CALIFORNIA

DBSA-CA NEWS

Depression and Bipolar Support Alliance–California
(formerly California Depressive and Manic-Depressive Association)

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DBSA–California

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Federal Budget Cuts to Mental Health Programs: Just Say "NO!"

Last month, the mental health community received a huge blow when the administration released its 2008 budget recommendations. If approved, the $2.9 trillion budget would cut major funding to mental health programs, as well as to Medicaid.

The Center for Mental Health Services (CMHS)—part of the Substance Abuse and Mental Health Services Administration (SAMHSA)—faces the largest cuts, an astronomical $76 million. This would drastically reduce, or even eliminate, CMHS funding for many important programs like the National Training and Technical Assistance Centers (NTTAC). The NTTAC strengthens consumer organizations by providing research, informational materials and financial aid. Another example is Statewide Family Network Grants which promotes improvements to state programs for children and adolescents with serious emotional disturbances and their families. Beyond these cuts, the budget would also keep funding for basic CMHS programs at this year's levels, with no increase for inflation.

The administration's recommendations also mean less Medicaid spending on many significant public mental health services funded under the Medicaid program. The budget would cut approximately $25 billion over five years through changes in legislation and regulations. While this would save more than $1.2 billion over five years, it would, in turn, increase costs for states and/or reduce services for people served by Medicaid.

In an effort to save $2.3 billion over five years, the administration's plan would also restrict rehabilitation services that are now allowed. The result? States will either be forced to pay more to cover these services or individuals who need these services will be left without them. People living with mental illness greatly need rehabilitation services to help them lead productive lives within their communities.

These services include the following:

- Skills training
- Illness self-management
- Peer services
- Intensive in-home services
- Therapeutic foster care services for children
- Other interventions that promote recovery

Lastly, the administration proposes to stop federal Medicaid reimbursement for school-based administration and transportation costs, to save $3.6 billion over five years.

Other recommended budget changes include the following:

- Less funding for mental illness research by the National Institute of Mental Health (NIMH)

*Continued on page 2 (***Budget Cuts***)*

BUDGET CUTS *(Continued from page 1)*

- An almost 50 percent cut in funding for the Department of Housing and Urban Development, which provides supportive housing for non-elderly, low-income people with disabilities
- Caps on payments to government providers for social service programs
- Elimination of the Safe and Drug-Free Schools and Communities State Grants program
- A $76 million cut to Medicare over five years, reducing Medicare reimbursement to providers

It's time to just say "NO!" to these federal budget cuts. The only way to do this is to let your legislators know how you feel. You put your legislators into office. And it is you that will keep them there or see that they're replaced in the next election.

Take time now to send letters to both your senators and representatives. At **http: //capwiz.com/ndmda/issues/alert/?alertid =9495621 &type=CO**, a sample letter is provided for you. You can send it as is or add your own personal story.

Rally your family and friends to send letters as well. At the bottom of the Advocacy web page, you'll see the "Tell-A-Friend" box. Or click on **http://capwiz.com/ndmda/taf/.** This feature lets you easily ask 10 friends, family members or coworkers to join you in fighting these budget cuts. A note about this issue's importance is already written for you. All you have to do is enter their e-mail addresses. It's easy—and effective.

Source: DBSA Outreach
Spring 2007

VNS Therapy Questioned

Peter Barglow, M.D. and
Irwin Feinberg, M.D.

Sacramento, California

Vagus nerve stimulation (VNS) therapy, a $25,000 treatment administered by an implanted medical device manufactured by Cyberonics, has been approved for the treatment of refractory depression by the Food and Drug Administration (FDA). But the success of VNS in patients with treatment-resistant depression has not been demonstrated. An acute-phase, randomized, controlled trial of VNS, a study by Dr. John Rush and colleagues published in the September 2005 *Biological Psvchiatiy,* did not yield definitive evidence of short-term efficacy for the therapy. A follow-up, long-term study of these patients showed some improvement; however, this finding is not interpretable because patients were

Continued on page 3 (**VNS Therapy Questioned**)

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Riverside, CA 92504

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Have you gained weight taking medication to treat bipolar disorder?

