

**Subject:** Studies in the News: (July 15, 2011)

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## Studies in the News for



## California Department of Mental Health

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## CONTENTS

### **ANTIPSYCHOTICS**

[Continuity of Psychotic Medication for Medicaid Patients with Schizophrenia](#)  
[Effectiveness of Switching From Antipsychotic Polypharmacy to Monotherapy](#)

### **CHILDREN AND ADOLESCENTS**

[America's Children: Key National Indicators of Well-being, 2011](#)  
[International Variation in Treatment Procedures for ADHD](#)  
[Profiles of Family Adverse Experiences through Childhood and Early Adolescence](#)  
[School-Based Trauma Intervention-Program for Mental Health in Schools](#)  
[Schools and the Challenge of LD and ADHD Misdiagnoses](#)

### **DEPRESSION**

[Guided Internet-based Cognitive-behavioural Treatment for Depression](#)

### **HOMELESS AND MENTALLY ILL**

[Helping the Homeless in School and Out](#)

### **SUICIDE PREVENTION**

[Death in the United States, 2009](#)  
[National Trends in Prescribing Antidepressants on Suicidality Risk in Youths](#)

### **VETERANS**

[Military Doctors Explore Way to Treat Traumatic Brain Injuries](#)  
[Length of Parental Military Deployment Associated with Children's Mental Health](#)

### **NON-PROFIT RESOURCE CENTER**

### **CONFERENCES, MEETINGS, SEMINARS**

## ANTIPSYCHOTICS



**“Continuity of Psychotic Medication Management for Medicaid Patients with Schizophrenia.” By Joel F. Farley, University of North Carolina at Chapel Hill, and others. IN: Psychiatric Services, vol. 62, no. 7 (July 2011) pp. 747-752.**

[“The purpose of this study was to examine whether medication refill behavior varies by the number of prescribers of antipsychotic medication a patient has. *Methods:* A total of 7,868 patients with schizophrenia were identified from North Carolina Medicaid records for the period 2001–2003. Medication switching and adherence outcomes in 2003 were constructed from Medicaid pharmacy claims. Adherence was categorized into four levels (nonadherence, partial adherence, full adherence, or excess filler). Patients were stratified into four groups on the basis of the number of providers who prescribed antipsychotics in 2002 (one prescriber, two prescribers, three prescribers, or four or more prescribers). Medication switching was modeled via logistic regression, and the four-level adherence outcome was modeled via ordered logistic regression, with both regressions controlling for the number of prescribers, age, gender, race, and comorbidity. Medication switching in 2003 was also controlled for in the adherence regression. Predicted probabilities of being in the four adherence groups were estimated to examine the impact of the number of prescribers on adherence. *Results:* Fifty-seven percent of Medicaid patients with schizophrenia had one prescriber for antipsychotic medication, 29% had two prescribers, 10% had three prescribers, and 4% had four or more prescribers in 2002. Patients with more prescribers were significantly more likely than patients with one prescriber to switch medications ( $p < .01$  for patients with three prescribers) and to be either fully adherent or excess fillers ( $p < .001$ ). *Conclusions:* Patients with schizophrenia who received medication from multiple prescribers frequently changed medications and filled prescriptions too soon. Care coordination, such as with medical homes, may be effective in improving medication use in this vulnerable population.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/7/747.pdf>

[\[Back to top\]](#)



**“Effectiveness of Switching From Antipsychotic Polypharmacy to Monotherapy.”  
By Susan M. Essock, New York State Psychiatric Institute, and others. IN:  
American Journal of Psychiatry, vol. 168, no. 7 (July 2011) pp. 702-708.**

[“This randomized trial addressed the risks and benefits of staying on antipsychotic polypharmacy or switching to monotherapy. Method: Adult outpatients with schizophrenia taking two antipsychotics (127 participants across 19 sites) were randomly assigned to stay on polypharmacy or switch to monotherapy by discontinuing one antipsychotic. The trial lasted 6 months, with a 6-month naturalistic follow-up. Kaplan-Meier and Cox regression analyses examined time to discontinuation of assigned antipsychotic treatment, and random regression models examined additional outcomes over time.

