THE CATIE STUDY: A Glass Half Full or Half Empty?
contents

3 The CATIE Study: A Glass Half Full or Half Empty?
5 Using Results from CATIE: NIMH Perspective on Antipsychotic Reimbursement
6 NAMIWalks 2005
10 Annual Conference 2005
11 Breaking the Silence
12 Texas Team Solutions: A New Recovery Opportunity
13 Advocates for the Mentally Ill to Improve Awareness: Hospital Hosts NAMI Kaufman County Forum
14 2005 Mental Health Seminar
15 After Suicide Attempts, Man Manages Bipolar Disorder with Medicine, Psychiatry
16 Let’s Stamp Out the Stigma of Mental Illness
17 Rebalancing My Life: “Mental Illness 101”
18 National Day of Prayer

Cover photo: Sandy Skelton, Photographer
Registration and staging area for NAMIWalks. On October 2, 2005, over 1,200 NAMI members, friends and supporters from all over the state gathered at Auditorium Shores to celebrate the vital work we do for consumers, their families and our mental health care delivery system. Over 35 Walk teams marched the 3.1 miles down Congress Ave., around the Capitol and back to the Shores.

To find a NAMI Texas affiliate in your area, please call 1-800-633-3760 or visit www.namitexas.org
The initial finding of the CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) study were published in September in The New England Journal of Medicine. The study was widely anticipated because it was to be the first head-to-head trial of the newer antipsychotic drugs to treat schizophrenia not financed by the drug industry.

The study included four new generation drugs, called atypical antipsychotics, and one older drug, to treat schizophrenia. It was funded by the National Institute of Mental Health (NIMH) and included over 1400 subjects who were considered to be in need of a change in antipsychotic medication.

The Phase 1 findings that three-fourths of the patients who participated stopped taking the drugs they were first started on, brought banner headlines in the national press. Many journalists quickly claimed that there was little difference found between the highly promoted and widely prescribed – and more costly – new schizophrenia drugs and the older ones that sell for a fraction of the cost.

To shed “Texas Light” on the topic, I took the opportunity to interview an investigator in the study, Dr. Alec Miller, Professor of Psychiatry at U.T. Health Science Center San Antonio to gain further insight into the results.

1. **What is the CATIE study?**
   
   **A:** CATIE is the largest, longest, and most comprehensive independent trial ever done to examine medications for the treatment of schizophrenia. It was designed to show the effectiveness of the older medications (first available in the 1950s) and newer medications (available since the 1990s).

2. **What medications were studied?**
   
   **A:** New medications in the study included olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), and ziprasidone (Geodon). Perphenazine (Trilafon) was included as a representative of the older generation of anti-psychotics. Clozapine was studied as a second or third option. Results so far are only for the first treatment started in the study.

3. **Why was perphenazine chosen as the older medication rather than haloperidol (Haldol)?**
   
   **A:** Many patients have had bad experiences with haloperidol and refuse to take part in studies where they may receive it. Perphenazine is typical of the older medications, but does not have the same reputation for causing problems as haloperidol, mainly because it was never as widely used.

4. **Were there any CATIE sites in Texas and describe the characteristic of the patients included in the study?**
   
   **A:** There were 5 sites in Texas – San Antonio, El Paso, Conroe, Dallas, and Houston. There were no “1st break” patients in the study. These were all patients who had a history of treatment – majority male, avg. age 40; avg. age of 1st treatment 24; majority never married; other medical conditions. These participants would be seen as the “typical patient” in a community mental health center in Texas.

5. **What was the Primary Question to be addressed by Phase 1 of the CATIE Study?**
   
   **A:** Phase 1 of the study was designed to measure the rate of discontinuing the first treatment received in the study, by patient or doctor choice.

6. **How were the trials conducted?**
   
   **A:** A total of 1493 patients with schizophrenia were recruited at 57 U.S. sites and randomly assigned to receive olanzapine, perphenazine, quetiapine, risperidone and ziprasidone for up to 18 months. Everyone received identical-appearing capsules. Neither patients nor their doctors were told which antipsychotic they were taking.

*Continued on next page...*
7. What were the results?

A. Overall, 74% of the patients discontinued the medication they were started on before 18 months. 50% of the patients discontinued the medication they were started on within 6 months.

8. 50% discontinued their initial medication in 6 months? That does not seem to me to be a good outcome. Am I wrong in my conclusion?

A. 50% stopping within 6 months is definitely not good news. The single most common reason for stopping was patient choice, not physician judgment that there was lack of effectiveness of medication or intolerable side effects. All patients were offered the opportunity to start another medication in the study, if they or their doctors wanted to stop the first one. Further reports will tell us how many patients chose this option and how they did.

9. Were there any significant variations between the drugs up to the time of discontinuation of treatment?

A. Yes, the time to discontinuation of initial treatment for any cause was significantly longer in the olanzapine group (64%). The dose range of olanzapine used in the CATIE study was up to 30 mg per day, because some large studies of higher doses have been done of olanzapine, but not of the other new generation medications. We do not know if allowing higher doses contributed to the better result for olanzapine.

10. What were the results for the patients on perphenazine?

A. Clinical improvement was about the same for perphenazine as for most of the other medications. Surprisingly, the common side effects of older medications (EPS = extra-pyramidal symptoms) were not seen more often with perphenazine, although discontinuations due to EPS were more frequent with perphenazine. So, the results with EPS seem somewhat inconsistent, depending on what you look at. It is very important to remember that low to medium doses of perphenazine were used.

11. Dr. Miller, this could be interpreted to mean that old medications are “as good as the new.” Do the results of this study suggest that a whole generation of patients have been oversold on the medications that they have been taking?

