

Subject: Studies in the News: (April 15, 2009)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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NEW CONVENTIONS

CHILDREN AND ADOLESCENT MENTAL HEALTH

“Quality of Life in Pediatric Bipolar Disorder.” By Andrew J. Freeman, University of North Carolina, Chapel Hill, and others. IN: *Pediatrics*, vol. 123 (March 2009) pp. e446-e452.

[“Bipolar disorder is a common mood disorder associated with significant disability and impairment in quality of life in adults. Little research has examined the impact of the disorder on quality of life in children and adolescents. The current study examines the quality of life in children and adolescents with bipolar disorder compared with other physical and psychiatric illnesses....

Youths with bipolar disorder reported lower quality of life than other youths encountered in pediatric practice. Pediatricians should attend not only to the child’s mood symptoms but also to the overall impairment of the disorder.”]

Full text at:

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“Screening for Child and Adolescent Depression in Primary Care Settings: A Systematic Evidence Review.” By Selvi B. Williams and others, Centers for Disease Control and Prevention. IN: *Pediatrics*, vol. 123 (March 2009) pp. e716-735.

[“Depression among youth is a disabling condition that is associated with serious long-term morbidities and suicide.

Objective: To assess the health effects of routine primary care screening for major depressive disorder among children and adolescents aged 7 to 18 years....

Results: We found no data describing health outcomes among screened and unscreened populations. Although the literature on diagnostic screening test accuracy is small and methodologically limited, it indicates that several screening instruments have performed fairly well among adolescents. The literature on treatment efficacy of selective serotonin reuptake inhibitors and/or psychotherapy is also small but includes good-quality randomized, controlled trials. Available data indicate that selective serotonin reuptake inhibitors, psychotherapy, and combined treatment are effective in increasing response rates and reducing depressive symptoms. Not all specific selective serotonin reuptake inhibitors, however, seem to be efficacious. Selective serotonin reuptake inhibitor treatment was associated with a small absolute increase in risk of suicidality (i.e., suicidal ideation, preparatory acts, or attempts). No suicide deaths occurred in any of the trials.

Conclusions: Limited available data suggest that primary care-feasible screening tools may accurately identify depressed adolescents and treatment can improve depression outcomes. Treating depressed youth with selective serotonin reuptake inhibitors may be associated with a small increased risk of suicidality and should only be considered if judicious clinical monitoring is possible.”]

Full text at: <http://www.ahrq.gov/clinic/uspstf09/depression/chdeprart.htm#abstract>

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Strengthening Children and Families. By the Administration of Children and Families. (The Administration, Washington, D.C.) 2009. 87 p.

[“This Resource Guide was written to support service providers in their work with parents, caregivers, and their children to strengthen families and prevent child abuse and neglect. The guide includes information about protective factors that help reduce the risk of child maltreatment, strategies for changing how communities support families, and evidence-informed practices. It also offers suggestions for enhancing protective factors in families, tools to build awareness and develop community partnerships, information about child abuse and neglect, a directory of national organizations that work to strengthen families, and tip sheets in English and Spanish on specific parenting topics.”]

Full text at:

http://www.childwelfare.gov/pubs/res_guide_2009/

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DEPRESSION AND SUBSTANCE USE DISORDERS

“Integrated Psychological Treatment for Substance Use and Co-Morbid Anxiety or Depression vs. Treatment for Substance Use Alone. A Systematic Review of the Published Literature.” By Morton Hesse, University of Aarhus, Denmark. IN: *BMC Psychiatry*, vol. 9, no. 6 (February 20, 2009) pp. 1-8.

[“There is an increasing consensus in favour of integrated treatment of substance use disorders and co-morbid conditions, such as depression or anxiety. However, up till now no systematic reviews have been published. Based on a systematic search of MedLine and PsychInfo, trials of integrated treatment for depression or anxiety plus substance use disorder were identified. Where possible, metaanalyses were carried out, using random effects models....

Psychotherapeutic treatment for co-morbid depression and substance use disorders is a promising approach, but is not sufficiently empirically supported at this point. Psychotherapeutic treatment for co-morbid anxiety and substance use disorders is not empirically supported. There is a need for more trials to replicate the findings from studies of integrated treatment for depression and substance use disorders, and for the development of new treatment options for co-morbid anxiety and substance use disorders.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-9-6.pdf>

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EVIDENCE-BASED SCHOOL INTERVENTIONS

“Evidence-Based Interventions in Schools: Developers’ Views of Implementation Barriers and Facilitators.” By Susan G. Forman, Rutgers, the State University of New Jersey, and others. IN: *School Mental Health*, vol. 1 (2009) pp. 26-36.