Bipolar Disorder Research Study

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If you are 18 to 65 and have gained weight taking medications to treat bipolar disorder, you may be eligible to participate in a yearlong research study.

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You will receive free medication as part of this study.

UCLA MOOD DISORDERS RESEARCH PROGRAM

Mark Frye, M.D. ■ Lori Altshuler, M.D.
Natalie Rasgon, M.D. P.h.D.

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VNS THERAPY QUESTIONED

(Continued from page 2)

unblinded, and some also received ECT or antidepressant medications.

In July 2005 Dr. Daniel Schultz, the director of the FDA's Center for Devices and Radiological Health (CDRH), signed a final approval letter for VNS as a treatment for refractory depression despite the fact that no further robust studies had been published. Usually the director of CDRH is not involved in such decisions, but in this instance Dr. Schultz overruled more than 20 FDA staff scientists, medical officers, and management staff opposed to approval, precipitating a U.S. Senate investigation and official criticism ("Review of the FDA's Approval Process for the Vagus Nerve Stimulation Therapy System for Treatment-Resistant Depression," prepared by the staff of the Committee on Finance, U.S. Senate, February 2006).

On September 9, 2006, APA submitted an official letter endorsing Medicare reimbursement for VNS after consulting with APA's Council on Research. It is not clear whether this was based upon a scientific review of VNS treatment, and whether the endorsement followed an actual meeting or a conference call. Are minutes of the meeting available? One member of the Council on Research, Dr. Charles Nemeroff~ had been associated with a potential conflict of interest related to VNS because of an article in the July 2006 *Neuropsychopharrnaco/ogy* of which he was one of the authors. Also, APA accepted money from cyberonics at least four separate times, in 2002, 2004, *2005,* and 2006. Also, Cyberonics has been a target of an SEC investigation for backdating of stock options, and its CEO and CFO resigned recently in the midst of the fallout from the backdating.

On February *5* the Medicare Coverage and Analysis Group at the Centers for Medicare and Medicaid Services (CMS) proposed that Medicare adopt a "national noncoverage determination" for VNS for patients with treatment-resistant depression who had received or had refused electroconvulsive

therapy or who had been hospitalized for depression. CMS stated that "vagus nerve stimulation is not reasonable and necessary for treatment of resistant depression" and that research "provides little evidence that a patient will experience a health benefit as a direct result of VNS therapy" (CMS Medicare Coverage Database, 2007; posted at <www.cms.hhs.gov/mcd/viewdraftdecjsjonmemo.asp?id= 195>). CMS is expected to make a final decision on the noncoverage proposal for VNS in May.

Medicare reimbursement for VNS would absorb considerable finances, reducing funds available for proven treatments. APA's official support for Medicare reimbursement did not consider input from members of APA's Medicare Corresponding Committee (MAC), which serves as an information-gathering body for APA as psychiatry representatives to states~ Medicare advisory committees. By September 6, 2006, Cyberonics had sought and had been denied approval by 10 local CMS contractors from 14 states, according to a press release from Public Citizen.

The risks of using an expensive, invasive, and unproven treatment for refractory depression are obvious. APA should explain its support of this controversial VNS therapy.

Source: Psychiatric News
April 20, 2007
Vol. 42, No. 8, pg. 42

Yale Findings Hold Promise For Stopping Progression of Bipolar Disorder

Changes in the brain that are important indicators of bipolar disorder are not prominent until young adulthood and are reduced in persons taking mood-stabalizing medications, Yale School of Medicine researchers report this month in *Biological Psychiatry.* The reseachers used magnetic resonance imaging [MRI] to measure a part of the brain that regulates emotions, the ventral prefrontal cortex, that lies above the eyes. The changes in persons with bipolar disorder were not prominent until young adulthood, suggesting that the illness progresses during the teenage years. Bipolar disorder is also known as manic-depressive illness.

"The brain changes were diminished in persons with bipolar disorder who were taking mood-stabalizing medications," said Hilary Blumberg, M.D., associate professor in the Department of Psychiatry and director of Yale's Mood Disorders Research Program. "This brings hope that it may someday be possible to halt the progression of the disorder."

Blumberg added, "Research to understand bipolar disorder in youths is especially important because of their high risk for suicide.