A. One main reason clinicians have preferred the newer medications is that they seem to produce a lot less tardive dyskinesia (TD) – uncontrolled, sometimes irreversible movements that can range from barely noticeable to severely disabling. Thus far, the CATIE data does not really address this important question. Another advantage of most newer medications is that higher doses are less likely to cause EPS than higher doses of older medications. As noted, CATIE did not look at higher doses of perphenazine. It does seem to me that many patients have been very enthusiastic about the newer medications, without having to be persuaded by doctors or others of their benefits. We need to remember that it is ultimately patients who decide what they prefer.

12. Texas Medicaid has placed Olanzapine under a “prior authorization.” Does this report provide any reason for those policy makers to review that decision?

A. I have always thought it best to let patients and doctors have open access to these medications, without prior authorization. The report does provide a reason for reviewing the prior authorization decision for olanzapine.

13. Are there other findings that we can expect to be published soon from the CATIE study that may shed further light on the treatment of schizophrenia?

A. Definitely. We will learn about medication effects on cognitive functioning and quality of life. Economic impact data will be presented. Responses to clozapine and to other newer antipsychotics for persons who went on to second and third medications will be forthcoming. We may learn more about frequencies of TD with each drug. Stay tuned, there is a lot more to come and the headlines will as always, not tell the full story.

A full copy of the report is available at the following web address: http://content.nejm.org/cgi/content/abstract/NEJMo051688

Joe Lovelace
Executive Director, NAMI Texas
Using Results from CATIE: NIMH Perspective on Antipsychotic Reimbursement

The recent publication of the phase I results from the National Institute of Mental Health (NIMH)-funded Clinical Antipsychotic Trials in Intervention Effectiveness (CATIE) has raised questions among advocates and clinicians alike about reimbursement policies for antipsychotic medications. Antipsychotics have now become the fourth largest group of medications prescribed in the United States, with a collective cost expected to surge past $10 billion this year. As 80 percent of the prescriptions for antipsychotics are paid via the public sector, it is not surprising that the phase I CATIE results could be interpreted by some as an opportunity to save several billion dollars in public funds. NIMH would like to raise a note of caution about how the CATIE results are used to inform reimbursement policy.

In the September 22, 2005, New England Journal of Medicine (NEJM) report, the CATIE research team compared discontinuation rates with four atypical antipsychotics (olanzapine, quetiapine, risperidone, ziprasidone) and one older conventional antipsychotic (perphenazine). The new atypical medications, representing 90 percent of the current market, are approximately 10 times the cost of the older conventional antipsychotics. The results demonstrated few differences among the various medications. The older medication, perphenazine, was as well tolerated as the newer compounds and as effective as three of the four newer drugs. The fourth compound, olanzapine, was slightly better than all the others in terms of discontinuation and hospitalization rates but paradoxically was also associated with higher rates of weight gain and metabolic side effects.

Understandably, these results appear to invite a “fail-first” policy with perphenazine as the treatment of choice or possibly a restriction to reduce access and use of the atypical antipsychotics. NIMH believes that such a change in reimbursement policy is premature for the following reasons:

1. The NEJM publication only reports results from phase I of this three-phase study and focuses on the major outcomes of discontinuation.

2. Forthcoming papers will look at outcomes more relevant to reimbursement. For instance, cost effectiveness is more than a comparison of medication costs. Differences in rates of hospitalization, use of support services, employment, and other factors all need to be considered in a comparison of cost-effectiveness. A cost-effectiveness analysis will be published in the next several months, along with results of the effectiveness of these various medications on quality of life and cognitive deficits. Phases II and III will also investigate the response to other medications in patients who discontinued their first antipsychotic.

3. While phase I suggests little difference in the overall effectiveness for the entire cohort, individual patients may have responded far better to one of the available drugs. To say the medications are equivalent is not to say they are identical. Do patients respond better to a combination of atypical antipsychotics or to combinations that involve conventional antipsychotics? We will know more about this with the completion of the analysis of phases II and III, when we can look at results following a switch from one medication to another.

4. Finally, it is important to remember that CATIE was limited to a moderately treatment-resistant cohort of people with chronic schizophrenia. Patients with acute, first onset schizophrenia and those with other psychotic disorders were not included in this study.

Given each of these considerations, we feel that it is premature to alter reimbursement policies for antipsychotic medications. Already we know that there is great variability in the response of individuals to these treatments. A one-size-fits-all policy for treating schizophrenia could be harmful, essentially turning the clock back 40 years when conventional antipsychotics were the only medications available for patients with this chronic, disabling disorder affecting 3.2 million Americans. Patients, families, and physicians need more, not fewer, choices for addressing schizophrenia. While we are mindful of the financial implications of CATIE, we hope that those making policy decisions about reimbursemens will wait until the rest of the outcome data are available from this landmark study in order to inform more fully health care policy decisions for this highly vulnerable population.

Robin Peyson new NAMI Texas E.D.

After an extended search by the NAMI Texas Executive Committee, Robin Peyson, MHSA, LCDC, will replace Joe Lovelace as Executive Director of the National Alliance on Mental Illness (NAMI) Texas on January 23, 2006.

Currently she is a senior-level community mental health specialist with the Department of State Health Services where her responsibilities include liaison between DSHS and the statewide advocacy organizations, including NAMI Texas. Prior to DSHS, she was the Program Director for several community-based organizations delivering mental health services to children and adolescents.

