

Subject: Studies in the News: (June 24, 2009)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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CHILDREN AND ADOLESCENTS

Adolescent Mental Health in the United States. By Susan Wile Schwarz, National Center for Children in Poverty. Facts for Policymakers. (The Center, New York, New York) June 2009. 4 p.

[“Adolescence is a critical period for mental, social, and emotional wellbeing and development. During adolescence, the brain undergoes significant developmental changes, establishing neural pathways and behavior patterns that will last into adulthood. Because their brains are still developing, adolescents are particularly receptive to the positive influences of youth development strategies, social and emotional learning, and behavioral modeling. But adolescents’ developing brains, coupled with hormonal changes, make them more prone to depression and more likely to engage in risky and thrill-seeking behaviors than either younger children or adults. These and other factors underline the importance of meeting the mental, social, and emotional health needs of this age group.

Mental health and social and emotional wellbeing – combined with sexual and reproductive health, violence and unintentional injury, substance use, and nutrition and obesity – form part of a complex web of potential challenges to adolescents’ healthy emotional and physical development.”]

Full text at: http://www.nccp.org/publications/pdf/text_878.pdf

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“Perceived Barriers to Treatment for Adolescent Depression.” By Lisa S. Meredith and others. IN: *Medical Care*, vol. 47, no. 6 (June 2009) pp. 677-685.

[“*Background and Objective:* Adolescent depression is common, disabling, and is associated with academic, social, behavioral, and health consequences. Despite the availability of evidence-based depression care, few teens receive it, even when recognized by primary care clinicians. Perceived barriers such as teen worry about what others think or parent concerns about cost and access to care may contribute to low rates of care. We sought to better understand perceived barriers and their impact on service use.

Design: After completing an eligibility and diagnostic telephone interview, all depressed teens and a matched sample of non-depressed teens recruited from 7 primary care practices were enrolled and completed telephone interviews at baseline and 6 months (August 2005-September 2006).

Participants: Three hundred sixty-eight adolescent patients aged 13 to 17 (184 depressed and 184 non-depressed) and 338 of their parents.

Measures: Perceived barriers to depression care and use of services for depression (psychotherapy and antidepressant medication).

Results: Teens with depression were significantly more likely to perceive barriers to care compared with non-depressed teens. Parents were less likely to report barriers than their teens; perceived stigma and concern about family member response were among the significant teen barriers. Teen perceived barriers scores were negatively associated with

any use of antidepressants ($P < 0.01$), use of antidepressants for at least 1 month ($P < 0.001$), and any psychotherapy or antidepressant use ($P < 0.05$) at 6 months.

Conclusions: To improve treatment for adolescent depression, interventions should address both teen and parent perceived barriers and primary care clinicians should elicit information from both adolescents and their parents.”]

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“Prevention of Depression in At-risk Adolescents.” By Judy Garber, Vanderbilt University, and others. IN: Journal of the American Medical Association, vol. 301, no. 21 (2009) pp. 2215-2224.

[“*Context:* Adolescent offspring of depressed parents are at markedly increased risk of developing depressive disorders. Although some smaller targeted prevention trials have found that depression risk can be reduced, these results have yet to be replicated and extended to large-scale, at-risk populations in different settings.

Objective: To determine the effects of a group cognitive behavioral (CB) prevention program compared with usual care in preventing the onset of depression.

Design, Setting, and Participants: A multicenter randomized controlled trial conducted in 4 US cities in which 316 adolescent (aged 13-17 years) offspring of parents with current or prior depressive disorders were recruited from August 2003 through February 2006. Adolescents had a past history of depression, current elevated but sub-diagnostic depressive symptoms, or both. Assessments were conducted at baseline, after the 8-week intervention, and after the 6-month continuation phase.

Intervention: Adolescents were randomly assigned to the CB prevention program consisting of 8 weekly, 90-minute group sessions followed by 6 monthly continuation sessions or assigned to receive usual care alone.

Main Outcome Measure: Rate and hazard ratio (HR) of a probable or definite depressive episode (ie, depressive symptom rating score of ≥ 4) for at least 2 weeks as diagnosed by clinical interviewers.