The research was conducted at Yale in collaboration with co-author John Krystal, M.D., Ravi Bansal, Andr'es Martin, M.D., James Dziura, Kathleen Durkin, Laura Martin, Elizabeth Gerard, M.D., Dennis Charney, M.D., and Bradley Peterson, M.D. Biological Psychiatry: Published online January 20, 2006.

Source:DBSA Tampa Bay Newsletter
March, April, May, 2007
*As seen in Dallas **DBSA** May 2006*

Bipolar Disorder in Children

Difficult to diagnose, important to treat

Childhood bipolar disorder made unwanted headlines several months ago when a four-year-old child in Massachusetts died as a result of a drug reaction. Given a diagnosis of bipolar disorder and attention deficit hyperactivity disorder (ADHD) at age 2, she was taking an antipsychotic drug, an anticonvulsant, and clorlidine, a blood pressure medication that is sometimes used to treat complex behaviors that include agitation and hyperactivity. The cause of the death may have been an overdose of clonidine, and the girl's parents have been charged with homicide. This tragedy has given wider publicity to a continuing controversy about the diagnosis and treatment of bipolar disorder in children.

The disorder was once thought to be rare—according to a 1997 estimate, occurring in only one out of 20,000 children. Now, though, it's believed that at least a third of the time, the symptoms of bipolar disorder appear first in childhood or adolescence—at a rate that may be closer to one in 200. Some believe this indicates belated recognition of a previous1y neglected condition. Near1y two-thirds of children and adolescents with mood disorders of all kinds, they say, are still not diagnosed or are inadequately treated. Others suspect that the diagnosis of bipolar disorder is now being overused. As a result, they say, drugs are dispensed too freely and not enough attention is paid to social and psychological issues that may include abuse and trauma or simply family conflict and inadequate parenting skills.

Symptoms

The main reason for the past neglect of this diagnosis and the present concern about it is that the symptoms rarely follow a discrete pattern. Children, especially young children, usually do not show the adult cycle of distinct mood swings from mania to depression lasting for several months, with intervals of normal mood in between. Many symptoms that *may* be a result of bipolar disorder also occur in other childhood disorders: moods fluctuating in very rapid cycles, even sometimes from hour to hour; irritability and agitation instead of euphoria; or bursts of rage. Children can become dangerous to themselves and others. There are reports of three-year-olds so violent that their parents fear for their own safety and four-year-olds who throw hour-long tantrums on being asked to tie their shoes.

Children may also have more classic and unmistakable manic symptoms, which include racing thoughts, compulsive volubility, decreased need for sleep, unwanted sexual touching, and inappropriate giddiness or clowning (for example, after being suspended from school). Another symptom is extreme bossiness and defiance of authority; one 12-year-old told his soccer coach and teachers how to do their jobs.

Mania may alternate with depressive states in which the child is listless, withdrawn, unable to enjoy life, and plagued by physical complaints and morbid thoughts. Suicide is a danger for adolescents and can occur even in younger children. To add to the difficulty of diagnosing childhood bipolar disorder, irritability is probably the most common symptom of depression as well as mania in children.

These children's symptoms can take so many different forms that they are often assigned a diagnosis of bipolar disorder "not otherwise specified?" This term is used in the American Psychiatric Association's manual to describe severe mood fluctuations that for various reasons don't easily fit into any of the standard categories.

The National Institute of Mental Health--funded Course and Outcome of Bipolar Illness in Youth (COBY) Study followed 263 children ages 7 to 17 for two years. The results, published last year, showed a continuum of symptoms from mild to severe. About 70% of the children eventually recovered from their first episode of mania or depression (meaning two months without symptoms). But during the two years of the study, they relapsed an average of three times. The children had some symptoms 60% of the time, but enough to warrant a diagnosis of bipolar disorder only 20% of the time. Even during the symptom-free periods, most had other problems, especially ADHD. Many children who were originally diagnosed with bipolar disorder not otherwise specified eventually developed more typical bipolar symptoms that resembled the adult disorder.

