

Subject: Studies in the News: (October 28, 2009)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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AUTISM

“Blood Mercury Concentrations in CHARGE Study Children with and without Autism.” By Irva Hertz-Picciotto and others, University of California, Davis. IN: Environmental Health Perspectives (published online on October 19, 2009) 36 p.

[“This study found that 2- to 5-year-old children diagnosed with autism or autism spectrum disorders (AU/ASD) had blood mercury levels similar to those of typically developing control children after adjusting for a variety of sources. The study was conducted through Childhood Autism Risks from Genetics and the Environment (CHARGE), an ongoing study to identify and understand factors contributing to childhood AU/ASD and developmental delays.

Mercury has drawn particular attention in terms of AU/ASD because of its known neurotoxicity. The objective of this study was to compare blood mercury concentrations in typically developing children to concentrations in children with AU/ASD or developmental delay without autism, and to analyze whether differences in mercury sources such as fish consumption explained any differences in blood mercury levels among these groups. The authors also examined dental, medical (including vaccinations) and pharmaceutical sources of mercury exposure.

The authors reported that consumption of tuna, other ocean fish and freshwater fish was the primary predictor of total blood mercury for both typically developing children and those with AU/ASD or developmental delay. Higher blood mercury was also seen in children with amalgam dental fillings who ground their teeth and/or chewed gum. However, children with AU/ASD were less likely to consume tuna, other ocean fish and freshwater fish, and these children’s blood mercury was significantly reduced compared with that of typically developing controls when differences in fish intake were not accounted for.

This case-control study represents the most rigorous examination to date of differences in circulating blood mercury associated with AU/ASD. However, it did not address whether mercury could be a causative factor in AU/ASD. Analysis of specimens taken before diagnosis will be needed to assess the role of prenatal or early-life mercury exposures in the etiology of autism.” Press release from EHP (October 19, 2009)]

Full text at: <http://www.ehponline.org/members/2009/0900736/0900736.pdf>

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“Prevalence of Parent-Reported Diagnosis of Autism Spectrum Disorder among Children in the US, 2007.” By Michael D. Kogan, Health Resources and Services Administration, US Department of Health and Human Services, Rockville, Maryland, and others. IN: Pediatrics (published online on October 5, 2009) 11 p.

[“Two new government studies suggest autism spectrum disorders are becoming more common in children in the USA. However, researchers say, it is not clear how much of the increase is a result of more frequent and earlier diagnoses and how much is a result of a real rise in the conditions.... One of the studies, published ...in the journal

'Pediatrics'... found that one in every 91 children ages 3 to 17 have such a disorder, as determined by a survey of the parents of 78,000 children.... In half the cases, parents report their children's symptoms as 'mild.' Prompted by the 'Pediatrics' study, the Centers for Disease Control and Prevention is announcing not-yet published results of a second study. It finds about one in 100 8-year-olds has an autism spectrum disorder, or ASD. In a similar 2007 study, the CDC placed the rate at one in 150. Details of the study are due this year. The 'Pediatrics' paper discusses several possible explanations for the apparent increase in ASD diagnoses. They include a broader definition of autism disorders and a heightened awareness of them on the part of parents and doctors. 'This is something that further research is going to have to look at,' Michael Kogan, lead author of the 'Pediatrics' paper, said in an interview.... Pediatrician Susan Levy, founder and director of the Regional Autism Center at Children's Hospital of Philadelphia, notes that Kogan's study is based only on what parents said about their children, not information from doctors involved in their care.... Surprisingly, Kogan's survey found that the parents of nearly 40% of children reported to have been diagnosed with ASD said they no longer had the disorder. Perhaps their doctor labeled them as having ASD so they could get services for developmental delay, Kogan speculated." USA Today (October 5, 2009.)]

Full text at: <http://pluk.mt.typepad.com/files/peds.2009-1522v1.pdf>

NIMH's Response to New Autism Prevalence Estimate:

<http://www.nimh.nih.gov/about/director/updates/2009/nimhs-response-to-new-autism-prevalence-estimate.shtml>

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“Risk of Autism and Increasing Maternal and Paternal Age in a Large North American Population.” By Judith K. Grether, California Department of Public Health, and others. IN: American Journal of Epidemiology, vol. 170, no. 9 (September 2009) pp. 1118-1126.