Ms. Peyson is a cum laude graduate from Williams College with a degree in Psychology and received a Masters in Health Services Administration from the University of Michigan. She lives in Bastrop, Texas.
NAMIWALKS 2005

NAMIWalks 2005

By Diana Kern, Special Events Coordinator

On October 2, 2005, over 1,200 NAMI members, friends and supporters from all over the state gathered at Auditorium Shores to celebrate the vital work we do for consumers, their families and our mental health care delivery system. Over 35 Walk teams marched the 3.1 miles down Congress Avenue, around the Capitol and back to the Shores. Walk teams wore colorful t-shirts specially made for NAMIWalks; we carried signs and banners to represent our teams; we pulled kids in wagons; we walked with our pets; and families and children held helium balloons, some letting go to watch the yellow and blue colors make their way to the skies in memory of a loved one.

October 2nd is a day we won’t soon forget. When a large group of committed NAMI advocates and educators come together to Walk for the Mind of America, we feel the power of hope and recovery for all persons with a serious mental illness.

NAMI Dallas will hold their second NAMIWalks in May, 2006 and NAMI Metropolitan Houston will have their first walk in May also. Stay tuned for more details about these Walks and the NAMI Texas Walk! Photographs courtesy of Sandy Skelton, Henry Friedman, Cassie Carpenter, Margie Gardner and Barbara Kern.
NAMIWALKS 2005
This year NAMI Texas held a one day conference on October 1st in conjunction with NAMIWalks. Attendees learned many skills necessary to increase capabilities within their local affiliates: board member training; grant writing; designing a newsletter; webmembership skills; Texas Team Solutions and more.

Our keynote speaker was Dr. Dave Wanser, Deputy Commissioner of Behavioral and Community Health Services at the Dept. of State Health Services. He delivered a “State of the State” message to keep us updated on relevant issues regarding services that impact persons with serious mental illness and their family members.

The Awards Presentation was an exciting part of the day. Award honorees were: **Legislators of the Year:** Representative Garnet Coleman and Senator Jon Lindsay; **Media Award:** James M. O’Neill, Dallas Morning News; **The Charley H. Shannon Advocate for Justice Award 2005:** Donna J. Snyder; **Quality of Life Award:** David Dillon; **Professional of the Year:** Dr. Bernardo Tarin-Godoy; and **Volunteer of the Year:** Margie Gardner.

*Photographs by Henry Friedman.*

**Clockwise from top right:** Victor Ortiz and Dr. Bernardo Tarin-Godoy; Donna Snyder; Stennie Meadows, Kari McAdams, accepting for Sen. Jon Lindsay; and Patsy Gilliam; Diana Kern and Margie Gardner; Julie Noble and David Dillon; James O’Neill; Rep. Garnet Coleman; and Dr. Dave Wanser.
Suppose a NAMI “think-tank” wanted to seclude themselves in a conference room with plenty of coffee and catered meals until they came up with a strategy to stomp out the stigma of biological brain disorders known as mental illnesses, and to replace mental illness myths with facts for groups like legislators, public and private service providers, law enforcement officials, media professionals, and teachers. In my opinion they could do no better than the NAMI Queens/Nassau folks who created three wonderful lesson plans on teaching mental illness facts and sensitivity to reduce stigma to upper elementary, middle, and high school students, especially if they use existing physical health teachers to integrate and teach “Breaking the Silence” (BTS). Lesson Plans are $15 each or $40 for a set of all three grade levels. Also available is the Tool Kit, a FREE “how to” manual for school/community outreach, including all the necessary tools for introducing mental illness education to your community and schools. Both the order forms and Tool Kit are available at www.btslessonplans.org.

**What Students Learn**
- It is biology, not a character flaw, that causes mental illness.
- Mental illness has never been more treatable
- How to overcome the stigma that surrounds mental illness
- Teachers and students learn the warning signs of mental illness
- Since mental illness, substance abuse, and suicide are closely connected, local expertise can be used to bring added prevention benefit to the students and community

**Lesson Plans are Easy to Use**
- For upper elementary, middle school, high school
- Fully scripted lessons and suggested activities
- Eye catching posters and board game
- Lesson Plans can be used for one day or extended for several days
- No prior knowledge of the subject required

Al Forsten, past Board Chair of Texas Council, and John Hoelzel, President of NAMI GFC are working together to help get BTS into our Texas schools. They have slides summarizing the BTS content and how to approach your local Independent School District to add BTS to the curriculum of these three grades.

Their business plan works bottom-up through local community volunteers to make ISD contact, and also top-down through the TEA. Volunteers can come from groups like retired/active teachers, supporters of local MHMRs and from local NAMI Affiliates. Al and John are supporting local Texas BTS volunteers with the regional oversight resources outlined above and with slides for their ISDs.

Al and John also envision writing a grant proposal to fund the BTS effort across Texas in a multi-year approach. Such a grant seems to fit well within the scope of NAMI Texas directions. Cooperation and collaboration with Texas Council and their MHMR Center supporters is also anticipated. The use of these Texas Council and NAMI Texas regions can provide a concurrent effort across the 1041 Independent School Districts in Texas.

In addition to the public educational system there are many home schooled and private schools in this State. After we initiate the pilot for our BTS Program in the public system, we will start to market the materials and benefits to other educational venues starting in 2008.

It is very important to begin now to identify, equip, and support BTS volunteers from all over Texas to begin contacts with their local school districts and education committees. If you are willing to make such contacts, or find someone in our community to do so, please contact Al Forsten (E-mail: aforsten@earthlink.net; Phone: 281-488-1979) or John Hoelzel (E-mail: john.hoelzel@juno.com; Phone: 903-664-2471). They will e-mail you the Powerpoint slides and the Tool Kit. You can order BTS Lesson Plans at www.btslessonplans.org. Call NAMI Texas at 1-800-633-3760 to enlist as a BTS volunteer.