*Continued on page 5 (***Bipolaar Disorder in Children***)*

BIPOLAR DISORDER IN CHILDREN *(Continued from page 4)*

Making the diagnosis

Children can be sad or silly or irritable or agitated for many reasons. It's important to be sure that a child's mood changes are not better understood as a reaction to events and circumstances, including child abuse, other forms of trauma, or stress in the home. Longer-lasting and more severe symptoms could have other causes, including temporal lobe epilepsy, intermittent explosive disorder (see *Mental Health Letter,* October 2006), fetal alcohol syndrome, oppositional defiant disorder, and post-traumatic stress disorder.

Bipolar disorder in children is especially difficult to distinguish from ADHD, since many of the symptoms—impulsiveness, distractibility, and hyper-activity—are similar. Today up to 30% of children originally diagnosed with ADHD are eventually given a diagnosis of bipolar disorder. Up to 50% or more of children and adolescents with bipolar disorder also fit the criteria for a diagnosis of ADHD. The two conditions may also overlap genetically, since children with a bipolar parent have a higher than average rate of ADHD.

Some preliminary research suggests that many children now diagnosed with bipolar disorder, especially bipolar disorder not otherwise specified, actually have a condition that has recently been labeled severe mood dysregulation. Its symptoms are periodic irritability and hyperactivity, and it is often associated with oppositional defiant disorder and ADHD. In a recent experiment that involved the performance of a mildly frustrating task, the EEGs (brain electrical signals) of children supposed to be suffering from severe mood dysregula-tion differed from the EEGs of children with bipolar disorder. One implication is that the treatment might also be different. Drug treatment

Bipolar disorder in adults is treated with mood stabilizers—frequently several drugs in combination—and the same drugs are now increasingly prescribed for children. Lithium, the favored drug treatment for adult bipolar disorder, is also the only medication that has been proved effective in controlled studies and granted FDA approval for bipolar disorder in children. But other drugs are also commonly used. These include the anticonvulsant vaiproate (Depapote) and several second-generation antipsychotic drugs.

Experts working with the Child and Adolescent Bipolar Foundation have recently published treatment guidelines for mania in children. They recommend starting with a single drug, usually lithium or valproate, then substituting or adding other drugs in various combinations depending on the response. For depression, lithium and antipsychotic drugs are sometimes prescribed, along with the anticonvulsant lamotrigine (Lamictal). Fluoxetine (Prozac) and other antidepressants may also be helpful, but some believe they raise the risk of switching from depres-sion to mania. Once mood swings are damped down, a treatment for ADHD can be added—usually a stimulant, either methylphenidate (Ritalin) or dextroamphetamine (Dexedrine).

Mostmood stabilizers have the potential for uncomfortable or worrisome side effects. Antipsychotic medications can cause irregular heart rhythms, movement disorders, weight gain, and a rise in cholesterol and blood sugar. Lithium has a long list of potential side effects, including weight gain, nausea, acne, and excessive thirst and urination. It requires periodic blood tests, includ-ing tests of thyroid and kidney function. Valproate may cause an upset stomach, and lamotrigine can produce a hyper-sensitivity reaction that appears as a ppears as a rash. Most of these drugs can be sedating, making a child sleepy or sluggish. Children often drop out of treatment because of side effects. Adolescents in particular may reject lithium because it causes weight gain and acne.

Psychosocial treatment

Whether children with bipolar disorder take drugs or not, psychotherapy can help them in the same way it helps adults with the disorder. Supportive therapy provides sympathy, reassurance, and strategies for managing everyday problems. Psychodynamic therapy may help older children and adolescents explore their present and past personal relationships, their psychological development, and how they defend against uncomfortable feelings. With cognitive therapy, they can examine and re-examine their thoughts and ways of interpreting experience. Behavioral treatment helps them observe and change their behavior. They can be taught social skills and problem-solving and rehearse what to do when threatened with relapse. Sleep hygiene— rising and going to bed at the same time every day—may help to prevent mania.

Some bipolar children need tutoring and special education for learning disabilities.

Parents often need help to cope with a child whose erratic behavior, defiance, agitation, or withdrawal is causing family chaos and conflict. They can be educated about the illness, provided with training in stress management and communication skills, and shown how to avoid words and actions that exacerbate a child's symptoms. Family therapy and support groups may improve the lives of both parents and children. Information on support groups is available at the Child and Adolescent Bipolar Foundation (see Resources).