Results: Through the post-continuation session follow-up, the rate and HR of incident depressive episodes were lower for those in the CB prevention program than for those in usual care (21.4% vs 32.7%; HR, 0.63; 95% confidence interval [CI], 0.40-0.98).

Adolescents in the CB prevention program also showed significantly greater improvement in self-reported depressive symptoms than those in usual care (coefficient, -1.1 ; $z = -2.2$; $P = .03$). Current parental depression at baseline moderated intervention effects (HR, 5.98; 95% CI, 2.29-15.58; $P = .001$). Among adolescents whose parents were not depressed at baseline, the CB prevention program was more effective in preventing onset of depression than usual care (11.7% vs 40.5%; HR, 0.24; 95% CI, 0.11-0.50), whereas for adolescents with a currently depressed parent, the CB prevention program was not more effective than usual care in preventing incident depression (31.2% vs 24.3%; HR, 1.43; 95% CI, 0.76-2.67).

Conclusion: The CB prevention program had a significant prevention effect through the 9-month follow-up period based on both clinical diagnoses and self-reported depressive

symptoms, but this effect was not evident for adolescents with a currently depressed parent.”]

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Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities. By Mary Ellen O’Connell and others, Committee on the Prevention of Mental Disorders and Substance Abuse among Children, Youth and Young Adults. Report Brief for Policymakers. (The National Academies Press, Washington DC) March 2009. 4 p.

[“Mental health and substance use disorders among children, youth, and young adults are major threats to the health and well-being of younger populations which often carryover into adulthood. The costs of treatment for mental health and addictive disorders, which create an enormous burden on the affected individuals, their families, and society, have stimulated increasing interest in prevention practices that can impede the onset or reduce the severity of the disorders.

Prevention practices have emerged in a variety of settings, including programs for selected at-risk populations (such as children and youth in the child welfare system), school-based interventions, interventions in primary care settings, and community services designed to address a broad array of mental health needs and populations. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* updates a 1994 Institute of Medicine book, *Reducing Risks for Mental Disorders*, focusing special attention on the research base and program experience with younger populations that have emerged since that time.

Researchers, such as those involved in prevention science, mental health, education, substance abuse, juvenile justice, health, child and youth development, as well as policy makers involved in state and local mental health, substance abuse, welfare, education, and justice will depend on this updated information on the status of research and suggested directions for the field of mental health and prevention of disorders.”]

Full text of policy brief is at: http://www.bocyf.org/prevention_policymakers_brief.pdf
The 576 page book will be ordered and added to the CDMH collection.

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CRIMINAL JUSTICE SYSTEM

From Corrections to Community: The Juvenile Reentry Experience as Characterized by Multiple Systems Involvement. By Gretchen Ruth Cusick and others, Chapin Hall at the University of Chicago. (The University, Chicago, Illinois) 2009. 88 p.

[“This report describes findings on the extent of system involvement among Illinois youth released from correctional facilities, tracking a population of youth under age 18 in Illinois following their release. Using administrative records, researchers develop profiles

of reentry experiences across the many systems that serve youth and their families. Researchers examined their involvement with school, public assistance, foster care, and government-assisted services for health, mental health, and substance abuse needs. Because involvement in multiple services as part of the reentry experience is likely to impact the chances of reoffending, this body of information will be valuable to policymakers and practitioners.”]

Full text at: http://www.njjn.org/media/resources/public/resource_1185.pdf

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“Prevalence of Serious Mental Illness among Jail Inmates.” By Henry J. Steadman, Policy Research Associates, Delmar, New York, and others. IN: *Psychiatric Services*, vol. 60, no. 6 (June 2009) pp. 761-765.

[“A new study of more than 20,000 men and women entering jail offers the most accurate accounting in more than two decades of the number of adults with serious mental illnesses in these facilities.

Using screening instruments to identify individuals entering jails with the most serious mental illnesses and the greatest need for comprehensive and continuous treatment, a team of researchers from the nonpartisan Council of State Governments Justice Center and Policy Research Associates found that 14.5 percent of males and 31 percent of females - or 16.9 percent overall - met that criteria. The percentage of women with serious mental illnesses in jail is double that of men - a particularly troubling finding given the overall growth in the female jail population and the lack of research on the reasons for this overrepresentation.