[“This study examined the factors that are important to successful implementation and sustainability of evidence-based interventions in school settings. Developers of interventions that have been designated as “evidence-based” in multiple vetted lists and registries available to schools participated in a structured interview. The interview focused on potential facilitators and barriers to implementation and sustainability of their

intervention. The interviews were transcribed and coded to identify similarities and differences among the responses as well as themes that cut across participants. Results indicated that those concerned with effective implementation and sustainability need to address several areas: (a) development of principal and other administrator support; (b) development of teacher support; (c) development of financial resources to sustain practice; (d) provision of high-quality training and consultation to ensure fidelity; (e) alignment of the intervention with school philosophy, goals, policies, and programs; (f) ensuring that program outcomes and impact are visible to key stakeholders; and (g) development of methods for addressing turnover in school staff and administrators.”]

Full text at: <http://www.springerlink.com/content/95gg77kl66n42tpx/fulltext.pdf>

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MENTAL HEALTH AND THE WORKPLACE

“Mental Health and the Workplace: Issues for Developing Countries.” By Prem Chopra, University of Melbourne, Australia. IN: International Journal of Mental Health Systems, vol. 3, no. 4 (February 20, 2009) pp. 1-9.

[“The capacity to work productively is a key component of health and emotional well-being. Common Mental Disorders (CMDs) are associated with reduced workplace productivity. It is anticipated that this impact is greatest in developing countries. Furthermore, workplace stress is associated with a significant adverse impact on emotional wellbeing and is linked with an increased risk of CMDs. This review will elaborate on the relationship between workplace environment and psychiatric morbidity. The evidence for mental health promotion and intervention studies will be discussed. A case will be developed to advocate for workplace reform and research to improve mental health in workplaces in developing countries in order to improve the wellbeing of employees and workplace productivity.”]

Full text at:

<http://www.ijmhs.com/content/pdf/1752-4458-3-4.pdf>

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POLICIES AND PROCEDURES

Characteristics of State Mental Health Agency Data Systems. By Theodore C. Lutterman and others, Center for Mental Health Services. (U.S. Department of Health and Human Services, Rockville, Maryland) 2008. 52 p.

[“A new report provides a nationwide overview of the increasingly crucial role information technology (IT) plays in helping the states provide mental health services. The report issued by the Substance Abuse and Mental Health Services Administration

(SAMHSA) also reveals the differences in the size, types, and uses of IT resources among the nation's state mental health agencies.

Public mental health services are primarily provided by the state mental health agencies which increasingly rely upon their IT systems to provide essential functions such as:

- Monitoring the public mental health service system for service gaps
- Ensuring that persons living with a mental illness receive timely, appropriate, and needed services
- Reimbursing mental health providers for services provided
- Building accountability performance targets and outcome measures.”]

Full text at:

http://download.ncadi.samhsa.gov/ken/pdf/URS_Data07/CMHS_State_MH_DataSystem_s.pdf

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PSYCHIATRIC EMERGENCY SERVICES

“Is psychiatric emergency service (PES) use increasing over time?” By Michel Paradis, University of Montreal, and others. IN: International Journal of Mental Health Systems, vol. 3, no. 3 (February 3, 2009) pp. 1-5.

[“Several recent studies have reported a significant increase in medical emergency department (ED) use for reasons of mental health. The diagnostic profile of these patients however differs from that usually described for patients visiting the psychiatric emergency service (PES). Few studies have specifically focused upon long-term PES utilization rates. Those that do typically present data from the early 80s, suggesting that deinstitutionalization may be an important contributing factor to the increases found. The aim of this study was to assess PES use using a more recent time frame and, the effects of non-specific factors, such as population growth, on this use....

Long observation periods are required in order to detect stable changes in PES utilization rates over time. As such, population growth may be but one of several factors underlying these increases. Organizational changes in mental health care delivery in the vicinity of the services that showed an increase could also have contributed. These latter would simply have redistributed (to the PES) the pre existing pool of mental health care patients, resulting in an increase that is more apparent than real.”]

Full text at:

<http://www.ijmhs.com/content/pdf/1752-4458-3-3.pdf>

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STIGMA

“Global Mental Health Needs Services, Barriers, and Challenges.” By Abhinav A. Shah and Richard H. Beinecke, Suffolk University, Boston. IN: International Journal of Mental Health, vol. 38, no. 1 (Spring 2009) pp. 14-29.

[“Mental health problems represent 5 of the 10 leading causes of disability in the world and affect as many as 500 million people. The direct and indirect burden of mental health problems is great. Limited resources are devoted to mental health care, and there are many barriers to receiving it. Stigma, human rights violations, war, and migration contribute to the problem. We need to do much more to address this critical issue.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=36961273&site=ehost-live>

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“Perceived Stigma of Poverty and Depression: Examination of Interpersonal and Intrapersonal Mediators.” By Kristin D. Mickelson, Kent State University, and Stacey L. Williams, East Tennessee State University. IN: Journal of Social & Clinical Psychology, vol. 27, no. 9 (November 2008) pp. 903-930.

