DBSA-CA NEWS

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

Volume 12, No.3 Fall, 2007

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A Look at Depression Beyond STAR*D:

Emerging Neurotechnologies as the Next Generation of Treatment

"A wide range of new technologies will soon be available to consumers to address mental health, neurological health, and intellectual disability problems. Even as emerging therapies are made accessible to consumers, it is likely that these new treatments will not have the maximum clinical or financial impact on health conditions due to several potential obstacles. One such obstacle is the absence of standardized payer policies in place to address the appropriateness of new technologies, an issue that needs to be considered sooner than later. Additionally, challenges regarding adaptation of these new technologies to clinical and administrative management structures need to be reviewed.

"A number of key factors in shaping policy [include] the following issues: The majority of health care-related costs associated with depression can be attributed to the comorbid conditions of consumers with treatment-resistant depression. As a matter of fact, 33% of consumers with depression do not achieve remission with currently available treatments and are referred to as having treatment resistant depression.

"Unfortunately, existing depression treatment guidelines are outdated and do not address the needs of treatment-resistant consumers. Assuming that safety is demonstrated, consumers with behavioral and neurological conditions who are not able to achieve remission with currently available treatments should have provisional access to emerging neurotechnologies. Additionally, the need to expand research methodologies should be considered when evaluating the efficacy of new treatments for chronic health care conditions.

Depression Treatment Efficacy — Research Implications for Treatment Guidelines

"Researchers have studied depression and its related treatment for decades. The most recent research was conducted by the National Institute of Mental Health (NIMH). The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study has provided the health care community with new perspectives on the effectiveness of currently available treatment options for depression. STAR*D was a seven-year, 4,000-consumer study to determine the best "next-step" treatments for patients failing to respond to prior treatment attempts. STAR*D was also designed to compare relative efficacy of different treatment strategies and specific treatments; and to provide important information on the long-term course of depression, including its nature and the timing of relapses.

"The STAR*D research findings are numerous and compelling. One critical finding for health care policy is that after using four different courses of currently available treatment options, only 67% of patients achieved remission of their symptoms.

"It is clear that no one medication (or combinations of medications and/or cognitive therapies) is a panacea for all consumers, and the clinical predictors of treatment selection are weak. In addition, current depression treatment guidelines are limited in

*Continued on page 3 (***Beyond STAR*D)**

2004 Total Spending on Outpatient Mental Health Medications Hits $20 Billion

In 2004 total spending on mental health medications was $20 billion, more than double the $7.9 billon spent in 1997. The 150% increase in spending was led by spending on antidepressants, which more than doubled from $5.1 billion in 1997 to $12.1 billion in 2004. Other spending increases were noted in the following classes:

- Spending on antipsychotic medications increased to $4.1 billion in 2004 from $1.3 billion in 1997 — a nearly 300% increase
- Spending on central nervous system stimulants increased from $600 million in 1997 to $1.7 billion in 2004 — a 283% increase
- Spending on sedatives, hypnotics, and anxiety medications increased from $900 million in 1997 to $2.1 billion in 2004 — a 230% increase

Total number of medication purchases for mental health disorders increased from 141.9 million in 1997 to 244.3 million in 2004. The number of patients purchasing treat-ments increased from 21 million to 32.6 million.

These are findings of a report entitled "Trends in the Use & Expenditures for the Therapeutic Class Prescribed Psychotherapeutic Agents" led by senior survey statistician Marie Stagnitti at the federal Agency for Healthcare Research and Quality (AHRQ). The study is part of the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) and is co-sponsored by AHRQ. The study compares 1997 and 2004 data for the U.S. civilian non-institutionalized population's purchases of prescribed psychotherapeutic agents. MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care utilization and expenditures, health insurance, and health status, as well as a wide variety of social, demographic, and economic characteristics for the civilian non-institutionalized population

The full text of "Trends in the Use & Expenditures for the Therapeutic Class Prescribed Psychotherapeutic Agents" by Marie N. Stagnitti, may be accessed through the OPEN MINDS Industry Resources Library at www.openminds.com/indres/05147mepspsychmeds.htm.

Source: OPEN MINDS
June 2007

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BEYOND STAR*D*(Continued from page 1)*

their utility for addressing the needs of all consumers with depression. Current guidelines address the use of medication and cognitive behavioral therapy in a process involving selection of initial medication use and subsequent combination therapies. These guidelines assume that remission of symptoms is achieved. However, the current guidelines do not address interventions for the 33% of consumers who do not achieve remission of their depression using currently available therapies.