[“Previous studies are inconsistent regarding whether there are independent effects of maternal and paternal age on the risk of autism. Different biologic mechanisms are suggested by maternal and paternal age effects. The study population included all California singletons born in 1989–2002 ($n = 7,550,026$). Children with autism ($n = 23,311$) were identified through the California Department of Developmental Services and compared with the remainder of the study population, with parental ages and covariates obtained from birth certificates. Adjusted odds ratios and 95% confidence intervals were used to evaluate the risk of autism associated with increasing maternal and paternal age. In adjusted models that included age of the other parent and demographic covariates, a 10-year increase in maternal age was associated with a 38% increase in the odds ratio for autism (odds ratio = 1.38, 95% confidence interval: 1.32, 1.44), and a 10-year increase in paternal age was associated with a 22% increase (odds ratio = 1.22, 95% confidence interval: 1.18, 1.26). Maternal and paternal age effects were seen in subgroups defined by race/ethnicity and other covariates and were of greater magnitude among first-born compared with later-born children. Further studies are needed to help clarify the biologic mechanisms involved in the independent association of autism risk with

increasing maternal and paternal age.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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CHILDREN AND ADOLESCENTS

“A Comparison of Systematic Screening Tools for Emotional and Behavioral Disorders.” By Kathleen Lynne Lane and others, Vanderbilt University. **IN: Journal of Emotional and Behavioral Disorders, vol. 17, no. 2 (June 2009) pp. 93-105.**

[“Early identification of students who might develop emotional and behavioral disorders (EBD) is essential in preventing negative outcomes. Systematic screening tools are available for identifying elementary-age students with EBD, including the *Systematic Screening for Behavior Disorders* (SSBD) and the *Student Risk Screening Scale* (SRSS). The SSBD is considered the gold standard for systematic EBD screening. The brevity of the SRSS is often favored with respect to resource allocation. The authors evaluated the concurrent validity of the SRSS to predict SSBD results when used to detect school children with externalizing or internalizing behavior concerns. Between low- and high-risk categories, the SRSS had excellent accuracy for predicting both externalizing (95%) and internalizing (93%) problems on the SSBD. Sensitivity (94%) and specificity (95%) were both excellent for externalizing behavior, but for internalizing behavior, sensitivity was lower (44%), while specificity was excellent (95%). Receiver-operating characteristic analysis also suggested that the SRSS was more accurate for detecting externalizing than internalizing behaviors. Limitations and future directions are offered.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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“Maternal Tobacco, Cannabis and Alcohol use during Pregnancy and Risk of Adolescent Psychotic Symptoms in Offspring.” By Stanley Zammit, Cardiff University School of Medicine, and others. **IN: British Journal of Psychiatry, vol. 195, no. 10 (October 2009) pp. 294-300.**

[“Mothers who smoke during pregnancy put their children at greater risk of developing psychotic symptoms in their teenage years.

Smoking during pregnancy was found to be associated with an increased risk of psychotic symptoms in the children. The researchers observed a 'dose-response effect,' meaning that the risk of psychotic symptoms was highest in the children whose mothers smoked the most heavily during pregnancy.

The study also examined whether alcohol use and cannabis use during pregnancy was associated with a higher risk of psychotic symptoms.

Drinking during pregnancy was associated with increased psychotic symptoms, but only in the children of mothers who had drunk more than 21 units of alcohol a week in early pregnancy. Only a few mothers in the study said they had smoked cannabis during pregnancy, and this was not found to have any significant association with psychotic symptoms.

The reasons for the link between maternal tobacco use and psychotic symptoms are uncertain. But the researchers suggest that exposure to tobacco in the womb may have an indirect impact by affecting children's impulsivity, attention or cognition. They have called for further studies to investigate how exposure to tobacco in utero affects on the development and function of children's brains.

Dr Stanley Zammit, a psychiatrist at Cardiff University's School of Medicine and lead author of the study, said 'In our cohort, approximately 19 per cent of adolescents who were interviewed had mothers who smoked during pregnancy.'