**Results:** Patients assigned to switch to monotherapy had shorter times to all cause treatment discontinuation than those assigned to stay on polypharmacy. By month 6, 86% (N=48) of those assigned to stay on polypharmacy were still taking both medications, whereas 69% (N=40) of those assigned to switch to monotherapy were still taking the same medication. Most monotherapy discontinuations entailed returning to the original polypharmacy. The two groups did not differ with respect to psychiatric symptoms or hospitalizations. On average, the monotherapy group lost weight, whereas the polypharmacy group gained weight.

**Conclusions:** Discontinuing one of two antipsychotics was followed by treatment discontinuation more often and more quickly than when both antipsychotics were continued. However, two-thirds of participants successfully switched, the groups did not differ with respect to symptom control, and switching to monotherapy resulted in weight loss. These results support the reasonableness of prescribing guidelines encouraging trials of antipsychotic monotherapy for individuals receiving antipsychotic polypharmacy, with the caveat that patients should be free to return to polypharmacy if an adequate trial on antipsychotic monotherapy proves unsatisfactory.”]

Full text at:

<http://ajp.psychiatryonline.org/cgi/reprint/168/7/702>

[\[Back to top\]](#)

**CHILDREN AND ADOLESCENTS**

**America's Children: Key National Indicators of Well-being, 2011.** By the Federal Interagency Forum on Children and Family Statistics. (The Forum, Merrifield, Virginia) 2011. 223 p.

[“The Federal Interagency Forum on Child and Family Statistics’ primary mission is to enhance the practice of and improve consistency in data collection and reporting on children and families. *America’s Children: Key National Indicators of Well-Being, 2011* provides the Nation with a summary of national indicators of children’s well-being and monitors changes in these indicators. The purposes of the report are to improve Federal data on children and families and make these data available in an easy-to-use, non-technical format, as well as to stimulate discussions among policymakers and the public and spur exchanges between the statistical and policy communities.”]

Full text at:

[http://www.childstats.gov/pdf/ac2011/ac\\_11.pdf](http://www.childstats.gov/pdf/ac2011/ac_11.pdf)

**“International Variation in Treatment Procedures for ADHD: Social Context and Recent Trends.”** By Stephen P. Hinshaw, University of California, Berkeley, and others. IN: *Psychiatric Services*, vol. 61, no. 5 (May 2011) pp. 459-464.

[“Scientific and clinical interest in attention-deficit hyperactivity disorder (ADHD) is increasing worldwide. This article presents data from a cross-national workshop and survey related to questions of variability in diagnostic and, particularly, treatment procedures. *Methods:* Representatives of nine nations (Australia, Brazil, Canada, China, Germany, Israel, the Netherlands, Norway, and the United Kingdom), plus the United States, who attended a 2010 workshop on ADHD, responded to a survey that addressed diagnostic procedures for ADHD; treated prevalence of medication approaches, as well as psychosocial interventions; types of medications and psychosocial treatments in use; payment systems; beliefs and values of the education system; trends related to adult ADHD; and cultural and historical attitudes and influences related to treatment.

*Results:*

Use of both medication and psychosocial treatment for ADHD varies widely within and across nations. More expensive long-acting formulations of medications are becoming more widespread. Nations with socialized medical care provide a wide array of evidence-based interventions. Economic, historical, and political forces and cultural values are related to predominant attitudes and practices. Strong antipsychiatry and antim medication voices remain influential in many nations. *Conclusions:* There is considerable variation in implementation of care for ADHD. Recognition of the social context of ADHD is an important step in ensuring access to evidence-based interventions for this prevalent, chronic, and impairing condition.”]

Full text at:

<http://ps.psychiatryonline.org/cgi/reprint/62/5/459>

[\[Back to top\]](#)

**“Profiles of Family-focused Adverse Experiences through Childhood and Early Adolescence: The ROOTS Project, a community investigation of adolescent mental health.”** By Valerie J. Dunn, University of Cambridge, Cambridge, United Kingdom, and others. IN: *BMC Psychiatry*, vol. 11, no. 109 (July 7, 2011) pp. 1-41.