Critics continue to worry about the sometimes frustrating and confusing symptoms of childhood bipolar disorder and about the increasing use of drugs to treat those symptoms. The complaint is often heard that physicians and mental health professionals turn to pharmacological solutions because of cost-cutting pressure from insurers and HMOs. ~

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*Continued on page 6 (***Bipolaar Disorder in Children***)*

"Depression is Real" a Key National Resource

Concerned about popular misconceptions that trivialize depression as "just the blues" or dismiss it entirely as an "imaginary disease," seven prominent physician, patient, and civic nonprofit organizations have joined together to launch a public education campaign to tell Americans the facts about depression.

The Depression Is Real public education campaign is sponsored by the American Psychiatric Foundation (a philanthropic and educational subsidiary of the American Psychiatric Association), the Depression and Bipolar Support Alliance, the League of United Latin American Citizens, the National Alliance on Mental Illness, the National Medical Association, the National Mental Health Association and the National Urban League.

The Depression Is Real campaign consists of television, radio, and print public service announcements (PSAs), print and radio advertisements, a Web site (**www.DepressionIsReal.org**), and other educational activities. Print ads are running in public policy publications in Washington, DC and in key national dailies including *USA Today* and *The New York Times,* as well as in *Black enterprise* and Hispanic *Business* magazines. Radio ads will also air in the Washington DC area. The PSAs, produced in English and Spanish, will be distributed nationally beginning in October, 2007.

Source: NAMI Tulare County
December 2006
As seen in: NAMI San Matco County News,
October 2006
From: NAMT.org Web site

National Mental Health Facts

It is estimated that during a 1-year periods, 22 to 23 percent of the U. S. adult population -- or 44 million people -- have diagnosaable mental disorders.

The National Institute of Mental Health (NIMH) extimates that one in five children and adolescents may have a mental health disorder.

Approxiamately 82 million self-insured and 31 million insured employees will receive mental health parity under the new bill.

Approxiamately 98% of workers with employer sponsored healtrh insurance have coverage for mental health care.

Aproximately 14-20% of group health plan participants use their mental health coverage.

Information above was excerpted from an article by Klaus Marre published in *"The Hill"* Newspaper, from a peice on the subject in the current *American Foundation for Suicide Prevention* newsletter, and a February 12, 2007 Kennedy, Domenici, and Enzi press release.

Source: DBSA Tampa BAy Newsletter
March, April, May, 2007

BIPOLAR DISORDER IN CHILDREN*(Continued from page 5)*

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For more references, please see www.health.harvard.edu/mentalextra.

Resources

Child and Adolescent Bipolar Foundation
847-256-8525
www.bpkids.org

American Academy of Child and Adolescent Psychiatry
202-966-7300
www.aacap.org

Juvenile Bipolar Research Foundation
866-333-JBRF (toll free)
www jbrf.org

Source: HARVARD MENTAL HEALTH LETTER
May 2007

Current Research

Alternative medicine for depression

According to the National Comorbidity Survey Replication, only about 40% of people with major depression receive adequate conventional treatment, so it's important to get a better understanding of the other measures depressed patients are taking. A survey of American women indicates that a high proportion of them use alternative and complementary medicines for depression.

Researchers analyzed a national telephone survey of more than 3,000 women, with Mexican Americans, Chinese Americans, and African Americans somewhat over-represented-in order to get a picturc of ethnic differences. Of these women, 220 said they had been medically diagnosed with depression in the previous year, and 54% of them had used alternative medicine to treat the symptoms. The authors point out that the percentage would have been even higher if they had been able to include depressed women who never received a medical diagnosis.

The most popular alternatives were manual therapies, including chiropractic, massage, and acupressure, used by 26%; medicinal herbs and teas, used by 20%; and vitamins and nutritional supplements, used by 16%. Other unconventional remedies were yoga, meditation, tai chi, Chinese medicine, Ayurveda, and Native American healing.

African Americans were least likely to use alternative medicine and Chinese Americans most likely. Women with a college education and those employed outside the home were more likely to use alternative medicines, especially vitamins. Herbal medicines were used most by Mexican Americans, Chinese Americans, the unemployed, and immigrants. Manual therapies were used most by women over 35 who thought their health was poor.