"Indeed, this severity of illness in depression must be recognized and needs to be incorporated into the existing treatment guidelines. Also needed is the creation of a methodology for identifying consumers with treatment-resistant depression. Within the scientific community, the current definition ranges from two to four failed treatments. The lack of a standardized definition creates problems for consumers, clinicians, and payers. Without consensus regarding appropriate treatment algorithms, it is difficult to determine the related costs or to evaluate the appropriateness of new treatment methodologies for consumers of different clinical profiles.

Health Care-Related Costs of Treatment-Resistant Depression

"The cost of depression in the United States in the year 2000 was estimated to be $83 billion. Of this figure, $26 billion was associated with treatment costs and the remaining *$57* billion in costs was due to absenteeism, reduced productivity at work, and the value of lifetime earnings lost as a result of suicide-related deaths. While the costs of depression are certainly significant, the major portion of costs can be attributed to the condition of treatment-resistant depression. A recent study found that the annual treatment costs for individuals with non-treatment-resistant depression were $6,500 while the annual costs for individuals with treatment-resistant depression were over six times that amount, or $42,300. (In this study, individuals with treatment-resistant depression were defined as those who switched medications at least once, were hospitalized, and/or had a recorded suicide attempt.) Another study found that total health care costs for individuals with treatment-resistant depression (defined as eight medication switches) were $14,000 versus $6,200 for those with two medication switches or less. For those organizations that provide health care benefits, whether corporations, government entities, or health plans, treatment-resistant depression is a major cost contributor.

"From an ethical and moral standpoint, in addition to being arguably more important than the issues surrounding health care costs associated with chronic depression, one must consider the issue of suicide. In 2001, in the United States, suicide took the lives of 30,622 people; 132,353 individuals were hospitalized following suicide attempts; and 116,639 were treated in emergency departments and released. Depression is a major risk factor for suicide and individuals whose depressive symptoms are not relieved through conventional treatment are at elevated risk for suicide.

Standards of Scientific Evidence & Consumer Access to New Technologies

"Given the limited efficacy of currently available treatments for a third of the consumer population with depression, and the costs of treatment-resistant consumers to health plans, the question of treatment alternatives arises. There is an emerging group of non-pharmaceutical neurotechnology treatments for consideration in patient care. There are two related questions to contemplate as health care payers and policymakers evaluate the issues of evidence required to make decisions to facilitate consumer access to these emerging neurotechnologies. The first is a question relevant to all chronic health care conditions — what evidence and related policies are required to determine that a new treatment is safe and/or efficacious for individuals with chronic health care conditions? The second question is one of treatment options— how should this evidence be evaluated in situations where consumers have a life-threatening disease and no other treatment options?

"With regard to evaluation of treatments for chronic disease, there has been discussion of alternatives to the use of randomized controlled trials (RCT). RCT has long been the 'gold standard' of evidence for approval by the Food and Drug Administration (FDA). However, RCT has limitations in the evaluation of treatment interventions for chronic diseases. RCT designs are typically short-term, consider a single variable, and do not evaluate efficacy in the context of complex, multi-factor chronic diseases. In fact, RCT study designs

About the Task Force

The National Task Force on Consumer Access to Emerging Neurotechnologies was formed with a three-fold focus:

1. To increase understanding within the payer, provider, and consumer advocacy communities of the available and appropriate use of new neurotechnologies
2. To promote standardized clinical decision-making criteria, consumer access processes, and reimbursement policies for appropriate neurotechnologies
3. To promote parity and equity in consumer access to new technologies for treatment of these conditions

The inaugural meeting of the Task Force revolved around a discussion of the policy, financing, and clinical practice issues that will affect consumer access to new neurotechnologies, specifically focusing on the recently available neurotechnologies for the treatment of depression.

The discussion centered on four areas — the state of current research on depression treatment efficacy and its implications for depression treatment guidelines; how to define depression that is resistant to currently available treatment options; the cost of treatment-resistant depression; and current thinking on the standards of scientific evidence required to make new depression treatment technologies available to consumers.

*Continued on page 4 (***Beyond STAR*D)**

BEYOND STAR*D *(Cont'd. from page3)*

typically exclude individuals with chronic illness because of design requirements to withhold treatment from a 'control' group --- a clinical situation that is neither practical nor ethical for individuals with a chronic life-threatening disease.