These estimates are three to six times higher than the general population, and indicate that as many as 2 million bookings of people with serious mental illnesses may occur each year. The findings, published today in the journal *Psychiatric Services*, underscore the challenges faced by jail administrators to address the needs of individuals with mental illnesses in the face of budget cuts and extremely limited resources.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/6/761>

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DEPRESSION

Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Edited By Mary Jane England and Leslie J. Sim, Committee on Depression, Parenting Practices, and the Healthy Development of Children, National Research Council, Institute of Medicine. (National Academies Press, Washington, DC) 2009. 25 p. summary.

[“Depression is a widespread condition affecting approximately 7.5 million parents in the U.S. each year and may be putting at least 15 million children at risk for adverse health outcomes. Based on evidentiary studies, major depression in either parent can interfere with parenting quality and increase the risk of children developing mental, behavioral and social problems. *Depression in Parents, Parenting, and Children* highlights disparities in

the prevalence, identification, treatment, and prevention of parental depression among different socio-demographic populations. It also outlines strategies for effective intervention and identifies the need for a more interdisciplinary approach that takes biological, psychological, behavioral, interpersonal, and social contexts into consideration.

A major challenge to the effective management of parental depression is developing a treatment and prevention strategy that can be introduced within a two-generation framework, conducive for parents and their children. Thus far, both the federal and state response to the problem has been fragmented, poorly funded, and lacking proper oversight. This study examines options for widespread implementation of best practices as well as strategies that can be effective in diverse service settings for diverse populations of children and their families.

The delivery of adequate screening and successful detection and treatment of a depressive illness and prevention of its effects on parenting and the health of children is a formidable challenge to modern health care systems. This study offers seven solid recommendations designed to increase awareness about and remove barriers to care for both the depressed adult and prevention of effects in the child. The report will be of particular interest to federal health officers, mental and behavioral health providers in diverse parts of health care delivery systems, health policy staff, state legislators, and the general public.”]

Full text and summary at: http://www.nap.edu/catalog.php?record_id=12565#toc

The 382-page book will be ordered and added to the CDMH collection

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MENTAL HEALTH CRISIS RESPONSE

“A Mental Health First Aid Training Program for Australian Aboriginal and Torres Strait Islander Peoples: Description and Initial Evaluation.” By Len G. Kanowski and others. IN: *International Journal of Mental Health Systems*, vol. 3, no. 10 (June 3, 2009) 22 p.

[“*Background:* Mental Health First Aid (MHFA) training was developed in Australia to teach members of the public how to give initial help to someone developing a mental health problem or in a mental health crisis situation. However, this type of training requires adaptation for specific cultural groups in the community. This paper describes the adaptation of the program to create an Australian Aboriginal and Torres Strait Islander Mental Health First Aid (AMHFA) course and presents an initial evaluation of its uptake and acceptability.

Methods: To evaluate the program, two types of data were collected: (1) quantitative data on uptake of the course (number of Instructors trained and courses subsequently run by these Instructors); (2) qualitative data on strengths, weaknesses and recommendations for the future derived from interviews with program staff and focus groups with Instructors and community participants.

Results: 199 Aboriginal people were trained as Instructors in a five day Instructor Training Course. With sufficient time following training, the majority of these Instructors subsequently ran 14-hour AMHFA courses for Aboriginal people in their community.

Instructors were more likely to run courses if they had prior teaching experience and if there was post-course contact with one of the Trainers of Instructors. Analysis of qualitative data indicated that the Instructor Training Course and the AMHFA course are culturally appropriate, empowering for Aboriginal people, and provided information that was seen as highly relevant and important in assisting Aboriginal people with a mental illness. There were a number of recommendations for improvements.”]

Full text at: <http://www.ijmhs.com/content/3/1/10>

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MILITARY

“Military Deployment: the Impact on Children and Family Adjustment and the Need for Care.” By Alexander C. McFarlane. IN: **Current Opinion in Psychiatry**, vol. 22, no. 4 (July 2009) pp. 369-373.

[“Purpose of Review: Over a million children and their families have now experienced the stress of the deployment of a family member during the recent wars in Iraq and Afghanistan. Whereas there is an extensive clinical literature about the developmental challenges facing children and issues of family adjustment, there is a lack of systematic research. This review summarizes the findings of recent publications.