'If our results are non-biased and reflect a causal relationship, we can estimate that about 20 per cent of adolescents in this cohort would not have developed psychotic symptoms if their mothers had not smoked. Therefore, maternal smoking may be an important risk factor in the development of psychotic experiences in the population.'" Eureka Alert (October 1, 2009)]

Full text at: <http://bjp.rcpsych.org/cgi/reprint/195/4/294>

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POLICY

“A Cry for Mental Health Change: Reform Legislation could be Huge Step Forward, Advocates Say.” By Meredith Cohen. IN: The Baltimore Sun (October 4, 2009) 2 p.

[“On Capitol Hill, the debate has centered on issues such as government-run health care and sideshows about ‘death panels.’ But the main goal of the overhaul is to provide general health coverage to 30 million Americans with no insurance. Even more lack mental health coverage or are underinsured, leaving an estimated 25 million with an untreated behavioral disorder. Many also are substance abusers.

Providing more mental health care will be costly. The bill for health care reform is expected to be in the hundreds of billions of dollars. Premiums could rise 1 percent to 3 percent for everyone if basic mental health benefits were mandated, and more for fuller coverage, according to the Council for Affordable Health Insurance, which represents small insurance companies.

The major House version of the health care overhaul bill would require behavioral and addiction coverage on par with medical coverage for just about everyone. On the Senate side, the two major bills exempt smaller employers from providing coverage and one exempts some larger employers, too.”]

Full text at: <http://www.baltimoresun.com/health/bal-md.hs.mental04oct04,0,7871195.story?page=1>

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“Mental Health Policy Development in the States: The Piecemeal Nature of Transformational Change.” By Rachel L. Garfield, University of Pittsburgh. IN: Psychiatric Services, vol. 60, no. 10 (October 2009) pp. 1329-1335.

[“*Objective:* Transformation—systemic, sweeping changes to promote recovery and consumerism—is a pervasive theme in discussions of U.S. mental health policy. State

systems are a fundamental component of national transformation plans. However, it is not clear how the vision of transformation will be balanced against the idiosyncratic political forces that traditionally characterize state policy making. This article examines the development of state mental health policy to assess whether and how it reflects the broader context of transformation versus political forces. *Methods:* Analysis used qualitative evidence collected from semistructured interviews in four states (California, Massachusetts, New Jersey, and New Mexico), which were chosen to capture variation in geography and population, health systems, and political environment. Interviewees included 35 key mental health officials, directors of principal mental health consumer and family advocacy groups, and executives of major mental health provider groups. Interviews were conducted between May 2007 and March 2008. *Results:* Many recent state policy priorities in mental health are consistent with the overall goals of transformation, but some are particular to a state's circumstance. The case studies showed that these priorities are largely shaped by executive control, stakeholder interests, and crises. There is mixed evidence on whether these drivers of state priorities reflect an underlying transformative process. *Conclusions:* States' mental health policies are largely guided by the problems and resources of the states: sometimes these forces dovetail with nationwide transformation goals and processes, and sometimes they are idiosyncratic to a particular state. Thus, although states can play an integral role in forwarding transformation, their own mental health policy agendas are not eclipsed by this nationwide movement.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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“State Mental Health Policy: Implementation of Computerized Medication Prescribing Algorithms in a Community Mental Health System.” By Karen K. Milner and others, University of Michigan. IN: *Psychiatric Services*, vol. 60, no. 8 (August 2009) pp. 1010-1012.

[“This article describes a Michigan initiative to implement medication prescribing algorithms for schizophrenia, bipolar disorder, and major depression. The algorithms were incorporated into the electronic medical records system of a four-county community mental health system. Guideline adherence of 30 providers who treated nearly 3,000 patients was measured at mid- and endpoints of the first year. They were adherent for about a third of their patients in the first six months (32%) and more than half in the second (52%). Scores on scales measuring providers' perceptions of algorithm ease of use and usefulness were in the midrange at both time points.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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SCHOOLS

School-based Telehealth: An Innovative Approach to Meet the Health Care Needs of California's Children. By Jenny Kattlove and others, The Children's Partnership. *Digital Opportunity for Youth Issue Brief*. No. 6. (The Partnership, Santa Monica, California) October 2009. 20 p.