As BTS volunteers emerge across Texas we will plan regional training and support meetings. Please go to the BTS web site www.btslessonplans.org and we believe you will become as excited as we are about leaving this wonderful Texas legacy of factual education about mental illness and how to help as early as possible. Together we make a difference.
Texas Team Solutions: A New Recovery Opportunity

By Cliff Gay, Consumer Network/Education Coordinator

If you are a person who lives with a serious mental illness or a person who loves them and cares for them a new recovery opportunity is now available. It is called Texas Team Solutions.

Texas Team Solutions is an evidenced based psychosocial education program. This program allows a person who lives with a serious mental illness to educate themselves about themselves. The program addresses the elements necessary to get yourself recovered and stay recovered, which I have discovered during my thirty plus years of recovery experience, is a must. How can you work on a problem or solve a problem if you are not educated about the problem?

Texas Team Solutions is a flexible educational workshop that uses 12 different modules addressing medications, coping skills, types of mental illnesses, medication compliance, supportive services, and more. Mental health consumers along with a mental health professional or family member teach the workshops.

Program Description
Texas Team Solutions is a recovery orientated education program which requires a partnership between the consumers, family members, and providers. In order for the partnership to operate successfully it must have an infrastructure and operate like a business. The business products of this partnership are education, support, and outreach/advocacy, and the partnership must have a business plan.

Texas Team Solutions is the Texas Implementation of the Medication Algorithms (TIMA) Consumer-to-Consumer Education materials placed appropriately within the Team Solutions curriculum developed by UBHC University Behavioral Healthcare in New Jersey for E. I. Lilly. TIMA is primarily about medication education, but after a thirty year Mental Illness career, education about medication is only one element required for recovery.

Team Solutions educates about other elements required for recovery, interventions to stop an episode, support by those that love you and care for you, as well as medication. You then have to educate yourself about yourself. These are all the elements that I used to get myself recovered and stay recovered over thirty plus years. These elements are contained in Texas Team Solutions. During the training sessions we also talk about the requirement of accepting the fact that you have a mental illness.

Texas Team Solutions meets all the levels of care education requirements within the Resiliency Disease Management Accountable System of Care Model.

Texas Team Solutions is currently being used in the Hill Country MHMR.

Take care and expect recovery.

Texas Team Solutions: Class Topics

| Class 1: Helping Yourself Prevent Relapse |
| Class 2: Avoiding Crisis Situations |
| Class 3: Managing Crisis and Emergency Situations |
| Class 4: Recovering from Mental Illness |
| Class 5: Understanding Your Illness |
| Class 6: Understanding Your Symptoms |
| Class 7: Coping with Symptoms and Side Effects |
| Class 8: You and Your Treatment Team |
| Class 9: Understanding Your Treatment |
| Class 10: Getting the Best Results from Your Treatment |
| Class 11: Nutrition, Wellness, and Living a Healthy Lifestyle |
| Class 12: Fitness and Exercise |

Cliff Gay and Susan Marshall walking for the Expect Recovery Team at this year’s NAMIWalks on October 2.
Advocates for the Mentally Ill to Improve Awareness

Hospital Hosts NAMI Kaufman County Forum

Reprinted from “The Terrell Grapevine”, a monthly newsletter of news and events from Terrell State Hospital, August 2005.

Advocacy groups in the state, such as the National Alliance for the Mentally Ill (NAMI), need to get better at advocacy and publicity in order to help their cause in the Texas Legislature. That was the advice given by Mr. Joe Lovelace, Executive Director of NAMI Texas at a recent forum held at Terrell State Hospital and sponsored by NAMI of Kaufman County. Lovelace provided the attendees with his vision for the future, as well as a summary of legislation passed in the 79th session that had a positive impact on providers and consumers of mental health services. There were many successes. For example, legislators restored counseling benefits to the Medicaid and CHIP programs, increased funding for state mental health hospitals and community centers, and passed many reforms benefiting the mentally ill such as those in county jails. “We’ve been good about raising awareness of the need to improve screening of persons with mental illnesses at our county jails,” Lovelace said. “The result has been to get these individuals in the proper environment and provide them with the treatment they need.”

Lovelace encouraged the attendees to become more closely connected with the community centers and hospitals in their region and help each other through collective support of educational programs. He also has urged NAMI groups to work together to seek more funding for state psychiatric hospitals and community centers. “I have been encouraging NAMI groups to develop closer relationships with hospitals and community centers and have urged them to develop stronger collaborations between county organizations in the NAMI regions.”

A large number of bills were passed in the last legislative session that dealt with mental illness related issues. One in particular, Senate Bill 679, should have a positive impact on patients who have been deemed competent to stand for trial while waiting for a hearing with a judge. The bill allows for video conferencing between the court and the hospital for a defendant who has been committed as incompetent to stand trial. It requires the defendant to remain in the hospital to await a competency hearing until 72 hours prior to the hearing, thereby reducing time spent waiting in jail. It also reduces the costs in time and travel for the hospital staff. TSH currently has the technology to provide this service.

Another primary goal of NAMI Texas is to encourage education and support programs such as NAMI of Kaufman County’s Family-to-Family Educational Programs geared toward family members, partners and friends of persons with mental illness. “We appreciate the hospital’s willingness to help us with our outreach programs by providing such a nice facility for these educational sessions,” stated Ms. Emma Glenn, President, NAMI Kaufman County.

The series of 12-week classes are structured to help give caregivers a better understanding and means to support those with mental illness. For more information on NAMI Kaufman’s educational and advocacy programs, contact Emma Glenn at 972-962-3784.

NAMI Texas also has a variety of programs and resources. For information, please visit their website at: www.texas.nami.org. An outline of the legislation and appropriation riders from the 79th legislative session can be viewed at the same site by selecting, “Advocacy.”