With controls for income, employment, marital status, age, and other demographic factors, most ethnic differences canceled out, although non-Hispanic whites were still more likely than blacks to use alternative medicine.

The women responded to interviewers' suggestions of various specific and general reasons for using unconventional medicines. Forty-five percent mentioned side effects of conventional medicines, and 43% said conventional medicines were ineffective. Seventeen percent said they could not afford conventional treatment. Sixty-five percent preferred a natural approach, 59% said that use of alternative remedies was consistent with their beliefs, 45% had become familiar with these remedies in childhood, and 39% had read or heard something about an alternative medicine. About one-third said a doctor had recommended alternative treatment, usually a manual therapy and almost never herbs or vitamins.

Although an alternative treatment that has not been studied sci-entifically should not *substitute* for an evidence-based medical treatment, the authors believe physicians should generally remain neutral about their patients' use of these remedies as supplementary. In particular, criticism of remedies accepted in a given culture or by a given ethnic group could be interpreted as disrespectful.

Wu P, et a!. "Use of Complementary and Alternative Medicine among Women with Depression: Results of a National Survey," *Psychiatric Services* (March 2007): Vol. 58, No. 3, pp. 349—56.

Source: HARVARD MENATAL HEALTH LETTER
June 2007

Antidepressants Trump Side Effects
Benefits Outweigh Risks in Children, Teens, Researchers Say

The Associated Press

Authors of a new comprehensive analysis of antidepressants for children and teenagers say the benefits of treatment trump the small risk of increasing some patients' chances of having suicidal thoughts and behaviors.

The risk they found is lower than the one the Food and Drug Administration identified in 2004, the year the agency warned the public about the drugs' risk of suicide in children. After the warning, U.S. youth suicides increased and some mental health experts said reluctance to try antidepressants might be to blame.

The new analysis includes data from seven studies that were not part of the previous FDA analysis, including two large pediatric depression trials that were unavailable three years ago.

Researchers analyzed data on 5,310 children and teenagers from 27 studies. They found that for every 100 kids treated with antidepressants, about one additional child experienced worsening suicidal feelings above what would have happened without drug treatment. In contrast, the FDA analysis found an added risk affecting about two in 100 patients. There were no suicides in any of the studies. The ~antidepressants included Prozac~o[öft, Celexa, Lexapro, Effexor, Serzone, and Remeron.

"The medications are~safe and effective and should be considered as an important part of treatment," said study co-author Dr. David Brent of the University of Pittsburgh School of Medicine. "The benefits seem favorable compared to the small risk of suicidal thoughts and behavior."

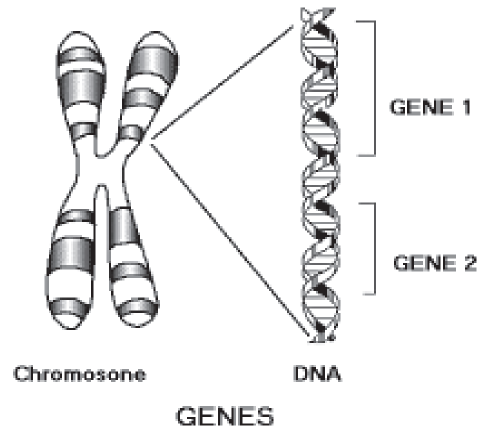
Antidepressants worked best when used to treat anxiety, the analysis found. They worked moderately well treating obsessive-compulsive disorders. They worked less well, but were still effective in treating depression.

Continued on page 8 (**Antidepressants**)

Gene Study Probes 7 Common Diseases

Disease Genes Found to Be Risk Factors, Not Fates

By Daniel J. DeNoon
WebMD Medical News
Reviewed by Louise Chang, M.D.



June 6, 2007— An analysis of 17,000 Britons has linked specific gene variants to bipolar disorder, high blood pressure, coronary artery disease, Crohn's disease, type 1 and type 2 diabetes, and rheumatoid arthritis.

The treasure-trove of genomic data comes from a consortium of 50 British groups called the Welicome Trust Case Control Consortium, or WTCCC.