[“This Issue Brief outlines how telehealth — the use of technology to provide health services at a distance — in schools is emerging as a valuable way to complement and expand the capacity of schools to meet the health care needs of children, particularly those who are low-income and living in medically underserved areas. This Brief is a blueprint for action — laying out practical steps to help California state and community leaders make real the promise of school-based telehealth to improve health outcomes for children.

With the vast majority of them attending one of California's nearly 10,000 schools, school-based telehealth has the potential to reach large numbers of underserved children. In addition, nearly 2.4 million California children live in federally designated health care shortage areas — both in urban and rural areas of the state.

In light of the unprecedented interest in and funding — especially at the federal level — for states to modernize and strengthen the delivery of health care through wise use of information technology, the time to take advantage of this innovation is now. School-based telehealth should be a priority consideration as California moves forward with implementing health information technology.

While this brief is geared toward California stakeholders, the lessons learned and recommendations in it can be applied to all states.”]

Full text at:

<http://www.childrenspartnership.org/AM/Template.cfm?Section=Reports1&Template=/CM/ContentDisplay.cfm&ContentID=13701>

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SUBSTANCE ABUSE

“Performance Measurement for Co-occurring Mental Health and Substance Use Disorders.” By David J. Dausey, Carnegie Mellon University and RAND Corporation, and others. IN: **Substance Abuse Treatment, Prevention, and Policy**, vol. 4, no. 18 (published online on October 14, 2009) 25 p.

[“*Background:* Co-occurring mental health and substance use disorders (COD) are the norm rather than the exception. It is therefore critical that performance measures are developed to assess the quality of care for individuals with COD irrespective of whether they seek care in mental health systems or substance abuse systems or both.

Methods: We convened an expert panel and asked them to rate a series of structure, process, and outcomes measures for COD using a structured evaluation tool with domains for importance, usefulness, validity, and practicality.

Results: We chose twelve measures that demonstrated promise for future pilot testing and refinement. The criteria that we applied to select these measures included: balance across structure, process, and outcome measures, quantitative ratings from the panelists, narrative comments from the panelists, and evidence the measure had been tested in a similar form elsewhere.

Conclusions: To be successful, performance measures need to be developed in such a way that they align with needs of administrators and providers. Policymakers need to work with all stakeholders to establish a concrete agenda for developing, piloting and implementing performance measures that include COD. Future research could begin to

consider strategies that increase our ability to use administrative coding in mental health and substance use disorder systems to efficiently capture quality relevant clinical data.”]

Full text at: <http://www.substanceabusepolicy.com/content/pdf/1747-597x-4-18.pdf>

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“Racial and Ethnic Differences in Substance Abuse Service Needs, Utilization, and Outcomes in California.” By Noosha Niv, Department of Veterans Affairs Desert Pacific Mental Illness Research, Education, and Clinical Center, Long Beach, and others. IN: *Psychiatric Services*, vol. 60, no. 10 (October 2009) pp. 1350-1356.

[“*Objective:* This study examined differences in service needs and treatment utilization, retention, and outcomes between African-American, Hispanic, and white substance abusers in community-based treatment programs. *Methods:* Data were collected from 2,401 African Americans, 3,222 Hispanics, and 7,980 whites who were admitted to 43 drug treatment programs across California from 2000 to 2001. The Addiction Severity Index (ASI) was administered at intake to assess clients' problem severity in a number of domains (alcohol use, drug use, employment, family and social relationships, legal, medical, and psychological), and treatment retention and arrest data were obtained from administrative records. A subsample was followed up at three months to assess service utilization (N=2,145) and again at nine months to readminister the ASI (N=2,566). *Results:* All three groups had similar severity levels of drug and legal problems upon treatment entry. Upon entry to treatment, white clients had the highest severity levels of alcohol, family, and psychiatric problems and African Americans had the highest severity levels of employment problems compared with the other two groups. Treatment retention did not differ between the three groups, but whites received a greater number of alcohol treatment services than did African Americans or Hispanics, and African Americans received a greater number of employment services than did Hispanic and white clients. All three groups showed significant improvement in all outcome domains except for medical outcomes. At the nine-month follow-up, whites had worse outcomes in the alcohol domain compared with the other two groups, and whites had worse outcomes in the legal domain compared with Hispanics. Compared with whites, African Americans were significantly less likely to be charged with driving under the influence in the year after treatment admission. *Conclusions:* All three groups improved after treatment, although benefits from treatment can be further enhanced if services underscore different facets of the psychosocial problems of each racial and ethnic group.”] NOTE: Please contact the California State Library for a paper or electronic copy of this article.