Depakote ER New Indication

The U.S. Food and Drug Administration (FDA) has approved a new indication for Depakote® ER (divalproex sodium extended-release tablets) for the treatment of acute manic or mixed episodes associated with bipolar disorder, with or without psychotic features. Depakote ER offers patients the convenience of taking this medication once a day. Compared with Depakote® (divalproex sodium delayed-release tablets), Depakote ER taken once a day helps provide more consistent levels of medication in the body.

Quote from Texas Thought Leader:
“Successful treatment for mania depends upon maintaining steady levels of medication in the blood throughout the day,” said Charles Bowden, M.D., professor of Psychiatry and Pharmacology, Department of Psychiatry, University of Texas Health Science Center at San Antonio. “Depakote ER produces consistent concentrations of medication throughout a 24-hour period. Depakote has been trusted by psychiatrists for a decade, and this once-a-day formulation is important for patients.”

— Abbott Corporate Communications December 7, 2005
2005 Mental Health Seminar

By John Hoelzel, President of NAMI Grayson, Fannin & Cooke Counties

On Thursday, October 27, 2005 NAMI GFC & MHMRST (Texoma MHMR) collaborated to hold our 2nd annual Mental Health Seminar at Grayson County College, just north of Sherman, Texas. There was a strong emphasis this year on peer support. For example when our local MHMR board chair asked Dr. Feiner what they should do about services in light of inadequate funding, his answer was simple, “emphasize peer support.” At that point we had taken several opportunities to demonstrate the fruit of our local Good News Peer Group, and to reference our intention to continue to glean ideas and best practices from many other national peer programs we got information on at the National Convention in Austin this year like: In Our Own Voice (speaker development); NAMI Peer to Peer (classes); NAMI C.A.R.E. (critical advocacy resource emergencies kit); Hearts and Minds (integrated health); and many classes offered free through Texas Mental Health Consumers. The seminar feedback sheets showed a genuine appreciation of the balance of professional and consumer (a person with mental illness) speakers. They also liked the consumer participation that included panel discussions on self esteem and on recovery, and multiple role plays on good vs. bad communication styles.

There is nothing like the encouragement from a consumer who has struggled through older style medicines and treatments and has now grown and matured through better medicines and best practice treatments into becoming able to speak, mentor, participate, and help others. It sends a very simple but strong message to a struggling consumer, “if they can do it, maybe I can do it.”

Recovery, last year’s theme, was evident all over the seminar. Bill Anthony calls recovery the restoration of meaning and purpose. At the foundation of recovery is hope that sparks a changed attitude that desires a better life. Diana Kern, a consumer herself, is Special Events Coordinator and Consumer Advocate for NAMI Texas in Austin and she is an extremely inspiring speaker and mentor. She said she cried out one day, “God, don’t you want something better for me in life?” His answer came in the form of people who believed in her and saw some of what she could become. Her parents focused on her strengths. A good therapist gave her hope. Others believed in her and gave her training and responsibilities where she could grow and blossom. Diana and Dr. Feiner observed that a common denominator that consumers mentioned about their recovery was the importance of God and their dogs! We saw the dramatic effect of “stress-relieving dogs” when we took 21 members of our affiliate to the National NAMI Convention in Austin this past June. Dr. Feiner's sessions on Supported Employment, Co-occurring Disorders, and “Ask the Doctor” were very well received, as was the session by Shirley Morris on Dealing with Anger & Mood Swings.

Other consumers talked about: a focus on increased self esteem that seeks to make every day the best yet; being inspired by other consumers; looking forward with anticipation to our Good News Peer Group meetings and outings; learning to say no and not taking ownership of someone else’s issues. There also was a story about Dr. Ed Knight, Value Options VP of Social Research, who had previously lived on the street with multiple hospitalizations. A Bonham pastor shared about mental illness in his family and in his congregation. He recounted that the renowned Charles Haddon Spurgeon, The Prince of Preachers from Bath Road Baptist Church, had terrible bouts of depression due to bipolar disorder.

Medicines were described as providing a path to stabilization, not a cure. The help that a person with diabetes receives from insulin provides a good picture of this. Thus recovery from mental illness is about hope, attitudes, and removal of fear. The stigma of mental illness stems from fear of the unknown. Research, better medicines, treatments that work, peer support and rehabilitation services, and recovery itself, all deliver to uniformed, prejudicial, fearful STIGMA, a decisive death blow! Make plans to join us in October 2006.

Symposium Spotlights
Advancements in BPD

Cullen Auditorium
Baylor College of Medicine
March 4, 2006, 7:30 am – 5 pm

Mental health professionals, consumers and families across the country are invited to a one-day continuing education symposium focusing on borderline personality disorder (BPD) March 4 in Houston.

Morning sessions will highlight the scientific advancements in understanding BPD, including developmental issues, neuroimaging and neurobiology. Afternoon presenters will focus on the similarities and differences in contemporary treatment methods, including family perspectives.

Symposium program details and registration form can be found online at <http://www.MenningerClinic.com/education/ce-calendar.htm>.

Cosponsors of the symposium are: Menninger, National Education Alliance for Borderline Personality Disorder, NAMI Metropolitan Houston and Baylor College of Medicine.
After Suicide Attempts, Man Manages Bipolar Disorder with Medicine, Psychiatry

By Kristen Lark
for The Lubbock Avalanche-Journal ©2005

Andy Gibson walked into the coffee shop without going from depressed to hyper in a matter of seconds.

He walked in wearing an orange T-shirt and khaki shorts. He had a firm handshake and a warm smile on his face. Nothing about the 23-year-old indicated that he has type II bipolar disorder or an alcohol dependency disorder.