"The field of human genetics has hoped for a decade or more to discover these genetic variants and how they interact and affect risk of disease," WTCCC Chairman Peter Donnelly, PhD, of the University of Oxford, said at a news conference.

The study already has yielded important new insights into the root causes of these seven common diseases.

The most important of these insights is that having a gene variant linked to disease doesn't mean you are fated to get that disease. It only means you're at higher risk of the disease — or at lower risk, as some of the genes are linked to protection against disease.

"These are risk factors, rather than genetics predicting who will get a disease," Donnelly said. "There is a large other part of the story: people's diets, and lifestyles, and so on."

The study analyzed the genomes of about 2,000 patients with each disease and compared their genetic codes to a shared group of about 3,000 healthy individuals. For each individual in the study, researchers analyzed 500,000 areas of their genomes.

"If you think of the human genome as a very long road where you are trying to find something in the dark, previously we were able to turn the lights on only in a very few places," Donnelly said. "It turns out that by turning on half a million lights along the genome, as we have done, you get to see a very large proportion of the variation that is there."

The Genetics of Common Diseases

Why look for genes linked to common diseases? The main reason is that very little is known about what causes these diseases.

"Genetics gives us a completely new way of looking at the problem," Donnelly said. "If we can understand the genetic basis of the disease, it gives us insight into what goes wrong and what triggers the disease. And then we can move on to develop new treatments and, potentially, new drug therapies."

If the diseases are common, so are the genes that affect them. Nearly everybody — at least everybody in Britain — carries one or more of the genes identified in the study.

"This is very different from rare mutations that always cause disease; the genes we have discovered are very common. All of us have them; all of us have more or less susceptibility to diabetes, for example," University of Cambridge researcher John A. Todd, PhD, said at the news conference. "This means we can study healthy people who haven't developed diabetes yet, and see what factors alter those characteristics.

"That is what is exciting about common genes," Todd added. "These genes are completely dominated by environmental effects. Now we can actually work out what environmental factors are altering the common genetic characteristics."

New Insights: Type 1 Diabetes

Todd's subgroup looked for genes linked to type 1 diabetes.

Continued on page 9 (**Gene Study**)

ANTIDEPRESSANTS *(Continued from page 7)*

Adolescents responded better than children to treatment for depression and anxiety, the researchers found. They also found that only Prozac worked better than dummy pills in depressed children younger than 12.

In the studies involving depression, 61 percent of patients improved while on antidepressants. But 50 percent of depressed patients taking dummy pills also improved. Among young patients with obsessive-compulsive disorders, 52 percent improved on dummy pills.

And in the studies of anxiety disorders, 69 percent improved on antidepressants and 39 percent improved on dummy pills.

Effectiveness of the drugs was measured in the studies using widely accepted rating scales. The analysis appears in today's Journal of the American Medical Association.

Visalia Times-Delta, Wednesday, April 18,2007

Source: NAMI Tulare County
May 2007

Clip and Keep!

Educational Resources

American Psychiatric Association
202 / 682-6220 • www.psych.org
American Psychological Association
800 / 374-2721 • www.apa.org
Advocacy Center
800 / 342-0823 • www.advocacycenter.com
Child & Adolescent Bipolar Foundation
847 / 256-8525 • www.bpkids.org
DBSA-California
(909) 780-3366
National Alliance for the Mentally Ill (NAMI)
800/ 950-6264 • www.nami.org
National Association for the Dually Diagnosed
800/ 331-5362
National Depression and Bipolar Support Alliance
800 / 826-3632 • DBSAlliance.org
National Family Caregivers Association
301 / 942-6430
National Foundation for Depressive Illnesses
800 / 248-4344
National Institute of Mental Health
800 / 421-4211 • www.nimh.nih.gov
Panic Disorder Line:
800 / 64PANIC
800 / 647-2642
Anxiety Disorder Line:
888 / 826-9438
National Mental Health Association
800 / 989-6642 • www.nmha.org
Confidential depression screening:
wwww.depression-screening.org

GENE STUDY *(Cont'd from pg 8)*

Genes linked to this disease, they found, affect immune regulation.The message is that type 1 diabetes is a disease of the immune system where there is innate destruction by the cells of your own immune system of the cells that make insulin.