"As the scientific and regulatory community considers the effectiveness of emerging treatments for chronic disease, research design should move beyond RCT. STAR*D is one such example --- a "practical trial" that assessed effectiveness in real-world clinical situations. Another such methodological option is the practice-based evidence (PBE) study design. PBE is a prospective, observational, cohort study methodology that allows analysis of 'real world' treatment factors (interventions, processes, professionals, etc.) and consumer factors (diagnoses, functionality, demographic characteristics, etc.) over time. These types of approaches can employ severity adjustment methodologies to remove selection bias, a critical factor for evaluating chronic conditions, and have the benefit of comparing active treatments in terms of a number of clinical outcomes. Research approaches like practical trials and PBE are better suited to evaluate new treatments for chronic diseases than traditional RCT models.

"For consumers, payers, and regulators, the juxtaposition of limited treatment options, costs of the illness, and ill-fitting standards of evidence have created a 'perfect policy storm.' A third of consumers suffering from depression do not respond to available treatment options and are at high risk for increased illness and mortality at a significant cost to health plans. At the same time, the standards of evidence typically used to assess new health care interventions are not appropriate in a population with a chronic condition like depression.

"To resolve this situation, the health care field needs a collaborative industry initiative representing regulators, payers, and consumers to develop a shared set of standards for addressing the issues of policy, financing, and practice for these emerging neurotechnologies. For each emerging treatment intervention, a collaborative consensus is needed to specify the instances where conditional use should be permitted and to establish shared clinical criteria for conditional use. In addition, a collaborative consensus is needed on standards of evidence for chronic health care conditions and a scientifically valid model for measuring the efficacy of each intervention in the population that is granted conditional use to the new treatment intervention.

"In the near future, the fruits of extensive clinical research will yield an expanding array of new neurotechnologies that will be available to consumers. These new technologies enter a health care policy environment where the standards of evidence must be re-evaluated to address the growing proportion of health care conditions that are chronic rather than acute. This evaluation must also consider the rapid growth in health care spending on these chronic conditions. To address this situation, payers need new clinical guidelines and standards of evidence to assure appropriate use of health care resources and safety for their members. These guidelines and standards must be forged by a consensus with regulators and consumer advocates. At the same time, these new standards must provide consumers who suffer from life-threatening conditions, and no other treatment options, with timely and appropriate access to these new treatment alternatives."

This article is excerpted from "Issues in Access to New Treatment Options for Individuals with Severe Depression, A White Paper" by the National Task Force on Consumer Access to Emerging Neurotechnologies, which can be accessed at www.openminds.com/indres/042507tfiwhitepaper.htm. The National Task Force is supported by grants and sponsorships, with Cyberonics prot'iding support for its initial meeting.

For more information regarding the Task Force, please contact Monica E.Oss, Chief Executive Officer or Laura Rudisill, Task Force Manager OPEN MINDS, 163 York Street, Gettysburg, Pennsylvania 17325; 717-334-1329,Fax: 717-334-0538; E-mail: lrudisill@openmindc.com; Web site: www.openminds. com

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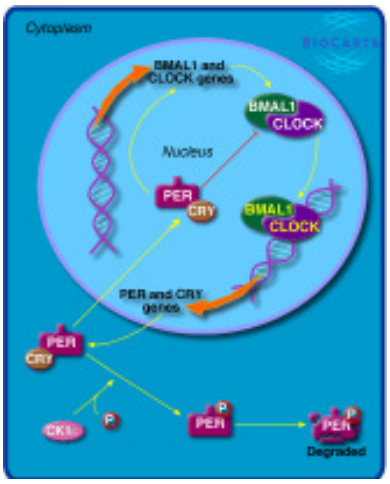
Source OPEN MINDS
June 2007

Circadian Rythm Linked to Bipolar Disorder



TUESDAY, March 20 (HealthDay News) — A gene involved in regulating circadian rhythms — daily rhythms, including the wake/sleep cycle — may also play a central role in the manic phase of bipolar disorder.

Mice with a particular mutation in the CLOCK gene, which is central in regulating circadian rhythms, displayed behavior very similar to manic behavior in humans. Given lithium, a drug used to treat bipolar disorder, the mice returned to many of their normal behaviors.

The findings could serve as a launching point for further research into bipolar disorder, whose mechanisms continue to elude scientists.