Gibson said he does have these disorders, though. He said he takes medication every day and sees a psychiatrist on a regular basis to keep his disorders under control. He said he has come a long way since his attempt at suicide in 1996 and setting his grandmother’s house on fire in 2000.

Bipolar disorder is not something a person deals with every day, but instead, the person suffers in cycles, said Brian Shannon, chairman of the board of trustees for Lubbock Regional Mental Health Mental Retardation Center.

“Bipolar disorder, at one time, was called manic-depression and is very characteristic that it – the person – will kind of cycle from stages of severe clinical depression and then, alternatively, be in a heightened manic state,” Shannon said.

The manic part of these cycles is what makes bipolar disorder – and especially bipolar II – so difficult to diagnose, according to Anita Deanda, a psychiatrist who works at Thompson Hall, the health clinic on the Texas Tech campus.

With bipolar II disorder, the patient’s manic cycles are less severe and, therefore, more difficult to diagnose, Deanda said.

“It’s a very difficult thing to get the manic part right, and that’s what’s hard,” she said.

Deanda emphasized the fact that every case of bipolar disorder is different and the only common thing is these cycles of depression and mania.

In third grade, Gibson said, he started realizing something was wrong with him. “I thought about death a lot,” he said, “and knew what the word ‘suicide’ was at 6 or 7.”

He said he was sent to a specialist in Lubbock who told his parents he would be fine if they put him in a different school environment. Gibson was moved from Honey Elementary to Trinity Christian School in fourth grade, but the change did not help.

Gibson said he was the odd man out most of the time, but high school brought some new experiences.

“In ninth grade, the big thing that happened to me was I had my first real, true girlfriend,” he said. “To make a long story short, my girlfriend dumped me on the trip for my best friend,” Gibson said. “I went home and freaked out and had my first suicide attempt.”

He said that he tried to overdose on Tylenol. His parents found him and took him to the hospital to have his stomach pumped.

Gibson said that after the death of his grandmother, he began drinking.

“I didn’t know how to deal with it,” he said. “So, shortly afterward, I started self-medicating with alcohol.”

In this, he said, he is not alone. He said 40 percent to 60 percent of people with bipolar disorder self-medicate in some form.

Gibson said he felt the worst in November of his senior year of high school. One day,
The Stigma is an invisible mark of disgrace and dishonor placed upon those with mental illness. The Stigma is essentially an attitude that promotes dehumanizing perceptions about and repugnance toward people with psychiatric disorders. When a person is viewed as undesirable, compassion, inclusion, and kindness die as does any commitment to defeating mental illness and restoring those human beings who are living with it.

The Stigma promotes in society an atmosphere of fear that interferes with the rights of those who have mental illness. We need to attack the ignorance and myths that surround mental illness and raise public consciousness, presenting a positive image of those with psychiatric disorders by restoring value, dignity, humanity, and potential, to those who experience the illness. The word Stigma implies psychiatric patients will never get well, and that they are sentenced to remain forever mentally ill, which, emphatically, is not the case today.

The Stigma of mental illness suggests that those who have psychiatric disorders are lazy, irresponsible, difficult, demanding, i.e., that their illness is a character defect. thus, these individuals are stereotyped by society as choosing bizarre behavior, being aggressive, perhaps rude, and a burden to society, whereas, in fact, they are suffering from an illness, improvable by treatment. The Stigma associated with mental illness is a blemish that tarnishes American culture.

The Stigma makes mental illness a non-priority. The Stigma suggests that people with brain disorders can be discriminated against in health care and excluded from needed forms of community service. As a society, we must do better than this. The Stigma causes mental health consumers to be cut off from communities, churches, jobs, organizations, even adequate mental healthcare because of the barriers and roadblocks of discrimination. In fact, the Stigma interferes with addressing the associated needs of people with mental illness, namely, unemployment, lack of social interaction, poverty, lack of housing.

People with mental illness are victims of exclusion, intolerance, bigotry, and because of the Stigma, they are humiliated, ignored, neglected. Those who have mental illness brain disorders are an invisible population excepting for the most severe and chronic patients in times of crisis. Most of the people who suffer from mental illness, after appropriate treatment and when given opportunities, can function reasonably well on the job, in social settings, and in community endeavors. Psychiatric patients need mentors/friends support systems where they are recognized as people of value and trust. They deserve respect and the opportunity to succeed. If we make situations less stressful, people with mental illness will do better. People with mental illness brain disorders need social interaction, the opportunity to be creative and to perform as productive citizens.

The Stigma of mental illness causes society to act unjustly toward people with brain disorders. One study established to determine the acceptability of disability groups found the public accepted the person with mental retardation, the alcoholic, the ex-convict over the person with mental illness, who scored the least acceptance out of a group of 21 different disabilities. The Stigma is nothing less than prejudice that ends in discrimination.

There has been too much silence in society, in our media, in our legislature, about the injustice of the Stigma. Thus, we continue to fail to eliminate discrimination against people with mental illness with its associated poverty. Our silence brutalizes and demeans people with brain disorders. Our goal is simply to destigmatize mental illness and the shame associated with it.

We need to let the public know the devastating impact mental illness has on mental health consumers and their families; indeed, on society at large, and that we’re outraged at the Stigma. Let’s educate all citizens about mental illness and the tragedy of the Stigma, both people with the illness and those who have not experienced its reality. To destigmatize mental illness, we need to take the “shame” away from it. Not to destroy the Stigma is a crime against people with brain disorders. Let’s reverse the dehumanization, devaluation, and exclusion of people with mental illness and restore dignity, respect, and value to those who have or have had a brain disorder.
Rebalancing My Life

“Mental Illness 101”

By Carol R. Schaper

It is the first session of a class of “Mental Illness 101.” The seventeen students sat forward in their chairs as the instructor continued the explanation of the course, what it would cover, how it would be presented, the workbooks, handouts, visiting professionals, and the expectation that all students would attend every one of the eight sessions in order to fulfill the requirements, although the class would be held on Saturday mornings.

