Church, 4007 Main Street, Amherst. Hospitality and Library Hour: 7:00 PM. General Meeting: 7:30 PM. Guest Speaker: Bellamkonda Ragu, MD, a NAMI-award winning psychiatrist.

NAMI Business Meeting, Thursday, July 20th, 7:30 PM, St. Paul's Lutheran Church, 4007 Main Street, Amherst. (Note new location!) All NAMI members are invited to attend business meetings.

NAMI Family Support Group, Wednesday, July 26th, 7:30 PM, St. Paul's Lutheran Church, 4007 Main Street, Amherst. (Use left rear entrance if you are facing the back of the building from the parking lot.)

August

NAMI Family Meeting, Thursday, August 10th, St. Paul's Lutheran Church, 4007 Main Street, Amherst. Library and Hospitality hour: 7:00 PM. General Meeting: 7:30 PM. Guest speaker: Christopher Syracuse, Executive Vice President, DePaul Mental Health Services, on housing for those with mental illness.

NAMI Business Meeting, Thursday, August 17th, 7:30 PM, St. Paul's Lutheran Church, Amherst. Feel free to attend our business meeting and see what your hard-working Executive Board does.

NAMI Family Picnic, Saturday, August 19th, 2-6 PM, at the home of Sophia Drapanas Paivanas, 63 Surrey Run, Williamsville

NAMI Family Support Group, Wednesday, August 23rd, 7:30 PM, St. Paul's Lutheran Church, 4007 Main Street, Amherst. (Use LEFT side entrance as you face the back of the building.)

September

NAMI Family Meeting, Thursday, September 14th, St. Paul's Lutheran Church, 4007 Main Street, Amherst. Library and Hospitality Hour: 7:00 PM. General Meeting: 7:30 PM. Guest speaker: To Be Announced

NAMI Business Meeting, Thursday, September 21st, 7:30 PM, St. Paul's Lutheran Church, Amherst. All NAMI members are welcome!

NAMI's Garage Sale, 70 Woodlawn Avenue, Lancaster, Saturday, September 16th (rain date Saturday September 23rd.) Volunteers needed! Call President Mary at 832-4035.

NAMI Support Group, Wednesday, September 27th, 7:30 PM, St. Paul's Lutheran Church, Amherst.

NAMI Buffalo News

Much has happened since our last newsletter a year ago--the first break in our publication schedule in 22 years.

We've moved!

Please note our new address and phone number:

302 Parkhurst Boulevard
Buffalo, NY 14223
862-8229

New 6th Edition of "The Mind Matters" is out. If you were somehow overlooked when we processed the members' bulk mailing, call President Mary at 832-4035 and she'll be glad to send you a copy. A special thanks to members and friends who gave hundreds of hours in preparation of the new edition: Mary Lou Bond, Sherry Shuster Byrnes, Sherwin Greenberg, Jenny Laney, Beth Lewin, Marcy Rose, Herman Szymanski, MD, and particularly JoEllen Pennella who spent grueling hours in the editing process. Heartfelt thanks as well to volunteers who assisted President Mary and husband Jim with getting the bulk mailings out!

NAMI Buffalo's coordinator, Lynne Shuster, is now in the midpoint of a two-year term on the NAMI NYS Board. Lynne spearheaded the establishment of a permanent endowment fund for NAMI New York State and the establishment of the NAMI small affiliates grant program to ensure that small affiliates have funds for basics such as postage, brochures, and stationery.

Look for word in August of NAMI's 22nd Anniversary Dinner and Celebration of Service. It's always a memorable evening.

Mailing Address • 302 Parkhurst Blvd. • Buffalo, NY 14223 • 716 832- 0028
HOPE HOUSE • 432 Amherst Street • Buffalo, NY 14207 • 716 877- 9415
www.namibuffalony.org



ANNOUNCING

**A SPECIAL 125TH
ANNIVERSARY EVENT
FOR OUR
COMMUNITY**



Presentation by

Dr. Daniel Fisher

National Spokesperson for Recovery from Mental Illness
Executive Director of the National Empowerment Center

“Creating a Communitywide Recovery Culture”

Thursday, July 20, 2006

6 p.m. Reception ■ 7 p.m. Presentation

Butler Rehabilitation Center
Buffalo Psychiatric Center
400 Forest Ave., Buffalo, NY

Dr. Fisher obtained a Ph.D. in biochemistry and carried out neurochemical research at the National Institutes of Mental Health into the possible biochemical basis of schizophrenia. During the course of that work, he, at age 25, was diagnosed with schizophrenia and was hospitalized several times.