Recent findings: Some veterans develop posttraumatic stress disorder as a consequence of their experiences. This condition drives many of the adverse changes in the families of returning veterans through the effects on intimacy and nurturance in their families of withdrawal, numbing and irritability that are components of posttraumatic stress disorder. There is the more general challenge that all families and children face when a partner/parent deploys of role ambiguity consequent on anxiety that is provoked by the threat that deployed family members experience. A study of Kuwaiti military showed that mothers' anxiety had the greatest impact on the children of deployed fathers, although absence of posttraumatic stress disorder in mothers could mitigate the effects of their fathers' posttraumatic stress disorder. Intervention programs are described, but there is a poverty of their evaluation.

Summary: A substantial advantage of focusing on family adjustment is that it can facilitate access to mental healthcare for veterans while assisting families' positive adaptation.’]

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NEGLECT AND ABUSE

Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers. By the U.S. Government Accountability Office. **Testimony before the Committee on Education and Labor, House of Representatives.** GAO-09-719T. (The Office, Washington DC) May 19, 2009. 62 p.

[“GAO found no federal laws restricting the use of seclusion and restraints in public and private schools and widely divergent laws at the state level. Although GAO could not determine whether allegations were widespread, GAO did find hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades. Examples of these cases include a 7 year old purportedly dying after being held face down for hours by school staff, 5 year olds allegedly being tied to chairs with bungee cords and duct tape by their teacher and suffering broken arms and bloody noses, and a 13 year old reportedly hanging himself in a seclusion room after prolonged confinement. Although GAO continues to receive new allegations from parents and advocacy groups, GAO could not find a single website, federal agency, or other entity that collects information on the use of these methods or the extent of their alleged abuse. GAO also examined the details of 10 restraint and seclusion cases in which there was a criminal conviction, a finding of civil or administrative liability, or a large financial settlement. The cases share the following common themes: they involved children with disabilities who were restrained and secluded, often in cases where they were not physically aggressive and their parents did not give consent; restraints that block air to the lungs can be deadly; teachers and staff in the cases were often not trained on the use of seclusions and restraints; and teachers and staff from at least 5 of the 10 cases continue to be employed as educators.”]

Full text at: <http://www.gao.gov/new.items/d09719t.pdf>

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RURAL MENTAL HEALTH

Mental Health: Overlooked and Disregarded in Rural America. By Dianne Travers Gustafson and others, Center for Rural Affairs. (The Center, Lyons, Nebraska) May 2009. 5 p.

[“Though nationally progress is being made, many issues remain before we meet the mental health needs of rural residents. Workforce shortages, confidentiality and cost are the most significant barriers. Programs like the Rural Response Hotline in Nebraska, offering vouchers for mental health services, have helped to meet the needs of rural residents. But such programs rely on adequate numbers of trained mental health care providers, who simply do not exist in many parts of rural America. Appropriate training for primary care providers may be the first step towards ensuring that rural residents have access to mental health services. The next step is reaching true parity in mental health coverage—all individuals should have insurance coverage for mental health services regardless of where they work or live. One way to achieve this is through health care reform that includes a public health insurance option. With such a choice, small business owners like farmers and ranchers and their employees can have access to the same mental health coverage that currently only larger groups enjoy. For health care reform that benefits rural America along with the rest of the nation, equal access to and coverage for mental health services must be part of the design.”]

Full text at: <http://www.cfra.org/>

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SUICIDE PREVENTION

“Characteristics of Suicide Attempters with Family History of Suicide Attempt: A Retrospective Chart Review.” By Makiko Nakagawa, Department of Psychiatry, Yokohama City University School of Medicine, Yokohama, Japan, and others. IN: *BMC Psychiatry*, vol. 9, no. 32 (June 5, 2009) 20 p.

[“*Background:* Family history of suicide attempt is one of the risks of suicide. We aimed at exploring the characteristics of Japanese suicide attempters with and without a family history of suicide attempt. *Methods:* Suicide attempters admitted to an urban emergency department from 2003 to 2008 were interviewed by two attending psychiatrists on items concerning family history of suicide attempt and other socio-demographic and clinical information. Subjects were divided into two groups based on the presence or absence of a family history of suicide attempt, and differences between the two groups were subsequently analyzed.