[“Adverse family experiences in early life are associated with subsequent psychopathology. This study adds to the growing body of work exploring the nature and associations between adverse experiences over the childhood years.

### **Methods**

Primary carers of 1143 randomly recruited 14-year olds in Cambridgeshire and Suffolk, UK were interviewed using the Cambridge Early Experiences Interview (CAMEEI) to assess family-focused adversities. Adversities were recorded retrospectively in three time periods (early and later childhood and early adolescence). Latent Class Analysis (LCA) grouped individuals into adversity classes for each time period and longitudinally. Adolescents were interviewed to generate lifetime DSM-IV diagnoses using the K-SADS-PL. The associations between adversity class and diagnoses were explored.

### **Results**

LCA generated a 4-class model for each time period and longitudinally. In early childhood 69% were allocated to a low adversity class; a moderate adversity class (19%) showed elevated rates of family loss, mild or moderate family discord, financial difficulties, maternal psychiatric illness and higher risk for paternal atypical parenting; a severe class (6%) experienced higher rates on all indicators and almost exclusively accounted for incidents of child abuse; a fourth class, characterised by atypical parenting from both parents, accounted for the remaining 7%. Class membership was fairly stable (~ 55%) over time with escape from any adversity by 14 years being uncommon. Compared to those in the low class, the odds ratio for reported psychopathology in adolescents in the severe class ranged from 8 for disruptive behaviour disorders through to 4.8 for depressions and 2.0 for anxiety disorders. Only in the low adversity class did significantly more females than males report psychopathology

### **Conclusions**

Family adversities in the early years occur as multiple rather than single experiences. Although some children escape adversity, for many this negative family environment persists over the first 15 years of life. Different profiles of family risk may be associated with specific mental disorders in young people. Sex differences in psychopathologies may be most pronounced in those exposed to low levels of family adversities.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-109.pdf>

[\[Back to top\]](#)

### **School-Based Trauma Intervention-Program for Mental Health Professionals in Schools. Website access is provided with this abstract.**

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is an evidence-based intervention for delivery by mental health professionals in schools. CBITS is designed to reduce trauma symptoms, including depression and behavioral problems, and improve functioning and coping skills. Using cognitive-behavioral techniques such as relaxation and social problem solving, CBITS can help students in 5th through 12th grade who have been exposed to various kinds of trauma, including abuse, accidents, and disasters.

The program consists of 10 group sessions and a smaller number of individual, parent, and teacher sessions. Materials and resources are available free of charge to professionals who register on the website. The CBITS website also includes success

stories of jurisdictions where CBITS has been used, including in Louisiana to help children after Hurricane Katrina.

Find more details and registration information on the CBITS website:

<http://cbitsprogram.org>

Full text at:

<http://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=128&articleid=3249>

[\[Back to top\]](#)

**Schools and the Challenge of LD and ADHD Misdiagnoses. By UCLA Center for Mental Health in Schools. (The Center, Los Angeles, California) July 2011. 9 p.**

[“Youngsters manifesting learning problems, misbehavior, and emotional upset commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as learning disabilities (LD), attention deficit/hyperactivity disorder (ADHD), depression, and so forth. This happens despite the fact that the problems of most youngsters are not rooted primarily in internal dysfunctioning. Indeed, many of the troubles manifested by youngsters would not have developed if their environmental circumstances had been appropriately different.

Currently at schools, LD and ADHD are the two most commonly diagnosed learning and behavior problems. Informed researchers, practitioners, and policy makers in the U.S. and in other countries have cautioned about widespread misapplications of the terms and large numbers of *false positive* misdiagnoses resulting from indiscriminate use and classification practices that leave much to be desired. The problem of false positives has become an increasing concern because a significant number of older students are feigning symptoms of LD and ADHD to obtain special accommodations in the classroom and in academic testing situations.”]