He recovered from schizophrenia, earned a medical degree and became a psychiatrist. He practices as a board-certified community psychiatrist in addition to his work as an advocate for recovery. He was a Commissioner on the White House New Freedom Commission on Mental Health.

Please R.S.V.P. by July 13th to: 816-2440

“We look forward to your joining us for this celebration of recovery!”

—Tom Dodson, Executive Director

Handbook for Families Tackles Cognitive Problems in Mental Illness

A new handbook has been developed to help families help their loved ones with the cognitive problems that are part of their mental illnesses.

Serious mental illnesses often significantly affect an individual's ability to think clearly, to pay attention and to remember. Recent research suggests these impairments may actually be defining characteristics of the illnesses themselves, as opposed to secondary deficits.

Accordingly, new behavioral and learning techniques are being developed to alleviate cognitive problems and promote recovery. "Cognitive Dysfunction Associated with Psychiatric Disabilities: A Handbook, for Families and Friends" provides guidelines, advice and information on resources for families to help their relatives with cognitive problems. It was written by Alic6 Medialia, Ph.D., of Montefiore Medical Center and Nadine Revheim, Ph.D., of the Nathan Kline Institute with the support of the state Office of Mental Health.

Single copies of the handbook can be obtained free of charge by writing Dr. Revheim at the Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962, or by sending her an e-mail at revheim@nki.rfmh.org.



State MH Victories

After years of effort by our grass roots members, our state NAMI NYS office, and coalitions of other organizations, we can savor long-awaited victories in several areas.

We've "booted the SHU". The state legislature has finally prohibited placing seriously mentally ill prisoners in state prisons from being confined to "Special Housing Units" or "the box" where inmates were confined in isolation for 23 hours a day.

The legislature has also passed legislation requiring the state Office of Mental health to develop a state-wide list of individuals waiting for group homes, supported/supervised apartments, and other special mental health housing. This will clearly document the urgent need for additional housing units as many NAMI families grow older and are no longer able to care for their adult children at home. While the legislature last year approved 5,000 new housing units in the next 10 years for New York City, no new housing has been approved for the Western New York area for years. Particularly acute is the shortage of group home beds needed for the sickest patients.

A last victory is also sweet. Following the tragic suicide of his 12 year old son Timothy, Tom O'Clair has been on a crusade to win mental health insurance parity for all New Yorkers so they can afford the treatment they need when they need it. NAMI, aligned with Tom O'Clair, joined that battle four years ago. This year, Timothy would have graduated from high school. The O'Clair family will not see that--or his wedding day, or grandchildren, but that can take some comfort and great satisfaction that the loss of their dear son may save hundreds of other families from such a painful, tragic loss.

Thanks to all NAMI members who helped--our calls, cards and letters finally turned the tide on some very, very important issues. We've done good work this year!

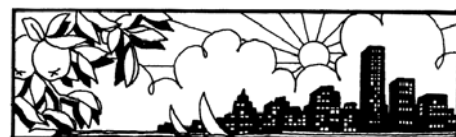
NAMI's Future Fund: Your Chance to Make a Difference Tomorrow

All of us in the NAMI movement give what we can: time, effort, energy, work--and not a few tears as well. One of the things that makes NAMI Buffalo very special is that we don't accept any government funds for operating expenses. As advocates, whistleblowers, and critics of the system, we can be strong, independent, and even harsh when necessary with no consideration about financial retaliation from our funders. This makes life simple for us as an organization--and complicated as well.

NAMI Buffalo has been blessed with dedicated long-term leaders and Board members, but eventually the day will come when we will have to have some paid staff to handle the day-to-day tasks and management of the organization. We operate on a very modest budget since all of us are volunteers now, but we can't depend on this indefinitely.

So with great foresight, the Board established The Future Fund, a permanent endowment to sustain NAMI through the years to come. The Future Fund can be used for two purposes. First, we use a portion of the funds donated in the purchase of our supervised homes in Project Homecoming. The other half of Future Fund income will be used, once the fund reaches one million dollars, to underwrite NAMI's operational expenses.

You should have received a Future Fund envelope with your new edition of "The Mind Matters." Please give as generously as you can, so that we will be able to make a difference both today and tomorrow.