"It gives us a really nice model of mania to be able to study how mania develops and how the treatments for mania work, because a lot of the actions of mood stabilizers have been a mystery," said Colleen McClung, study senior author and assistant professor of psychiatry at the University of Texas Southwestern Medical Center at Dallas. "Bipolar has been difficult to study."

David J. Earnest, a professor of neuroscience and experimental therapeutics at Texas A&M Health Science Center College of Medicine, added: "It really does provide something beyond an associative or correlative observation that circadian rhythms are disturbed when patients are experiencing bipolar disorder. In this animal model, this mutation in the CLOCK gene produces behavioral patterns which are very similar to bipolar disorder."

Scientists have long suspected that circadian rhythms might be involved in psychiatric disorders, particularly bipolar disorder.

Bipolar disorder is characterized by alternating swings of very high and very low — or depressed — moods, along with changes in energy and the ability to function. About 5.7 million American adults, or about 2.6 percent of the population 18 and older, may have bipolar disorder, according to the U.S. National Institute of Mental Health.

Almost all people suffering from this disorder also have irregularities in circadian functions including sleep/wake, hormonal, appetite and body temperature. Major disruptions in the sleep/wake cycle can trigger a bipolar episode. And many of the treatments for bipolar disorder, such as lithium, can shift circadian rhythms.

There has been some indication that the CLOCK gene, one of the most important genes involved in circadian rhythm, might also be implicated in the disorder. But the evidence hasn't been definitive.

"I think the connection has always been there, but most of the studies were correlative," Earnest said. "We really couldn't say that there was a definitive connection between circadian rhythm disturbances. It was just an association."

For the new study, which appears in this week's *Proceedings of the National Academy of Sciences*, McClung and her colleagues tested mice that had a mutation in the CLOCK gene to see if there were similarities to humans with bipolar disorder.

Indeed, the mice exhibited hyperactivity, more risk taking, a preference for "reward" substances such as cocaine and sugar, and less depression.

And when the mice were given lithium, their behavior stabilized.

"Taken together, this whole profile of behaviors is very similar to bipolar patients when they're in a manic stage," McClung said. "This is really important, because there hasn't been a good or complete model of human mania. This is the most complete model ever described."

The researchers went one step further to try to determine what part of the brain was involved. When they put a functional clock gene back into the dopamine cells of the mice (dopamine is involved in reward and mood regulation), they found this also corrected some of the manic behaviors.

"This is exciting, because it pinpoints the area of the brain where CLOCK is functioning," McClung said. "We really didn't know what CLOCK was doing there. It looks like CLOCK is regulating dopamine activities, and that could be what's causing these types of behaviors."

But Earnest also issued some caveats.

"The overall behavior of the mice looks very similar to what you see in patients with bipolar disorder," he said. "But how do we fully equate what we see in their activity to a clinical situation with regard to bipolar depression? We can argue one way or the other that this is fully indicative of an animal model for bipolar depression."

Source: National Institute of Mental Health
March 20, 2007

Bipolar Patients on Lithium Show Brain-Tissue Growth

By Mark Moran

Patients on lithium had significant increase in the cingulate and paralimbic regions of the brain, which regulate attention and emotion.

Lithium appears to increase gray matter in the brains of patients who use the drug, according to a report that will appear in Biological Psychiatry in July.

In a statement about the study released prior to publication, neuroscientists at UCLA said they have shown that lithium, long the standard treatment for bipolar disorder, increases the amount of gray matter in the brains of patients with the illness.

"Bipolar patients who were taking lithium had a striking increase in gray matter in the cingulate and paralimbic regions of the brain," Carrie Bearden, Ph.D., a clinical neuropsychologist and assistant professor of psychiatry at UCLA said in the statement. "These regions regulate attention, motivation, and emotion, which are profoundly affected in bipolar illness."

In this study, Bearden and colleagues at UCLA used computer analysis to analyze brain scans collected by collaborators at the University of Pittsburgh in order to determine whether bipolar patients showed changes in brain tissue and, if so, whether those changes were influenced by lithium treatment.

They employed high-resolution MRI and cortical pattern-matching methods to map gray-matter differences in 28 adults with bipolar disorder — 70 percent of whom were treated with lithium—and 28 healthy control subjects. Detailed spatial analyses of gray matter distribution were conducted by measuring local volumes of gray matter at thousands of locations in the brain.

While the brains of lithium-treated bipolar patients did not differ from those of the control subjects in total white matter volume, their overall gray matter volume was significantly higher, sometimes by as much as 15 percent.