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SUICIDE PREVENTION

“The Treatment of Adolescent Suicide Attempters Study (TASA): Predictors of Suicidal Events in an Open Treatment Trial.” By David A. Brent and others. pp. 987-996.

“Depressive Symptoms and Clinical Status during the Treatment of Adolescent Suicide Attempters (TASA) Study.” By Benedetto Vitiello and others. pp. 997-1004.

“Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP): Treatment Model, Feasibility, and Acceptability.” By Barbara Stanley and others. pp. 1005-1013

IN: Journal of the American Academy of Child and Adolescent Psychiatry, vol. 48, no. 10 (October 2009)

[“A novel treatment approach that includes medication plus a newly developed type of psychotherapy that targets suicidal thinking and behavior shows promise in treating depressed adolescents who had recently attempted suicide, according to a treatment development and pilot study funded by the National Institute of Mental Health (NIMH). The study, described in three articles, was published in the October 2009 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Background: Youth who attempt suicide are particularly difficult to treat because they often leave treatment prematurely, and no specific interventions exist that reliably reduce suicidal thinking and behavior (suicidality). In addition, these teens often are excluded from clinical trials testing depression treatments. The Treatment of Adolescent Suicide Attempters Study (TASA) was developed to address this need and identify factors that may predict and mediate suicide reattempts among this vulnerable population. A novel psychotherapy used in the study—cognitive behavioral therapy for suicide prevention (CBT-SP—was developed to address the need for a specific psychotherapy that would prevent or reduce the risk for suicide reattempts among teens. CBT-SP consisted of a 12-week acute treatment phase focusing on safety planning, understanding the circumstances and vulnerabilities that lead to suicidal behavior, and building life skills to prevent a reattempt. A maintenance continuation phase followed the acute phase.

In the six-month, multisite pilot study, 124 adolescents who had recently attempted suicide were either randomized to or given the option of choosing one of three interventions—antidepressant medication only, CBT-SP only, or a combination of the two. Most participants preferred to choose their intervention, and most (93) chose combination therapy. Participants were assessed for suicidality at weeks six, 12, 18 and 24.

Results of the Study: During the six-month treatment, 24 participants experienced a new suicidal event, defined as new onset or worsening of suicidal thinking or a suicide attempt. This rate of recurrence is lower than what previous studies among suicidal patients had found, suggesting that this treatment approach may be a promising intervention. In addition, more than 70 percent of these teens—a population that is typically difficult to keep in treatment—completed the acute phase of the therapy. However, many participants discontinued the treatment during the continuation phase, suggesting that treatment may need to include more frequent sessions during the acute phase, and limited sessions during the continuation phase.

The study revealed some characteristics that could predict recurrent suicidality, including high levels of self-reported suicidal thinking and depression, a history of abuse, two or more previous suicide attempts, and a strong sense of hopelessness. In addition, a high degree of family conflict predicted suicidality, while family support and cohesion acted as a protective factor against suicide reattempts. Other studies have found similar results, according to the researchers.

Significance: Although the study cannot address effectiveness of the treatment because it was not randomized, it sheds light on characteristics that identify who is most at risk for suicide reattempts, and what circumstances may help protect teens from attempting suicide again. In addition, the study found that 10 of the 24 suicide events occurred within four weeks of the beginning of the study—before they could receive adequate treatment. This suggests that a ‘front-loaded’ intervention in which the most intense treatment is given early on, would likely reduce the risk of suicide reattempt even more.” NIMH Science Update (September 29, 2009)] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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“Repetition and Severity of Suicide Attempts across the Life Cycle: a Comparison by Age Group between Suicide Victims and Controls with Severe Depression.” By Louise Bradvik and Mats Berglund, Lund University Hospital, Sweden. IN: BMC Psychiatry, vol. 9, no. 62 (published online on September 29, 2009) 21 p.