Don't Penalize Families for Helping Children

On Christmas morning, our disabled son, who had been ill, called to say he was feeling worse and was unable to reach the doctor. "The answering service said to go to the emergency room," he said. "I'll take a cab." "You're not going to the hospital alone in a cab on Christmas Day," I said, weary of the endless obstacles the disabled face. It wasn't the first time our son, who is on Medicaid, was told to use the emergency room for treatment. No wonder the system is straining under a financial burden. But after 10 years of observation, I've seen little effort to improve things. Now, crushed with an excessive tax burden, people want to cut benefits to an already destitute population. Our son was born with Lawrence Moon Bardet-Biedl Syndrome, a rare genetic disorder that causes blindness and a host of other ailments. Despite our son's disability, we have always encouraged him to be independent and to work. But the truth is that 70 percent of blind people are unemployed or underemployed, so when the telemarketing company our son worked for outsourced his position, he was left living on \$600 a month in Supplemental Security Income and Medicaid.

An individual living on SSI is allowed no more than \$2,000 in assets. If my husband and I assist our son with food, shelter, clothing, medical expenses or money, that is considered additional assets and can interrupt his SSI or Medicaid.

When my husband and I die, we cannot leave our son our home to live in (unless he's living with us at the time of our death) because that will be an asset. We cannot directly leave him one dime of our savings without jeopardizing his benefits. My husband and I are allowed to leave our son assets in an irrevocable Special Needs Trust, which, once established, cannot be dispersed until our son's death.

Although attorneys recommend a minimum of \$10,000 to establish the trust, the money cannot be used for food, clothing or

shelter. Our son can, however, use the funds for vacations and souvenirs.

Because our son is disabled, he was entitled to coverage under my husband's health insurance as long as he lived with us. But the moment he left the house, he was forced onto Medicaid.

While much of the out-of-control costs of Medicaid are due to nursing home care for the elderly, the whole system is askew. Why not establish urgent-care facilities to eliminate emergency-room costs, or at least provide on-call doctors or nurses for Medicaid recipients?

Why not allow parents of disabled children, who are able, to maintain health insurance for their adult children regardless of age or residence to avoid Medicaid?

Why not, in this day of \$400 gas bills and \$200 grocery bills, elevate the Draconian \$2,000 asset allowance for SSI recipients? Why penalize families for assisting loved ones, or force them to circumvent the law because the only other option is to see their life savings usurped? Why force our son into abject poverty and hoist the bill on to society?

Surely, these proposals would provide dignity for our family and benefit the taxpayer. And surely, they would make more sense than allowing vacations and souvenirs for a son who may desperately be in need of food or shelter.



Advocacy Works

Thanks to appeals from mental health activists, the NYS Department of Mental Health has made a verbal commitment to reimburse for Risperdal CONSTA separate from the clinic rate. This move will provide the opportunity for consumers for whom an injectable medication is needed to receive it. We are hoping that further pressure could speed up the six month time frame anticipated by the DOH. Your letters can help. Write to Kathy Kuhmerker, Deputy Commissioner of NYS Department of Health, Office of Medicaid Management, Corning Tower, Room 1466, Empire State Plaza, Albany, NY 12237.

Tops Markets Community Support Program Changes

Beginning in 2005, Tops Markets has changed its support program for community organizations. Tops will no longer provide a charitable rebate based on grocery tapes collected by such organizations. Tops will, however, offer a 5% rebate to organizations who sell Tops Shopper cards to members and friends.



The gift cards can be used just like cash and are available in denominations of \$10 to \$100 from President Mary Kirkland. Just call her at 832-4035 to order your shopper cards. The Shopper cards can be a significant source of revenue for NAMI Buffalo & Erie County if all our members who shop at Tops use the Shopper cards!

The NAMI Great American Garage Sale

70 Woodlawn Avenue
Lancaster, New York

Saturday September 16th

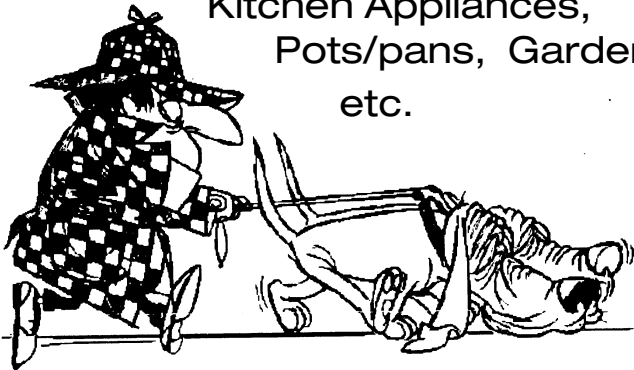
(Rain Date: September 23rd)

*Donations
and
Volunteers Needed!*

Call Mary at 832-4035
for Pickups and Signup.