Although other studies have measured increases in the overall volume of the brain, Bearden said, this imaging method allowed the researchers to see exactly which brain regions were affected by lithium. These new findings suggest that lithium may work by increasing the amount of gray matter in particular brain areas, which in turn suggests that existing gray matter in these regions of bipolar brains may be underused or dysfunctional. Bearden added that there is no evidence that the increase in gray matter persists if lithium treatment is discontinued. "But it does suggest that lithium can have dramatic effects on gray matter in the brain," she said. "This may be an important clue as to how and why it works."

Source: Psychiatric News
As seen in: DBSA Tampa Bay Newsletter
June-July-August 2007

Victories Over Borderline Personality Disorder

Success in the care and treatment of borderline personality disorder (see *Harvard Mental Health Letter,* June and July 2006) is likely, according to two studies published in the *American Journal of Psychiatry* this spring. One study finds that several kinds of psychotherapy are effective treatments for the disorder; the other concludes that over a longer period, people often recover from it anyway.

In the psychotherapy trial, 62 patients were divided into three groups and randomly assigned for a year to transference-focused therapy, dialectical behavior therapy, or supportive therapy.

Transference-focused therapy (a version of psychodynamic therapy) concentrates on feelings and attitudes derived from earlier relationships that reemerge in the relationship between the patient and the therapist. Dialectical behavior therapy uses various structured techniques and education to help patients regulate their emotions. Supportive therapy provides sympathetic listening, practical feedback, and reassurance. Dialectical behavior therapy and transference-focused therapy were conducted twice a week, supportive therapy once a week.

All three psychotherapies reduced depression and anxiety and improved patients' social functioning. Transference-focused therapy and dialectical behavior therapy reduced suicidal thinking and behavior. Transference-focused therapy and supportive therapy reduced anger. Only transference-focused therapy reduced impulsiveness, irritability, and verbal assaults. The dropout rate was low and the same in all three groups.

A second study shows that many of the most serious symptoms of borderline personality disorder fade with time. The authors followed the progress of nearly 300 patients, most of whom were interviewed every 2 years for 10 years. In 85% of the patients, acute symptoms of borderline personality—delusional thinking, wrist cutting, overdoses, drug and alcohol abuse, stormy and demanding personal relationships, and wild mood fluctuations—largely disappeared.

Other symptoms, many of them reflecting chronic unhappiness and difficulty in maintaining connections with others—depression, intense anger, paranoid thinking, feelings of loneliness, emptiness and fear of abandonment, spending sprees and eating binges—were more likely to persist, but even these symptoms went away in 60% to 80% of patients. Over all, nearly 90% of patients diagnosed with borderline personality at the beginning of the study no longer qualified for the diagnosis at their last interview.

The authors wonder whether mental health professionals

*Continued on page 7 (***Victories Over BPD)**

Campaign to recognise dangers of mental illness

BY JEREMY LAURENCE

Published: September 4, 2007

An international alliance of specialists in mental health is launching a campaign today to shift the focus of the world's attention from disorders of the body to disorders of the mind.

Some 30 per cent of the world's population suffer some form of mental disorder each year, yet at least two-thirds receive inadequate or no treatment, even in countries with the best resources, such as the UK.

Mental illness outranks cancer and heart disease as a cause of chronic ill health — mainly due to the disabling nature of depression and alcohol or drug problems — yet it attracts a fraction of the resources of these more fashionable conditions.

In a series of articles published in The Lancet, experts from the World Health Organisation, the London School of Hygiene and the Institute of Psychiatry in the UK appeal to governments and medical organisations around the world to increase funding for mental health and make it a central theme of their wider health strategy.

As much as 14 per cent of the global disease burden is attributable to mental illness according to estimates by WHO in 2005, yet the condition is marked by stigma and neglect. Almost a quarter (23 per cent) of the global burden of disability is due to mental problems, compared with 21 per cent for heart disease and stroke and 11 per cent for cancer.

Professor Martin Prince of the Institute of Psychiatry said even those high figures were likely to be an underestimate because the impact of mental health on physical health went unrecognised.

The most obvious fatal impact of depression was when it led sufferers to take their own lives with 800,000 suicides each year around the world, nine out of ten of whom suffered a serious mental problem in the weeks leading up to their deaths.

But depression carried an increased risk of death for other reasons, such as by contributing to a less healthy lifestyle with more smoking and less exercise.