Since there were seventeen students who introduced themselves and told a bit of pertinent information on why they chose this class, the instructor casually said: “I would like for you to take about three minutes to think about this question and tell the class — What is the most important thing in your life? Then take another two minutes to tell us what it will take for you to attain this, or to maintain this.”

This is quite an unusual first question, to share personal information in an education class for students who may not have had any introduction to college. This course and this classroom are quite different from those of a traditional campus.

Rebalancing My Life is a program of educational workshops presented for individuals with severe mental illnesses. A series of classes was held in the home of the former executive director of NAMI Collin County in October of 2004 on Saturdays from 9 until 12. Ten of the students were consumers with neuro-psychiatric diagnoses. Seven were some of their family members who were there to also learn in this different class setting. The second course was given in July and August 2005, with 24 in attendance, fourteen consumers and ten family members.

Rebalancing My Life is an education course with a life-style approach which allows people to pursue the highest level of recovery in mental health within their capacity. Poor physical and mental health are serious obstacles to successful participation in treatment, rehabilitation and recovery from mental illness. It is not only possible for people with serious mental illness to work toward recovery in the midst of their illness, it is essential for their successful attainment of life goals.

Four general teaching methods, or approaches, were used in the classes: the informational (educational), the skills training (skills demonstrations), and the supportive (coping strategies and emotional sharing) and a combination of all three in a comprehensive approach.

Some of the topics in the Education Series included: What Is Mental Illness; Medications to Treat Mental Illness; Self Observation and Illness Monitoring; Communicating About the Illness; Decreasing Your Chance of Relapse; Stress Management; Family Interactions; and Community Resources.

In the Social Skills Application they became: So I Have a Mental Illness..., Taking Care of My Health; So That Is What Meds Do?; Communicating Effectively; Healthful Life Style; The Laundry, the Market, Cleaning; Money; Measure and Time; and Citizenship.

These two projects were made possible through a grant from the City of Plano, and the final reports to the funding source showed surprising outcomes, especially in the individual responses to the “most important thing in your life” objectives voiced by each person in their first class. The most exciting outcome is that there is now a “vision of recovery” that each now believes and is working toward. (Not to mention that of those who said ‘a job’ there are five who now have a job.)

This model program was only one of the projects developed as the result of a challenge brought forth about sixteen years ago by Dr. William Anthony, who has since that time become very well known as the Executive Director of Boston University’s Psychiatric Rehabilitation Center. He spoke about what kind of mental health system he would like to see in the future. He couldn’t talk about prevention or cure. But what he gave those who listened was a vision of recovery that he felt was possible.

Dr. Anthony said that “recovery, as we currently understand it, means growing beyond the catastrophe of mental illness and developing new meaning and purpose in one’s life. It means taking charge of one’s life even if one cannot take complete charge of one’s symptoms.”

— Dr. William Anthony

“Recovery, as we currently understand it, means growing beyond the catastrophe of mental illness and developing new meaning and purpose in one’s life. It means taking charge of one’s life even if one cannot take complete charge of one’s symptoms.”

See Rebalancing My Life…page 18
National Day of Prayer

On October 4, 2005 the San Marcos Support Group of NAMI Austin sponsored the second annual Service for National Day of Prayer for Mental Health Recovery and Understanding. The service was co-sponsored by Central Texas Medical Center’s Heritage Program and Gadarene Ministries of DBSA Texas.

First Presbyterian Church of San Marcos hosted the service, which was promoted as a community wide service. Dr. Gus Sicard, O.P. from San Antonio delivered the message with Dr. David Barker, Pastor, First Presbyterian Church, San Marcos giving the invocation. Chaplain Merlin Starr of CTMC read the Scripture and Ed Kuny, NAMI Austin member and Pastor, First Presbyterian Church of Luling presented the closing prayer. Other members of the San Marcos community participated in the Litany, music, and candlelighting ceremony. Dr. Theodore Dake, M.D. was kind enough to provide funding.

Refreshments were served following the service. The service was well attended and will be continued on a regular basis as all of the sponsors feel that this type of service should be offered to the community. It makes the community aware of mental illness and what is being done in all fields to help those with the disease. There are two very active support groups in San Marcos, both sponsored by NAMI Austin. A Family to Family Support Group for care givers, family, and friends of persons suffering from mental illness meets monthly. Weekly meetings are ongoing for the Peer to Peer Support group of consumers. Fifteen to twenty plus people are active and regularly attend this group.

For information about either of the support groups contact Sally or Ed Kuny at (512) 353-4339.

Rebalancing My Life...continued from 17

It is critical in recovering to learn to sort out that which one can influence from that which one cannot. Every person’s journey to recovery is unique. What is important is how people choose to define mental illness and the place it is playing in their lives. A person can believe that the whole of his/her life is defined by the illness. People may feel that they are synonymous with their illness, or that they have become complete victims of it. For many individuals there is a crucial distinction between having a mental illness and being mentally ill. It was when Phil said to his mother, “look, Mother, I have a mental illness, but I am not mentally ill all the time” that she realized that this distinction was his breakthrough to a useful concept. He could achieve “re-adaptation”, which involves reorganization and acceptance of self so that there could be meaningful purpose that transcends the mental illness in his life. Thus the Rebalancing My Life course was born. It meets the standards for ‘rehabilitation and recovery’ set out by the psychiatric rehabilitation professionals. At both Center for Mental Health Services in their new course Illness Management and Recovery, and the Center for Psychiatric Rehabilitation at Boston University’s new Second Edition of Psychiatric Rehabilitation the outcomes listed as expected are the same as listed of the consumers of Rebalancing My Life.