Wanted:

Knickknacks, Dishes, Small Furniture,
Sports Equipment, Baby Items,
Kitchen Appliances,
Pots/pans, Garden Equipment,
etc.



2006 NAMI Officers & Board

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The Challenger

Editor: Lynne Shuster

Antidepressants Can Worsen Bipolar Disorder in Kids, Say Advocates



"Depressed children should be screened for symptoms of mania and carefully evaluated for emerging bipolar disorder (formerly called manic-depressive illness) before taking antidepressants," says Martha Hellander, research policy director at the Child & Adolescent Bipolar Foundation (CABF).

Speaking at the annual conference of the American Academy of Child and Adolescent Psychiatry, Hellander hailed the recently announced FDA warnings that antidepressants are associated with an increase in suicidal behavior as a wake-up call to doctors and parents who may assume that all depressed kids have the same illness and need the same treatments. "Mood disorders in kids are a major public health crisis, and antidepressants are an essential part of treatment for some, but not all, of those kids," she said. "We desperately need more treatments for suffering children who can't take antidepressants and for whom psychotherapy is not enough."

She added that children with emerging bipolar disorder or schizophrenia, both complex genetic illnesses that can emerge gradually during childhood and adolescence, often display symptoms of depression or attentional

problems that are not recognized until much later as the early manifestations of these serious, lifelong illnesses.

Doctors often diagnose depression and prescribe antidepressants when those medications may not help and may even worsen mania, a syndrome that occurs in children with bipolar disorder. Hellander cited an internal survey of CABF members done in January, 2004, in which hundreds of CABF members reported that their children had first talked of wanting to kill themselves, or harmed themselves, within days or weeks of starting an antidepressant, and were later found to have bipolar disorder.

The survey also showed that hundreds of other parents attributed their child's improvement to antidepressants, usually in combination with lithium, or another medication such as an anticonvulsant or an atypical antipsychotic, the standard treatments used to treat bipolar illness in adults. "Our kids are suffering, and too many are dying or becoming disabled from mood disorders, which are associated with a shockingly high mortality rate exceeding that of some forms of cancer.

Bipolar disorder and depression in children are malignant, chronic, and life-threatening brain disorders, putting children at risk of school failure, addiction, and suicide. The FDA's action serves to alert parents and clinicians that a screening for mania= and consideration of different treatments is required." The language to be added to the warnings on antidepressants includes the recommendation that doctors screen children for bipolar disorder and mania and take a family history before prescribing the drugs.

Close monitoring is also recommended, but Hellander raised concerns whether most families realistically can provide a secure, suicide-proof environment with constant supervision. CABF calls for a federal research initiative on pediatric bipolar

disorder and depression, similar to those undertaken for ADHD and autism, and suggests that Congress consider mandating insurance companies to cover a two-week inpatient stay for children on antidepressants if recommended by the child's physician, to ensure adequate monitoring.

October 22, 2004



Please Remember

NAMI

Buffalo

&

Erie County

in your Will



Studies Could Alter Treatment for Depression, Schizophrenia

The results of the largest studies ever conducted of depression and schizophrenia will be released in coming months, potentially transforming the way patients are treated and shaking up some of the drug industry's most lucrative markets.

The federally funded studies are part of a six-year push by the mental-health division of the National Institutes of Health to come up with reliable scientific data on the differences between drugs and treatment strategies for the major psychiatric illnesses. The project comprises four trials, in serious depression, bipolar disorder, schizophrenia and adolescent depression.

The aim is to fill the information gap that plagues psychiatry, and hurts the quality of care given to patients. Clinical trials that companies do to get drugs approved aren't designed to provide the answers that doctors say they really need. For one, these trials don't compare one drug with another, because they are designed to show only whether a particular drug is effective against an illness. Thus, psychiatrists have little guidance on whether one drug works better than another or has fewer side effects than another.

Also, at eight to 12 weeks long, drug-company trials are too short to reveal how patients fare or what side effects crop up long-term. And, in order to stay focused on a drug's efficacy on one illness, they exclude the sickest patients and people with co-existing diseases.