Stigma also played a part in denying mental patients treatment for physical illness. An Australian study found mental patients with heart disease were less than half as likely to receive surgery for their condition and were 80 per cent more likely to die from it than unaffected patients.

"We have missed these links [between mental and physical health]. Without them we fail to capture the full impact of mental illness," Professor Prince said.

Almost a third of countries worldwide have no budget for mental health and one-fifth of those that have, spend less than one percent of their total health budget on it, compared with 10 per cent in the UK. Shekhar Saxena of WHO said inequities in provision were rampant.

"High income countries have up to 200 times more psychiatrists, psychiatric nurses and psychologists. Low income countries are losing resources — in two years time the situation will be even worse," he said.

"Too often, countries were training more psychiatrists and investing in expensive mental hospitals and beds when the money would be better spent on psychiatric nurses and community care," he said.

Professor Vukram Patel of the London School of Hygiene said there was robust evidence to show that scaling up services in countries where they were most sparse was cost-effective. Over 10 years the cost was estimated at $2 a person in tow income countries and $3-$4 in middle income countries.

Richard Horton, editor of The Lancet said there had been "a critical failure of leadership" by Western countries.

Source: Independent News and Media
The Independent Online Edition-Health
September 5, 2007

New drug effective with major depression

Desvenlafaxine is effective in the short term treatment of major depression, according to a report in the May issue of the *Journal of Clinical Psychiatry.* This is a new antidepressant that has completed Phase III trials and is awaiting FDA approval, according to the drug maker, Wyeth. It is expected to be marked under the brand name Pristiq.

In the tests, desvenlafaxine was most effective at the 100 and 400 mg in comparison to the placebo. It was well tolerated by patients, particularly at the 100 mg dosage. It is expected to have low potential for drug interactions and the most common side effects include nausea, insomnia, dry mouth, dizziness, sweating and nervousness.

Source: ADAMhs ADVANTAGE
as affiliate of DBSA Archbold, Ohio
July/August 2007

VICTORIES OVER BPD

(Continued from page 6)

have been thinking about borderline personality disorder in a way that unnecessarily discourages them from attempting to treat it. Adult personality may be relatively fixed, but this study shows that a personality disorder, as defined by the American Psychiatric Association, is subject to change. And results appearing in the same issue of the *American Journal of Psychiatry* show that psychotherapy can hasten that change.

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Source: Harvard Mental Health Letter
September 2007

As Co-pay Rises, Prescription Use Drops

BY NICOLE OSTRO
Bloomberg

When patients pay more for prescription medicine, they use it less, according to a new study. Researchers say this may spur more serious illnesses over time.

Consumers spend 2% to 6% less on prescription drugs for each 10% rise in their out-of-pocket costs for such things as rising deductibles, the amount paid up front for insurance-based healthcare, said a review of 132 studies released today by the Rand Corp., a Santa Monica-based public policy institute.

Consumer outlays are rising as companies seek to hold the line on spending by raising deductibles and offering their workers co-insurance plans that split costs.

A study this year in the journal Health Affairs found consumers may spend $440.8 billion out of pocket in 2016, or 76% more than in 2006.

More study is needed to determine if such an increase will push consumers to forgo necessary treatment, researchers said.

"For patients with certain chronic illnesses, when you increase cost-sharing on the pharmacy side, you end up with more hospitalizations and more use of emergency departments," said Dana Goldman, lead author of the new study, which was published in the Journal of the American Medical Assn.

Goldman, Rand's director of health economics, said his analysis also found that certain cost-containment programs, including requiring that patients get a note from a doctor for a specific medicine, don't affect general pharmaceutical costs.

The analysis included research on prescription drug cost-saving strategies that include use of co-payments and monthly prescription limits.

The results build on a 2004 Rand finding that said doubling drug co-payments decreased use of eight classes of medicines.

The latest Rand report suggests that businesses and the U.S. government need to better understand how patients will respond to cost-saving measures before choosing new directions for healthcare spending.

"The challenge for public and private plans is to make patients more sensitive to the cost of treatment without encouraging them to forgo cost-effective care," the study authors wrote.

Prescription drug spending in the U.S. was $200.7 billion in 2005, up from $40.3 billion in 1990, according to a May report by the Kaiser Family Foundation.

Source: Los Angeles Times
July 6, 2007

VA to Expand Mental Health Care

Initiative: It will help allow testing of all veterans from Iraq and Afghanistan for brain injuries.