The consumers of NAMI Collin County say that these session have helped them learn to understand the disorder, the various treatments, the medications, to create a low stress environment, manage disturbing behaviors, lean new skills, and gain psychosocial opportunities to enhance community integration which will promote growth and rehabilitation. In their recovery they are asking for more classes.
he went home from school and came clean with his parents about the way he was feeling.

“I can be Superman – on top of the world,” he said, “and five minutes later, I can be on the bed with Dad’s 12-gauge wondering, ‘If I killed myself, would anyone give a damn?’” Gibson said that his parents got him to see a psychiatrist the next day. He said the psychiatrist gave him antidepressants which, with his alcohol dependency, made the situation worse.

“When you mix alcohol and antidepressants, you go from depressed to so low that, when you look up, you see the rock bottom,” Gibson said.

He said he has been sober since Feb. 22, 2000. That day, he said, his parents brought police officers to his house after Gibson was suspended from school for arriving drunk.

Gibson said he had a very bad relationship with his father. The day after he graduated from high school, he said, he and his father got into an argument and Gibson blacked out. While he was blacked out, he said, he trashed his grandmother’s house, where he was living, and set it on fire.

He said he was charged with second-degree felony arson and taken to jail.

“I stayed in there for a week, and it was the most humbling experience,” Gibson said.

After the week in jail, his parents took him to Topeka, Kan., to the Menninger Clinic, which is now located in Houston.

“I meet with the psychiatrist for 15 minutes, and she says, ‘You have type II bipolar disorder,’” Gibson said.

He said he was there for 13 months, and that it was a relief to be diagnosed correctly.

Gibson said he worked hard at Menninger because, if he failed, he would go back to jail in Texas.

He said he left Menninger in 2001 and returned home to a better relationship with his father and support from both of his parents.

Gibson said he is now the consumer support coordinator for the Lubbock affiliate of the National Alliance for the Mentally Ill.

His mother, DeAnna Gibson, is the Region 1 director for the alliance. She said she feels lucky that her son wants to take care of himself.

“Andy has done so well,” she said. “We know that we can be thankful for today – that he’s taking his meds.”

For the particular illness he has, Andy Gibson said he takes Topamax as a mood stabilizer, Wellbutrin XL for depression and Lunesta as a sleep aid.

DeAnna Gibson said she wishes she could have known earlier what she knows now about mental illness because her son could have been diagnosed at a younger age. She said her son is in the majority, though, in how long it took him to be diagnosed.

“On average, it takes seven to eight years and two to three doctors before receiving a proper diagnosis,” she said.

Deanda, the psychiatrist from Tech, agreed, saying that it takes years to reach a diagnosis for bipolar II because the doctor usually does not get to see the actual episodes the patient goes through.

“It’s hard to find any common threads except for the cycle,” Deanda said. “In bipolar II it’s even harder because the cycling is more subtle.”

Andy Gibson’s father, David Gibson, is the president of the Lubbock chapter of the alliance. He said he is proud of his son but also knows that Andy will have to live with this illness the rest of his life.

“Even now,” David said, “he has a difficult time realizing that life just isn’t fair.”

Joe Lovelace, executive director for the alliance’s state chapter, said most of the 47 chapters in Texas are run by families.

“NAMI actually had its origins around a table in a dining room in Wisconsin,” Lovelace said. “It’s an organization that is really made up of people with mental illnesses and their family.”

Kristen Lark is a reporting student in the College of Mass Communications at Texas Tech.
Calling All Advocates
NAMI needs you in Washington, DC next June!

We are planning a major lobbying effort as part of the 2006 Annual Convention and we need YOU there. NAMI’s grassroots advocates have worked for years to change minds and change lives. Our efforts were given a huge boost two and a half years ago with the release of the President’s New Freedom Commission Report – written by a nationwide panel put together by the Bush Administration to devise a blueprint on how to transform the mental health system in America.

The Commission’s report echoes much of what NAMI has been saying for years – that mental health is essential to overall health, that the system must be consumer- and family-driven, that disparities in mental health services must be eliminated, and that early identification and intervention are a must.

Although the report provided six concrete goals and strategies to achieve them, not enough has been done since its release. It’s time for NAMI advocates to insist that promises are kept and to convince our Congressional representatives to take the necessary steps to turn the report’s recommendations into action. That’s why it’s so important for you to be present next June on Capitol Hill when we will unleash thousands of grassroots activists to talk face-to-face with their elected representatives to demand action NOW!

As we have for over 25 years, the 2006 Annual Convention will also offer you four days of top-notch educational opportunities, insights on new strategies to achieve our goals, and plenty of networking time with old friends and new contacts. If you are serious about transforming the mental health system in our country and improving the lives of people who live with mental illnesses, make sure you attend NAMI’s 2006 Annual Convention!

For more information and to register online go to www.nami.org/convention. And, remember, the earlier you register, the more you’ll save.

HOTEL INFORMATION
Washington Hilton & Towers
1919 Connecticut Ave. NW
Call 800/HILTONS or 202/383-3000 and be sure to tell the operator you are attending the NAMI Convention.

TRAVEL INFORMATION
Information on discounted airline tickets to Washington, DC, can be found by visiting the NAMI 2006 Convention website at www.nami.org/convention.

To find a NAMI Texas affiliate in your area, call 1-800-633-3760 or visit www.namitexas.org