The paucity of quality information about drugs has been a major issue in recent years as concerns have emerged about side effects, and drug companies have been criticized for hushing up unfavorable study results.

So, the NIH-funded trials aim to compare treatments to discover both positive and negative impacts of the drugs, and to mimic the real world with all of its imperfections. All kinds of patients are included and they are followed for years. The trials -- which include thousands of participants, versus the hundreds in a typical drug-company trial -- are conducted all over the country and include community clinics and primary-care offices, not just academic medical centers. As part of the \$140 million effort, the NIH is also collecting data on the cost effective-

ness of the various treatments and pitting older drugs, which are available as cheaper generics, against newer blockbusters.

Grayson Norquist, a former NIH psychiatrist who played a big role in conceiving the trials, says they aim to answer the main question doctors face every day. "Of the several drugs I have to choose from," says Dr. Norquist, now at the University of Mississippi Medical Center, "which one should I use for the person sitting in front of me?"

Enormous amounts of money are at stake if the trials reveal differences in the safety and efficacy of various drugs. Antidepressants and antipsychotics are the third- and fourth-biggest classes of drugs in the country after cholesterol and heartburn medicines, with U.S. sales of \$20.7 billion last year. Much of that cost is borne by government health-care plans. Both health-care payers and Wall Street investors are anxiously awaiting the results of the two trials in coming months. (Results from the first arm of the project, on adolescent depression, came out in August 2004 and showed that a combination of antidepressants and therapy was the most effective treatment. The study of bipolar disorder ends in September, and results will be published after the analysis is completed.)

In addition to comparing drugs, the trials are trying to fill another gap in the scientific literature: what to do with the many patients who don't get better on their first drug. Psychiatrists do a lot of switching patients from one antidepressant to another and tinkering with drug combinations. None of this is backed up with good evidence, and it can take months to find the right regimen. Practices and outcomes vary widely among doctors.

Steve Miller saw a dozen doctors before finding the drugs that alleviated his schizophrenia. The 45-year-old from Cedar Rapids, Iowa, first had hallucinations as a freshman in college, and took haloperidol, an older-generation antipsychotic, for years. He remained so anxious and depressed he contemplated suicide. A newer antipsychotic, Clozaril, worked better. But it was only when his doctor added Zyprexa to the mix that he finally recovered.

"Clinicians are just basically practicing seat-of-their-pants pharmacology based on their experience with patients," said Jeffrey Lieberman, the principal investigator on the schizophrenia study, which is known as CATIE. "When they look for hard data in the scientific literature to base their decisions on, they can't find it."

The problem is especially acute in depression -- about half of patients don't respond to standard antidepressant therapy. The depression study, called STAR.D, tests whether the subsequent treatment strategies doctors typically use for these patients actually work. It included 3,940 patients across the country who were followed for five years.

All of the patients first take the antidepressant Celexa, from Forest Laboratories Inc., which belongs to a class of drugs known as selective serotonin reuptake inhibitors. Those who don't get better can choose whether to try therapy or switch to other antidepressants -- either Pfizer Inc.'s Zoloft, another SSRI, or GlaxoSmithKline PLC's Wellbutrin or Wyeth's Effexor, which work by different mechanisms in the brain. In the third and fourth stages of the study, people who don't get better cycle through various antidepressants and combinations of drugs.

The CATIE schizophrenia study pits eight antipsychotic drugs against each other to determine their comparative effectiveness and safety. About 1,600 patients were enrolled and followed for 18 months.

In the first stage, patients are given either perphenazine (an older, generic antipsychotic medication) or one of four newer drugs: Eli Lilly & Co.'s Zyprexa, Johnson & Johnson's Risperdal, AstraZeneca PLC's Seroquel or Pfizer's Geodon. If they don't get better or encounter side effects, they are switched to other antipsychotics, including the newest, Abilify from Bristol-Myers Squibb Co.

One of the big benefits to patients of the CATIE trial will be high-quality, rigorous information about the comparative side effects of psychiatry medications. Concerns have emerged in recent years that some of the newer medicines, known as atypical antipsychotics, can cause extreme weight gain, worsen cholesterol and lead to dia-

betes. Although the Food and Drug Administration required that all atypical antipsychotics carry a warning about these side effects, the NIH trial might actually reveal whether certain drugs in the class are worse than others.

The CATIE investigators are now analyzing the results and preparing them for publication in September. But one striking fact has already emerged: nearly 70 percent of patients in the study didn't do well on their first drug, and switched to another.