Full text at:

<http://smhp.psych.ucla.edu/pdfdocs/lldmisdiagnoses.pdf>

[\[Back to top\]](#)

## DEPRESSION

**“Experiences of guided Internet-based cognitive-behavioural treatment for depression: A qualitative study.” By Nina Bendelin, Linköping University, Linköping, Sweden and others. IN: BMC Psychiatry, vol. 11, no. 107 (June 30, 2011) pp. 1-31.**

[“Internet-based self-help treatment with minimal therapist contact has been shown to have an effect in treating various conditions. The objective of this study was to explore participants’ views of Internet administrated guided self-help treatment for depression.

**Methods**

In-depth interviews were conducted with 12 strategically selected participants and qualitative methods with components of both thematic analysis and grounded theory were used in the analyses.

## Results

Three distinct change processes relating to how participants worked with the treatment material emerged which were categorized as (a) *Readers*, (b) *Strivers*, and (c) *Doers*. These processes dealt with attitudes towards treatment, views on motivational aspects of the treatment, and perceptions of consequences of the treatment.

## Conclusions

We conclude that the findings correspond with existing theoretical models of face-to-face psychotherapy within qualitative process research. Persons who take responsibility for the treatment and also attribute success to themselves appear to benefit more. Motivation is a crucial aspect of guided self-help in the treatment of depression.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-107.pdf>

[\[Back to top\]](#)

## HOMELESS

**“Helping the Homeless In School and Out.” By Helena Holgersson-Shorter, Teaching Tolerance. IN: Education Digest, vol. 76, no. 3 (November 2010) pp. 30-33.**

[“The article discusses education of homeless children and the challenges they face, including hunger, inadequate clothing, and a lack of school materials. The author reports that they are at risk for developmental delays, learning disabilities, and grade repetition and may suffer from depression and drug abuse. She suggests that the U.S. McKinney-Vento Education for Homeless Children Act is underfunded and that many communities, particularly suburbs, are not to not prepared to deal with the needs of homeless students. The article emphasizes the role of the teacher and the importance of nurturing student-teacher relationships to make schools safe spaces.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=54571230&site=ehost-live>

[\[Back to top\]](#)

## SUICIDE PREVENTION

**Death in the United States, 2009. By Arialdi M. Miniño, M.P.H., Division of Vital Statistics, the National Center for Health Statistics. (The Center, Hyattsville, Maryland) 2011. 8 p.**

[“Mortality in the United States is best summarized by the age-adjusted death rate—a measure that accounts for changes in the age distribution of the population. This rate has declined in an almost uninterrupted manner since 1960. The death rate is now 45 percent lower than in 1960 (declining from 1,339.2 per 100,000 standard population in 1960 to 741.0 in 2009) (1, 2). Although age-adjusted mortality has declined for all demographic groups over a period of many decades, long-standing gaps between black and white populations and between male and female populations have begun to narrow only since the mid-1990s. Many of the recent improvements in death rates and life expectancy for all population groups can be attributed to ongoing reductions in death rates from major causes of death, such as heart disease, cancer, stroke, and chronic lower respiratory diseases (1). The figures presented in this report are based

on preliminary mortality data for 2009....The leading causes of death for those aged 1–24 are external causes (i.e., accidents, homicide, and suicide), followed by cancer and heart disease. This pattern (of external causes accounting for more deaths than chronic conditions) shifts noticeably as age increases. In older age groups, chronic conditions account for more deaths than do external causes of injury.”]

Full text at:

<http://www.cdc.gov/nchs/data/databriefs/db64.pdf>

[\[Back to top\]](#)

**“National Trends in Prescribing Antidepressants before and after an FDA Advisory on Suicidality Risk in Youths.” By Shih-Yin Chen, United BioSource Corporation, and Sengwee Toh, Harvard Medical School. IN: *Psychiatric Services*, vol. 62, no. 7 (July 2011) pp. 727-733.**