[“This study examines the perceived stigma of poverty by assessing individuals' negative feelings about being poor (internalized stigma), and their beliefs about whether others treat them as stigmatized (experienced stigma). in a combined sample of low-income women (N = 210), we tested a dual-pathway model to explain how these perceived stigma dimensions are related to depression among the impoverished. We proposed that interpersonal (i.e., impaired support availability and heightened fear of support request rejection) and intrapersonal factors (i.e., impaired self-esteem) differentially mediate the relationship of internalized and experienced poverty stigma with depression. Structural equation modeling partially supported the model: internalized stigma and depression were partially mediated by self-esteem and fear of rejection, while experienced stigma was related to depression through fear of rejection only. in other words, internalized and experienced perceived stigma activate separate and similar mechanisms to influence depression among the poor.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=35752050&site=ehost-live>

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SUICIDE PREVENTION

An Examination of DSM-IV Borderline Personality Disorder Symptoms and Risk for Death by Suicide: A Psychological Autopsy Study. By Alexander McGirr, McGill University, and others. IN: *Canadian Journal of Psychiatry*, vol. 54, no. 2 (February 2009) pp. 87-92

[“To clarify whether certain Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), borderline personality disorder (BPD) symptoms are more prevalent among people who die by suicide, and thereby better predict suicide risk. Method: A psychological autopsy method with best informants was used to investigate DSM-IV BPD symptoms and suicide risk among people who died by suicide and met criteria for BPD (n = 62), and BPD control subjects (n = 35). Results: BPD symptoms in people who died by suicide were less likely to include affective instability and paranoid ideation-dissociative symptoms. The negative association between paranoid ideation-dissociative symptoms and suicide was independent of all other BPD symptoms, Cluster B comorbidity, and alcohol dependence. Conclusions: We found that discrete DSM-IV BPD symptoms differentiate people with BPD who die by suicide and those who do not. People with BPD who go on to die by suicide appear to constitute a specific subgroup of those who meet criteria for BPD, characterized by different general clinical presentation, but also by different characteristics within BPD.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=36850660&site=ehost-live>

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“Discrepant Comorbidity between Minority and White Suicides: A National Multiple Cause-of-Death Analysis.” By Ian RH Rockett, West Virginia University, and others. IN: *BMC Psychiatry*, vol. 9, no. 10 (March 18, 2009) pp. 1-36.

[“Clinician training deficits and a low and declining autopsy rate adversely impact the quality of death certificates in the United States. Self-report and records data for the general population indicate that proximate mental and physical health of minority suicides was at least as poor as that of white suicides....

The multivariate analyses indicate high consistency in predicting suicide-associated comorbidities across racial-ethnic groups using MCODE data. However, low prevalence of documented comorbid psychopathology in suicides, and concomitant racial-ethnic discrepancies underscore the need for training in death certification, and routinization and standardization of timely psychological autopsies in all cases of suicide, suspected suicide, and other traumatic deaths of equivocal cause.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-9-10.pdf>

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Media Portrayals of Suicide. By the PLoS Medicine Editors. IN: PLoS Medicine, vol. 6, no. 3 (March 2009) pp. 0233-0234

[“In a cohort study in this month’s *PLoS Medicine*, Nav Kapur (University of Manchester, United Kingdom) and colleagues report that young men (24 years and under) who had left the UK Armed Forces were at higher risk of suicide than either young men in the general population or those still in active service. The risk appeared to be greatest in the first two years after discharge, in those with a short length of service, and in those of lower rank. There was a low rate of contact with mental health specialists in the year before death—just 14% for those under 20 years and 20% for those under 24 years. This study has identified a vulnerable group and highlights the need for targeted intervention to save lives.

What kind of interventions might work? In an expert commentary on the new study, Jitender Sareen and Shay-Lee Belik (University of Manitoba, Canada) highlight one example of a program that was specifically targeted at an at-risk military population, and also consider more general public health approaches to suicide prevention. The success story is a multilayered program initiated by the US Air Force in 1996 (<http://afspp.afms.mil/>), which includes educating personnel about suicide prevention, helping them to deal with their emotional reactions to traumatic incidents, and providing guidelines for commanders on how and when to use mental health services.”]

Full text at:

http://medicine.plosjournals.org/archive/1549-1676/6/3/pdf/10.1371_journal.pmed.1000051-L.pdf

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NEWCONVENTIONS

California’s Ninth Annual National Information Management Conference and Exposition: Addressing the Needs of Mental Health, Alcohol, and other Drug Programs.

April 22-23, 2009 – Garden Grove, California.

Program and registration information:

http://elearning.networkofcare.org/cimh/content/IM0809_ConfProgram_v2.20.09web.pdf

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