*Leila Abboud
The Wall Street Journal
July 27, 2005*

Gluten Intolerance Linked to Schizophrenia

People with a genetic intolerance to gluten may also be at increased risk for schizophrenia, new research suggests. Investigators say the link, if proven, could lead to new treatments for a small subset of people with the disorder.

By studying a Danish health registry, researchers from Johns Hopkins University's Bloomberg School of Public Health found people with the genetic digestive disorder known as celiac disease to be three times as likely as the general population to develop schizophrenia. Lead researcher William Eaton, a professor at Johns Hopkins, says the next step is to determine if following a gluten-free diet makes a difference in the symptoms of people with schizophrenia who have celiac disease. Celiac disease is a lifelong condition in which foods that contain gluten damage the small intestine. Gluten is a form of protein found in some grains such as wheat, rye and barley. The damage to the intestine makes it hard for the body to absorb nutrients such as calcium, iron and fat from food.

Newsletter Book Reviews: Additions to Our NAMI Library

Coping with Anxiety and Panic Attacks, by Jordan Lee is a straight-forward easy to read book which explains the subjects' causes, treatments, medications, and discusses getting professional help.

Coping with Schizophrenia, by Evelyn B. Kelly, PH.D. is an easy-to read book which discusses in very understandable terminology, the symptoms, treatment, brain chemistry, early warning signs, and effective communication with a loved one who has schizophrenia. Especially helpful in crisis or for families who are in the early stages of a family members' diagnosis.

Schizophrenia Straight Talk for Family and Friends, by Maryellen Walsh, is a favorite of this NAMI affiliate's founder. It is a classic lost to our library until replacement recently. Though written in 1985, it is as relevant today as it was then. Written with a good deal of humor and useful information for families, it explores schizophrenia and its treatment with sensitivity and relevance, exploding some of the myths and stigma families have experienced first hand. Of special note is a tongue-in-cheek chapter entitled "Parents as Psychovermin".

The Bipolar Disorder Survival Guide, by David J. Miklowitz, PhD, is written in the style of a workbook to be used by consumers or families to examine ways to recognize signs of relapse and symptoms, working with a doctor to find the right medication and therapy, and how to deal with mood swings to stay in remission. It discusses coping strategies for work settings. An extensive reference section follows the text.

The Insider's Guide to Mental Health Resources Online, by John M. Grohol is an amazing compilation of web addresses, but also contains helpful advice for buying computer equipment, downloading online information, and online security. NAMI families will find the advice on researching

information valuable and understandable.

Borderline Personality Disorder Demystified: An Essential Guide for Understanding and Living with BPD, by Robert O., Friedel, MD, is written by a leading expert on the disorder and pioneer in its pharmacological treatment. Dr. Friedel explains the nature of BPD, the factors involved in its diagnosis, and the most effective ways to cope with it.

Instant Psychopharmacology: Up-to-Date information about the most commonly prescribed drugs for emotional health, by Ronald J. Diamond, MD, is an updated handbook for families, consumers, and non-medical therapists seeking to educate themselves about essentials of psychopharmacology.

Tormenting Thoughts and Secret Rituals: the hidden epidemic of obsessive-compulsive disorder, by Ian Osborn, M.D., who is a specialist in OCD, and a sufferer himself, is about the experience, diagnosis, and treatment of OCD. He reveals that OCD is a biological disorder, not a psychological abnormality. He discusses hopeful new therapies, guidelines for families, and early signs of OCD in children.

Lost in the Mirror: An Inside Look at Borderline Personality Disorder, by Richard Moskowitz, M.D. explores the frightening world of BPD patients and helps readers understand their turmoil. Causes, symptoms, behaviors, and treatments, are interspersed with patients' compelling stories.

Marcy Rose

Antidepressant Safety Debate May Include Adult Patients

The yearlong debate over whether antidepressant drugs increase the risk of suicide in some children may soon widen to include adults, as English and Canadian scientists are reporting findings from three new analyses of suicide risk in people over age 18 who have taken the medications.

The new findings are mixed, and apparently contradictory, and likely to encourage both patient advocates who believe that antidepressants like Prozac have hidden dangers, and manufacturers who insist that the medications are safe, experts said.

One of the reports, an analysis of data on antidepressants from previous studies, found that adults taking the drugs were twice as likely to attempt suicide as those receiving a dummy pill or other treatments, but no more likely to complete the act.