BY HOPE YEN
THE ASSOCIATED PRESS

ALEXANDRIA, VA. — Veterans Affairs Secretary Jim Nicholson pledged Monday to add mental health services at more than 100 VA medical centers to fight resistance to seeking help for depression and other illnesses.

The VA is being pressed by growing cases of mental health problems such as post-traumatic stress disorder and traumatic brain injury from veterans returning from Iraq and Afghanistan, Nicholson said at a forum of VA mental health experts. He said the department will work harder to meet the challenge.

To fight stigma against seeking help for anxiety and depression, the VA this year is devoting $37.7 million of its almost $3 billion mental health budget toward placing psychiatrists, psychologists and social workers within primary care clinics.

The additions will take effect in two-thirds of the VA's 153 medical centers, supplementing mental services already offered at the department's 882 outpatient clinics.

Such a move will help allow the VA to begin testing all veterans from Iraq and Afghanistan for mild to moderate brain injury, an often unseen problem that can emerge months after finishing service. It would also allow for brief treatment for those who may not require specialty care, Nicholson said.

"Given the possible reluctance of some veterans to talk about emotional problems, increasing our mental health presence in primary care settings will give veterans a familiar venue in which to receive care without actually going to an identified mental health clinic," he said.

Other measures under way:

- Adding 23 new VA-run Vet Centers, which are small, store-front walk-in clinics with a staff of about 5 people, to reach a total of 232 centers nationwide. The centers provide combat stress counseling, marriage therapy, job assistance and medical referrals, although recent congressional surveys found them to be understaffed with long wait times due to increased demand for services.
- Hiring more suicide prevention coordinators for VA medical centers and keeping emergency services for mental health open around the clock, as well as starting a full-time suicide prevention hot line. This comes after the VA inspector general earlier this year found that veterans were at increased risk of suicide because of spotty services in clinics nationwide.
- Hosting state mental health conferences to facilitate collaboration of veterans services on a state, local and community level. Some state officials have complained that the VA needs to do a better job of sharing information about wounded soldiers returning home so states can help.

Source: Riverside Press-Enterprise
July 17, 2007

Clip and Keep!

Educational Resources

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

HOSPITAL STAYS

(Cont'd from page. 9, column 3)

mood disorders (depression and bipolar) at 1 in 10 hospital stays, substance-related disorders (abuse, dependence or withdrawal) at 1 in 14 stays, dementia at 1 in 20 stays, and anxiety disorders, and schizophrenia.

Having some type of mental health or substance abuse related diagnosis was also related to longer hospital stays (*5.8* days compared to *4.5* days). Hospitalizations for the disorders mentioned above cost $9.9 billion with Medicare or Medicaid paying 78 percent of that.

Structural changes occur in the brain 4 years before cognitive impairment

Structural brain changes precede clinical signs and symptoms in "normal" subjects who go on to develop mild cognitive impairment, according to a study reported in the April 17 issue of *Neurology.*

"We found changes in brain structure are present in clinically normal people an average of four years before a diagnosis," study author Charles Smith, M.D., said.

While it is felt that mild cognitive impairment (MCI) is a frequent precursor to Alzheimer's disease (AD) this is the first study to show that there are physical changes in the brain even before these diseases become obvious.

"We knew that people with MCI or AD had less brain volume, but before now we didn't know whether these brain structure changes existed before memory loss begins and to what degree," Dr. Smith said.

Source: ADAMhs ADVANTAGE as affiliate of DBSA Archbold, Ohio July/August 2007

Mental health, substance abuse account for nearly I in 4 hospital stays

In 2004, some 24 percent of adults admitted to community hospitals in the United States had mental health or substance abuse disorders according to a recent report.

Anne Elixhauser, a co-author of the report which was issued by the US Department of Health and Human Services, explained, "Part of the motivation for putting (the report) together was that we know that psychiatric hospitals have been closing and there are fewer psychiatric treatment facilities." She added that learning one in four hospital stays involved adults with some mention of a mental illness was "really surprising."

Specifically, of the 32 million hospital discharges in 2004, 7.6 million involved patients with a mental illness (and for 1.9 million of those patients it was the primary diagnosis).

The most common diagnoses were

Source: ADAMhs ADVANTAGE as affiliate of DBSA Archbald, Ohio July/August 2007

Continued page 9, Column 1 **(Hospital Stays)**

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

☎

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

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

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