Results: Out of the 469 suicide attempters, 70 (14.9%) had a family history of suicide attempt. A significantly higher rate of suicide motive connected with family relations (odds ratio 2.21, confidence interval 1.18-4.17, $p < .05$) as well as a significantly higher rate of deliberate self-harm (odds ratio 2.51, confidence interval 1.38-4.57, $p < .05$) were observed in patients with a family history of suicide compared to those without such history. No significant differences were observed in other items investigated.

Conclusions: The present study has revealed the characteristics of suicide attempters with a family history of suicide attempt. Further understanding of the situation of such individuals is expected to lead to better treatment provision and outcomes, and family function might be a suitable focus in their treatment.”]

Full text at: <http://www.biomedcentral.com/1471-244X/9/32/abstract>

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The Role of Faith Communities in Preventing Suicide: A Report of an Interfaith Suicide Prevention Dialogue. By Suicide Prevention Resource Center, (Education Development Center, Newton, Massachusetts) 2009. 62 p.

[“*The following statement was developed at an Interfaith Suicide Prevention Dialogue held March 12-13, 2008 in Rockville, Maryland... The participants included representatives from the Buddhist, Christian, Hindu, Jewish, and Muslim faith communities.*

Life is a sacred gift, and suicide is a desperate act by one who views life as intolerable. Such self-destruction is never condoned, but faith communities increasingly support, rather than condemn, the *person* who contemplates or engages in suicidal behavior. They acknowledge that mental and substance use disorders, along with myriad life stressors, contribute significantly to the risk of suicide. And they reach out compassionately to the person who attempts suicide and to families and friends who have been touched by a suicide or suicide attempt. This increasingly charitable understanding finds agreement

between the historic precepts of faith and a contemporary understanding of illness and health. It renders no longer appropriate the practice of harshly judging those who have attempted or died by suicide. Life is a complex journey viewed through different lenses by different faith groups. But the varied eyes of all our traditions increasingly see the great potential of people of faith to prevent the tragedy of suicide. Spiritual leaders and faith communities - and now the research community - know that practices of faith and spirituality can promote healthy living and provide pathways through human suffering, be it mental, emotional, spiritual, or physical. Faith communities can work to prevent suicide simply by enhancing many of the activities that are already central to their very nature. They already foster cultures and norms that are life-preserving. By providing perspective and social support to their members and the broader community, they compassionately help people navigate the great struggles of life and find a sustainable sense of hope, meaning, purpose, and even joy in life. The time is right for the life-enhancing strengths that are the foundations of our most ancient faith traditions to find application in preventing suffering and loss from suicide. Suicide prevention will take a quantum leap forward as members of faith communities gain understanding and the necessary, culturally competent skills to minister to people and communities at heightened risk for suicide and to support the healing of those who have either struggled with suicide themselves or survived the suicide of someone they love.”]

Full text at: http://www.sprc.org/library/faith_dialogue.pdf

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TRAUMATIC BRAIN INJURY

**“Depression and Cognitive Complaints Following Mild Traumatic Brain Injury.”
By Jonathan M. Silver and others. IN: American Journal of Psychiatry, vol. 166, no. 6 (June 2009) pp. 653-661.**

[“Traumatic brain injury (TBI) is a common occurrence with multiple possible neuropsychiatric sequelae, including problems with cognition, emotion, and behavior. While many individuals experience significant improvement over the first months following mild TBI, a nontrivial minority will develop persistent, functionally impairing post-TBI symptoms. Depression and cognitive impairment are among the most common such symptoms, and they may respond to a combination of rehabilitative and pharmacologic treatments. This article discusses the clinical approach to treating an individual with depression and cognitive complaints following mild TBI. Recommendations regarding the diagnosis, evaluation, and treatment of these problems are offered.”]

Full text at: <http://ajp.psychiatryonline.org/cgi/reprint/166/6/653>

Enhancing the Traumatic Brain Injury System of Care: Florida’s 5-Year Strategic Plan, 2009-2010 – 2013-2014. By the Florida Department of Health - Brain Spinal Cord Injury Program, Brain Injury Association of Florida, and the WellFlorida Council. (The Council, Gainesville, Florida) 2009. 24 p.