[“*Background:* Suicide attempts have been shown to be less common in older age groups, with repeated attempts generally being more common in younger age groups and severe attempts in older age groups. Consistently, most studies have shown an increased suicide risk after attempts in older age. However, little is known about the predictive value of age on repeated and severe suicide attempts for accomplished suicide. The aim of the present study was to investigate the reduced incidence for initial, repeated, or severe suicide attempts with age in suicide victims and controls by gender. Methods The records of 100 suicide victims and matched controls with severe depression admitted to the Department of Psychiatry, Lund University Hospital, Sweden between 1956 and 1969, were evaluated and the subjects were monitored up to 2006. The occurrence of suicide attempts (first, repeated, or severe, by age group) was analyzed for suicide victims and controls, with gender taken into consideration.

Results: There was a reduced risk for an initial suicide attempt by older age in females (suicide victims and controls) and male controls (but not suicide victims). The risk for repeated suicide attempts appeared to be reduced in the older age groups in female controls as compared to female suicide victims. The risk for severe suicide attempts seemed reduced in the older age groups in female suicide victims. This risk was also reduced in male controls and in male controls compared to male suicide victims.

Conclusion In the older age groups repeated attempts appeared to be predictive for suicide in women and severe attempts predictive in men.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-9-62.pdf>

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Healthcare Inspection: Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities, January – June 2009. By the Department of Veterans Affairs, Office of Inspector General. Report No. 09-00326-223 (The Department, Washington, DC) September 22, 2009. 15 p.

[“*Introduction:* The VA Office of Inspector General, Office of Healthcare Inspections (OHI) completed an evaluation of Veterans Health Administration (VHA) facilities

implementation of suicide prevention programs in compliance with VHA requirements. VHA mental health (MH) officials estimate that there are approximately 1,600–1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans. OHI conducted this review at 24 VA medical facilities during Combined Assessment Program reviews performed across the country from January 1–June 30, 2009.

Results and Recommendations: Although all 24 facilities implemented suicide prevention programs that generally met the VHA requirements, program effectiveness could be strengthened through improvements in documented collaboration between MH providers and suicide prevention coordinators (SPCs) and in the development of comprehensive and timely safety plans. An additional area that needed attention was ensuring that very large CBOCs had full-time SPCs.

We recommended that the Acting Under Secretary for Health, in conjunction with Veterans Service Network and facility managers, ensure:

- Documentation of collaboration between SPCs and MH providers.
- MH providers develop comprehensive and timely safety plans.
- Full-time SPCs are appointed at very large CBOCs.

Full text at: <http://www.va.gov/oig/54/reports/VAOIG-09-00326-223.pdf>

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TREATMENT

“Packages of Care for Depression in Low- and Middle-Income Countries.” By Vikram Patel, London School of Hygiene & Tropical Medicine, and others. IN: PLoS Medicine, vol. 6, no. 10 (October 2009) 7 p.

[“Depression is the leading cause of disease burden in most regions of the world. The International Classification of Disease (ICD) 10 diagnostic criteria for depressive episode are shown. Somatic presentations are very common, especially tiredness, sleep problems, and aches and pains. Of these, only tiredness is considered a ‘core’ feature in current classifications. Anxiety symptoms often coexist with depressive symptoms, particularly in community or primary care samples. The term ‘common mental disorders’ is used to describe the heterogeneous presentation of anxiety, depressive, and somatic symptoms in these contexts.

The World Mental Health Surveys have described the prevalence and help-seeking behaviors of people with depression in a large number of countries. The major observations about the epidemiology of depression from these and other studies on depression can be summarized as follows: (1) the constellation of symptoms used to characterize depression can be identified in all cultures; (2) the prevalence rates of depression vary considerably between populations, with rates ranging from about 6% in China to over 20% in the US; (3) the age of onset is most commonly in young adulthood; (4) the disorder often runs a relapsing or chronic course; (5) the disorder is two to three times more common in women, although a few studies, particularly from Africa, have not shown this female excess; and (6) social factors, particularly related to economic or social

disadvantages such as low education and violence, are major determinants of the risk for depression [5].