The two other reports found no significant link between the medications and suicide. Suicide attempts occurred in less than 0.5 percent of the more than 200,000 people included in the three studies.

All three papers appeared yesterday in the online version of *The British Medical Journal*.

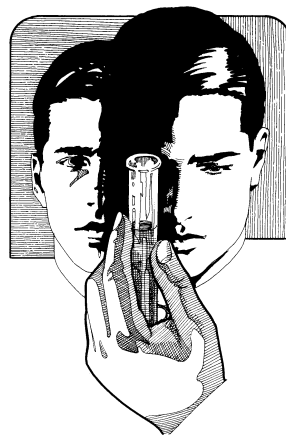
"There has been a phenomenal amount of pressure to study this issue in adults," in part because of the debate over the risk in children, said Dr. John Geddes, a professor of epidemiological psychiatry at Oxford University and the co-author of an accompanying editorial in the journal. Dr. Geddes was not involved in the studies and has received research money from drug makers.

"We know a certain amount of negative evidence on these drugs has been suppressed, and the more information we have on them in the public domain, the better to guide clinical practice," he said.

In the early 1990's, a panel of experts convened by the Food and Drug Administration concluded that there was not enough evidence to link drugs like

Prozac and Zoloft to increased suicide risk and most psychiatrists say that the drugs are more likely to prevent suicide.

But regulators in the United States and Britain recently issued warnings that the drugs, known as selective serotonin reuptake inhibitors, or S.S.R.I.'s, could raise the risk of suicidal thinking in a small number of children and adolescents. The F.D.A. is scrutinizing suicide attempts by adults reported in drug trials.



The risk is extremely difficult to determine, experts say, in part because suicide attempts are rare.

In one of the new analyses, researchers at the University of Ottawa re-evaluated data from 345 antidepressant trials for depression and other conditions, involving 36,455 men and women. The investigators found 143 total suicide attempts, and found that the rate was twice as high in people who were taking S.S.R.I.'s as it was in those getting placebo pills, or some other form of therapy.

"Many people are on these drugs, which makes the rare risk very important," said Dr. Dean Fergusson of the University of Ottawa, who is a lead author of the study.

Dr. David A. Freedman, a clinical trials expert and statistician at the University of California, Berkeley, who was not involved in any of the studies, said that reviews of this kind are not a very reliable way to

determine risks. Moreover, he said, the Ottawa study presumed that all antidepressants affected everyone the same way in terms of suicide risk.

"This is like saying your reaction to Prozac is the same as mine to Zoloft, which we know isn't true," he said. "This assumption exaggerates the significance of their findings."

Dr. Fergusson disagreed, saying the assumption of uniform effect gave a conservative estimate.

In another analysis, also in the British journal, doctors evaluated data from 477 trials involving 40,826 people, which were submitted by drug companies to British regulators for safety review. "We found no evidence that S.S.R.I.'s increased the risk of suicide," and weak evidence that the drugs increased the risk of self harm, the authors concluded.

The third study analyzed case records of 146,095 people prescribed antidepressants for the first time from 1995 to 2001. The researchers found no evidence of increased suicide risk in adults taking S.S.R.I.'s compared with people of the same age and similar histories taking other types of antidepressants.

Given that studies report suicidal behavior in a number of ways, experts are skeptical that reviews of trial data will resolve the issue. "We have machinery to pull diamonds from the earth, but we don't have machinery to pull truth from data in these studies," Dr. Freedman said.

Psychiatrists said the studies were not likely to change how they treat patients: the drugs tend to increase agitation and unusual behavior in the first few weeks after the treatment is started, when patients need to be closely monitored, they said.

*Benedict Carey
New York Times
February 18, 2005*

Plan gives mentally ill option to jail

2002 death of inmate, cost motivate proposal

By wandering naked down a West Side street, 28-year-old Michael T. Bennett won a spell of captivity that ended with his death after three days in the Erie County Holding Center.

Bennett's death, in turn, triggered a debate over whether he should have been placed in a mental hospital instead.

County Executive Joel A. Giambra cites that case from 2002 as one reason why officials should, over time, transfer inmates from county lockups into a system his officials are developing. Giambra's other reason is cost.

Each day, Erie County holds about 375 inmates with mental health problems, and about 275 are jailed on misdemeanors or low-level felonies. Those inmates are generally poor, homeless, or sometimes both.