[“*Issue 1: Statewide System for Information, Referral, Planning and Advocacy.* A widely recognized and known statewide system for information, referral, planning and advocacy is needed for the creation, dissemination and linkage of resources, programs, and education.

Issue 2: Traumatic Brain Injury Awareness.

Effective and uniform messages for traumatic brain injury are needed to increase awareness and promote advocacy.

Issue 3: Traumatic Brain Injury Provider and Professional Education.

Providers and professionals in the healthcare and support spectrum need education, including competency-based standards and training.

Issue 4: Lifelong/ Long-Term System of Care

A comprehensive lifelong/long-term system of care and supporting infrastructure that supports transitions through life stages is needed for persons with traumatic brain injury.”]

Full text at: http://www.biaf.org/documents/TBIStrategicPlan09_final.pdf

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“Neurocognitive Outcomes and Recovery after Pediatric TBI: Meta-analytic Review of the Literature.” By Talin Babikian and Robert Asarnow, University of California at Los Angeles. IN: Neuropsychology, vol. 23, no. 3 (May 2009) pp. 283-296.

[“Traumatic Brain Injury (TBI) is the single most common cause of death and disability in children and adolescents, according to the Centers for Disease Control. Now, according to a new study by UCLA researchers, the effects of a blow to the head, whether it's mild or a concussion, can linger for years. The authors analyzed 28 selected articles about TBI that were published between the years 1988 and 2007, quantifying for the first time a summary of all of the available literature on the effects of a traumatic brain injury on the developing brain of a child or adolescent. The key and surprising finding, the authors say, was that over time, children and adolescents with a severe traumatic brain injury appear to fall even farther behind their peers than one would expect, making intervention and monitoring especially important in this group.

‘Because younger children have more development ahead of them, the same injury can affect a four-year-old and a 12-year-old very differently. Further, children who suffer a severe brain injury may show a slower rate of development as a group, highlighting the importance of targeted treatment developed specifically for children with severe TBI. Equally important is the take-home message of prevention. Because younger children with a traumatic brain injury seem to generally do worse than their older counterparts,’ Babikian said, ‘the public health implication of this research is a reminder of the importance of the use of protective measures to minimize the effects of a brain injury, when one does occur, as well as prevention through consistent use of helmets and seatbelts.’ E-Science News]

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“Predicting Longitudinal Patterns of Functional Deficits in Children with Traumatic Brain Injury.” By Tarynn B. Fay and others. IN: Neuropsychology, vol. 23, no. 3 (May 2009) pp. 271-282.

[“Longitudinal patterns of functional deficits were investigated in 37 children with severe traumatic brain injury (TBI), 40 children with moderate TBI, and 44 children with orthopedic injuries. They were from 6 to 12 years of age when injured. Their neuropsychological, behavioral, adaptive and academic functioning was assessed at 6 months, 12 months, and 3–5 years post-injury. Functional deficits (<10th percentile for age) were identified within each outcome domain at each occasion. Children were classified into 4 a priori longitudinal patterns of outcomes within domains (i.e., no deficits, improvement, deterioration, persistent deficits). In multinomial logistic regression analyses, severe TBI predicted an increased likelihood of persistent deficits in all outcome domains, as well as deterioration in behavioral functioning and improvement in neuropsychological, adaptive, and academic functioning. Severe TBI also predicted a greater total number of functional deficits across domains at each occasion. However, many children with severe TBI showed no deficits from 6 months to 4 years post-injury in 1 or more outcome domains. The findings help clarify the course of recovery for individual children following TBI.”]

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NEW CONVENTIONS

Depression and Bipolar Support Alliance: 2009 National Conference.

September 10-13, 2009
Indianapolis, Indiana

For more information and registration:

http://www.dbsalliance.org/site/PageServer?pagename=events_conference2009

California Reach Us 2009 Conference: Reaching Ahead, Reaching for Change: Redefining the Health Landscape for 2010 and Beyond

September 23-24, 2009
Long Beach, California

For more information and registration: <http://www.chc-inc.org/userimages/REACH%20US%20Registration.pdf>

American Academy of Addiction Psychiatry's (AAAP) 20th Annual Meeting and Symposium

December 3-6, 2009
Los Angeles, California

For more information and registration:
<http://www.aaap.org/meetings/2009AM/2009info.html>