Depression is the leading neuropsychiatric cause of the burden of disease globally and in low- and middle-income countries (LMIC), and is projected to be, overall, the second leading cause of burden of disease by 2020 [6,7]. Apart from its profound impact on function, depression is associated with increased mortality (particularly through suicide). The condition is often comorbid with other chronic diseases such as diabetes and is responsible for a significant proportion of the disability associated with these conditions [8]. Depression has been associated with a range of poor health outcomes, including poor infant growth (in the case of maternal depression in some countries in South Asia, for example) and worse physical health (for example, cardiovascular or HIV outcomes through poor adherence) [9,10].

In this article we focus on the effective management of depression in LMICs, reviewing the evidence on efficacy of treatments and delivery of interventions derived from LMICs to the extent possible. Because that evidence is often limited, we also cite systematic reviews or meta-analyses based on global evidence and key trials from high income countries (HIC) where appropriate. On the basis of our review we propose a package of care—a combination of treatments aimed at improving the recognition and management of conditions to achieve optimal outcomes—for depression.”]

Full Text at:

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000159>

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“Packages of Care for Mental, Neurological, and Substance Use Disorders in Low- and Middle-Income Countries: *PLoS Medicine* Series.” By Vikram Patel, London School of Hygiene and Tropical Medicine, and Graham Thornicroft, Kings College, London. IN: *PloS Medicine*, vol. 6 no. 10 (October 2009) 2 p.

[“The world's poorer and less resourced countries face a significant burden of mental, neurological, and substance use (MNS) disorders. This burden will continue to grow as the epidemiological transition—the process by which low and middle countries see a rise in noncommunicable diseases—gathers pace.

Recent reports on the care of persons living with MNS disorders had two stark findings. First, there is enormous inequity in the distribution of specialist human resources, both within and between countries. One country alone (the US) enjoys more psychiatrists than the world's most populous countries (India and China) and an entire continent (Africa) put together. Second, due to a combination of factors including scarce resources, there is an astonishingly large treatment gap for people with MNS disorders. Worldwide at least two-thirds of all persons with mental illnesses, for example, go untreated, and in low resource countries this figures exceeds 90%.

These findings sit alongside a compelling evidence base indicating the strong social determinants of MNS disorders and the vicious cycle of deprivation and mental ill-health. Flagrant abuses of human rights of people with MNS disorders have been documented at every level of the health system including, most disturbingly, in the very institutions that are supposed to cater to their needs. In response to this global health scandal, the recently launched Movement for Global Mental Health (www.globalmentalhealth.org) has called

for the immediate scaling up of services for people with MNS disorders to close the treatment gap, on the basis of principles of evidence and human rights. Which treatments should be scaled up and how should these be delivered in settings where specialists are scarce—a common situation for the majority of the global population? Starting this week, with the article by Chowdhary and colleagues on depression, *PLoS Medicine* publishes a series of evidence-based reviews on packages of care for six MNS disorders. We were invited to be Guest Editors for this series. Each review follows a set format: the focus is on both the evidence of efficacy of specific treatments, as well as how these should be delivered. Indeed the routine delivery or implementation of such interventions is of vital importance. Therefore the series is concerned not only with questions about the treatments themselves (e.g., who should provide these, and in what settings they be provided), but also with improving access to these treatments to achieve optimal long-term clinical and social outcomes.

Full Text at:

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000160>

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CONFERENCES, MEETINGS AND WEBINARS

California Institute for Mental Health: *Cultural Competence & Mental Health Summit XVI - Embracing Social Justice and Equity to Build Healthier Communities*

November 17-18, 2009
Burlingame, California

For more information and registration:

<http://elearning.networkofcare.org/CiMH/PackageOverview.asp?id=231389>

Older Adults System of Care Conference presented by California Mental Health Directors Association & Riverside County. *What's Age Got To Do With It? Valuing All Elders: Eliminate Disparities, Increase Collaboration, Support Prevention and Recovery through The Mental Health Services Act (MHSA.)*

December 1-2, 2009
Riverside, California

[Click Here to View Preliminary Agenda](#)

[Click Here to View Registration Information](#)

National Federation of Families for Children's Mental Health. *20th Anniversary Conference.*

December 3-6, 2009
Washington DC

For more information and registration:

<http://www.ffcmh.org/conference2009/indexconference.html>

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