Without resources to post bail and with few other places for them to be monitored, they are locked up at an average cost of \$100 a day, typically for 30 days, according to a county report.

They repeat the experience three or four times a year.

The county's proposal would work like this: 100 of those 275 inmates could be housed in four residential units run by the Restoration Society and the Lakeshore Behavioral Health Corp., two not-for-profits already in the treatment business. Each person would have a small living space, and the facilities would run along the guidelines of the federal government's Safe Haven supportive housing program, addressing people with mental health problems.

Those 100, and the other 175, who would sleep in their own homes or in the community's other psychiatric units, would be treated at Erie County Medical Center by staff from the hospital and the state

University at Buffalo' Medical School's Department of Psychiatry. The staff would include an employment counselor and county probation officers with training in behavioral therapy.

The proposal emerged from the county's Holding Center Task Force, which studies ways to alleviate jail crowding, reduce overtime paid to corrections officers and avoid construction of a new jail or new jail space. The researchers modeled the county's idea on a program in Boulder, Colo.

"It has shown a significant reduction in the days that individuals spend in the holding center or jail," said Philip R. Endress, the county's mental health commissioner. "I believe there was a 65 percent reduction in the recidivism rate for the folks that are enrolled."

In theory the Erie County program would yield benefits beyond those provided by Buffalo's specialty courts - drug court and mental health court.

"I very much favor there being increased access to mental health treatment facilities and that law enforcement personnel be trained to recognize such individuals very early," said Sheriff Timothy B. Howard.

But he is not as optimistic as Giambra when it comes to the long-term savings of a mental health program.

While Giambra thinks it could lower the millions of dollars paid in overtime to corrections officers each year, Howard says it probably won't. The loss of these people might not reduce our staffing levels," he said. "But they might help us avoid having to build additional jail space."

While Giambra figures he will save county taxpayers money by getting people with mental health issues out of county lockups, the program will still require taxpayer money, \$16 million to start it up. But he

wants those millions to come through Albany and Washington.

His officials will request \$9 million from the U.S. Department of Housing and Urban Development to build the four 25-bed units, and they'll ask state government for the remaining \$7 million needed for the treatment program at ECMC, to operate the housing, and for construction aid.

Giambra put that \$7 million on the wish list he has given local state lawmakers.

County leaders have no shortage of ideas on how Albany can help after state legislators demanded the county share another \$12.5 million in sales tax income in 2007. The request also is signed by County Comptroller Mark C. Poloncarz and Legislature Chairwoman Lynn M. Marinelli, DTown of Tonawanda State Sen. Dale M. Volker, RDepew, supports the proposal and has contacted the state Department of Correctional Services and the state's mental health commissioner for their help in making it become reality, an aide said. "We are going to do our best to secure money to help the county with this," said Craig Miller.

Bennett, a diagnosed schizophrenic, died from traumatic asphyxia when at least eight deputies tried to restrain him in the holding center in July 2002.

"Had Bennett been afforded adequate emergency mental health care or been the subject of a properly supervised and controlled use of physical force, his death may have been prevented," a state Commission of Correction report said.

*Matthew Spina
The Buffalo News
March 27, 2006*

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What to Do If Someone With a Severe Mental Illness Becomes Assaultive

Don't underestimate the risk. People who are acutely psychotic, especially if also delusional and abusing alcohol or street drugs, are capable of extreme violence and are not predictable.

Discuss the situation with the person's case manager, social worker, and/or psychiatrist. Make sure they are aware of the person's threatening or assaultive behavior. If possible, put your concerns in writing to them: written notification is much more difficult to ignore.

Safe-proof your house or apartment. Have a room to which you can retreat if needed: it should have a secure lock and a telephone. Do not allow firearms in the house.

Clearly spell out the consequences for the person if he or she is assaultive (e.g., not longer being able to live at home). Be prepared to carry out these consequences.

Minimize alcohol or street drug use in whatever ways are possible. Substance abuse is often a trigger for assaultive behavior.

If threatened by someone with manic-depressive illness (bipolar disorder), remain calm, keep conversation to a minimum, and exit the situation. If threatened by someone with schizophrenia, stay calm, remain physically distant (give the person lots of space), do not look directly into his/her eyes, sympathize, try to find something on which you can both agree.

Do not allow yourself to become trapped: remain physically between the person and the open door.

Do not hesitate to call the police.

Information from E. Fuller Torrey's *Overcoming Depression and Overcoming Schizophrenia*.

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