"Type 1 diabetes is a dysregulation of the immune system," Todd said. "These new genes, and the genes that we have known before, begin to give usa due as to what has gone wrong. Our task in the next 10 to 15 years is to understand that and to turn the immune system away from this and toward healthy function."

New Insights: Crohn's Disease

University of Cambridge researcher Miles Parkes, FRCP, led the group that studied the genomics of Crohn's disease.

Crohn's disease is a type of inflammatory bowel disease.

A major puzzle in Crohn's disease has been whether the condition is caused by infection with unusual bacteria or simply by an abnormal immune response to the bacteria that normally live peacefully inside our intestines.

"The completely unexpected finding is that Crohn's disease is associated with a gene that affects how the body deals with bacteria that have got inside human cells," Parkes said at the news conference. "Prior to these genetic analyses, we had no idea this would be important.

"We are already aware of treatments that affect this pathway," Parkes added. "We can now begin to study these drugs in relation to Crohns disease."

More Genetic Insights to Come

Exciting as they are, the current crop of findings are only the first harvest from a rich field.

"I think we are just scratching the surface," Donnelly said. 'We expect over the next couple of years for the number of genes identified to grow substantially. What will happen, as these studies are extended, is our understanding of common diseases will change enormously over the next couple of years."

The findings appear in papers published in the June 7 issue of Nature and in the advance online edition of Nature Genetics.

SOURCES: Donnelly, P. Nature, June 7, 2007; vol 447: pp 661-678. Bowcock, A.M. Nature, June 7, 2007; vol 447: pp 645-646. Parkes, M. Nature Genetics, published online June 6, 2007. Todd, JA Nature Genetics, published online June 6, 2007. News conference, June 6, 2007, with Peter Donnelly, PhD, of the University of Oxford, England; Miles Parkes, FRCP, University of Cambridge, England; and John A. Todd, PhD, University of Cambridge, England.

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Centers for Medicare and Medicaid (CMS) Services Denies VNS Coverage

CMS has determined that there is sufficient evidence to conclude that vagus nerve stimulation (vns) is not reasonable and necessary for treatment of resistant depression. Accordingly, we are issuing the following national coverage determination: Vagus nerve stimulation is not coavered for treatment resistant depression.

Source: http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=195

Medi-Cal Mental Health Ombudsman's Office
1-800-896-4042
Help with Medi-Cal mental health services.

Health Rights Hotline
1-888-354-4474 TDD 916-551-2180
Local calls 916-551-2100 Fax 916-551-2158
http://www/hrh.org
Tells consumers in El Dorado, Placer, Sacramento and Yolo counties about their health care rights, and answers questions about health care coverage and managed care. HRH also has advocacy materials and referrals to other resources. HRH can help with HMOs, PPOs, Medicare, Medi-Cal, and CHAMPUS.

ADA Home Page — USDOJ
800-514-0301 800-514-0383 (TDD)
http://www.usdoj.gov/ crt/ada/adahom1.htm
ADA technical assistance, information line, enforcement, settlement information, regulations, mediation, and more.

The Seventeenth Annual Conference
Of the Depression and Bipolar Support Alliance
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Friday, October 12 and Saturday, October 13, 2007
Ontario Airport Marriott Hotel
Ontario, California

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Author of the Book
"Surviving Bipolar's Fatal Grip"

Tom Wootton
Author of the Books
"The Bipolar Advantage" and
"The Depression Advantage"
(New Book)

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Conference Speaker

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This special room rate will expire on 9/22/07

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Early Bird Registration = $99**
1 day only = $70

Registration does not cover the cost of hotel rooms. Registrants are responsible for making hotel reservations

Some meals will be included

Scholarships will be available

**** Early Bird Registration Deadline is 9/10/07**

There will be workshops on various topics, a talent show and dance, art exhibit, etc.

Ontario Airport Marriott Hotel
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Ontario, California 91761
For Hotel Information and Reservations:
Call: 1-800-284-8811

The Hotel Provides Free Shuttle Services
To and From Ontario International Airport

DBSA–California
16280 Whispering Spur
Riverside, CA 92504