[“This study evaluated the national trends in prescribing pharmacologic treatments for pediatric depression before and after a 2003 U.S. Food and Drug Administration advisory linking an increased risk of suicidality with antidepressants among pediatric patients with major depressive disorder. *Methods*: National estimates on outpatient visits between 1998 and 2007 with a diagnosis of depression, a prescription for an antidepressant, or both among children ages 5 to 17 and adults were obtained from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey. *Results*: Among children, depression visits increased from 1998–1999 to 2002–2003 (3.2 and 4.3 million, respectively) but decreased to 3.2 million in 2006–2007. Antidepressant visits increased from 1998–1999 to 2002–2003 (3.4 and 7.6 million, respectively) but dropped to 6.7 million in 2006–2007. Depression visits with an antidepressant prescribed rose from 1998–1999 to 2002–2003 (1.7 and 2.8 million, respectively) but dropped in 2004–2005 and 2006–2007 (2.4 and 2.1 million, respectively). Nevertheless, the proportion of depression visits with an antidepressant prescribed, having risen from 54% in 1998–1999 to 66% in 2002–2003, remained stable in 2004–2005 (65%) and in 2006–2007 (64%), the result, seemingly, of more prescribing of antidepressants for major depressive disorder and less for other depression. Utilization patterns among adults were not interrupted. *Conclusions*: Children’s depression visits and visits with an antidepressant prescribed dropped after the advisory, but children with major depressive disorder appeared no less likely to be prescribed antidepressants.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/7/727.pdf>

[\[Back to top\]](#)

## VETERANS

**How do you Exercise an Injured Brain? : Military Doctors Explore Way to Treat Traumatic Brain Injuries. By Barbara Starr and Jennifer Rizzo, CNN. (Turner Broadcasting, Atlanta, Georgia) July 11, 2011. 3 p.**

[“Soldiers in full combat gear file into a hot, deafeningly loud, and dark room. Fake blood covers the floor and drips off the plastic body parts that are scattered about. Smoke and strobe lights mix with heavy metal music and the sound of recorded screams. After weeks of behavioral therapy for traumatic brain injuries, the soldiers are facing this intense simulation to show that they can get back to their daily work--combat.

Staff Sgt. Aaron Potter is among the group of patients at Fort Campbell, Kentucky, going through this final assessment.

"It's probably the closest you can get without having the real thing. The smoke, the smells, the noises, the injuries," Potter says after exiting the simulation.

In 2009 Potter was knocked unconscious when he was hit by three IEDS at once in Iraq. This is his second round of therapy at Fort Campbell, after breaking down under the stress of the room simulation the first time around.”]

Read more: <http://www.wisn.com/health/28515283/detail.html#ixzz1RuRO03Sr>

Full text at:

<http://www.wisn.com/health/28515283/detail.html#ixzz1RuBmCr7x>

[\[Back to top\]](#)

**Length of Parental Military Deployment Associated with Children’s Mental Health Diagnoses, Study Finds. By ScienceDaily Staff. IN: ScienceDaily (July 4, 2011) pp. 1-2.**

[“Children with a parent who was deployed in the U.S. military efforts Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) for longer periods were more likely than children whose parents did not deploy to receive a diagnosis of a mental health problem, according to a report published Online First by *Archives of Pediatrics and Adolescent Medicine*, one of the JAMA/Archives journals.”]

Full text at:

<http://www.sciencedaily.com/releases/2011/07/110704174610.htm>

[\[Back to top\]](#)

**NON PROFIT RESOURCE CENTER-GRANT WRITING**

[“Our mission is to enhance the resources and improve the management of nonprofit organizations, primarily within California's northern Central Valley and Sierra Nevada regions.

We invite you to visit us often to find resources that will help your nonprofit grow stronger and be more successful -- from information on training opportunities, consultation and technical assistance, to building connections with your peers.

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[\[Back to top\]](#)

## **CONFERENCES, MEETINGS AND SEMINARS**

**Sixth Annual UC Davis Conference: Psychotic Disorders: Advanced Strategies for the Management of Psychosis: A State of the Art Conference for Experienced Clinicians.**

**Thursday  
September 15, 2011**

**Hilton Hotel Arden West  
Sacramento, California**

For more information at:

[http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/APSYC12\\_9-15-11w.pdf](http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/APSYC12_9-15-11w.pdf)

[\[Back to top\]](#)



