

Subject: Studies in the News: (July 31, 2007)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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The following are the Subject Headings included in this issue:

Children and Adolescent Mental Health

Maternal Depression

Mental Health Policies

Report to the President on Issues Raised by Virginia Tragedy

Suicide Prevention

Trauma/Posttraumatic Stress Disorder

The following studies are currently on hand:

CHILD AND ADOLESCENT MENTAL HEALTH

Challenges and Opportunities in Children’s Mental Health: A View from Families and Youth. By Sarah Dababnah and Janice Cooper, National Center for Children in Poverty. Unclaimed Children Revisited. Working Paper No. 1. (The Center, New York, New York) July 2007. 44 p.

[“Children and youth with mental health problems and their families need the appropriate skills, tools, services, and supports to reach their full potential as productive, contributing citizens. Quality mental health services and supports can significantly improve their ability to attain school success, mental health, and social and emotional well-being, to maintain healthy relationships, to remain in stable living situations, and to stay out of jail and the juvenile justice system.

This report, based on a meeting of youth and family members of children and youth who experience mental health problems, highlights how family-driven and youth-guided values and frameworks can improve research, policy, and practice and ultimately result in better care and healthier children and youth....The full report also includes examples of research, policy, and practice that involve families and youth as active partners.”]

Full text at: http://www.nccp.org/publications/pdf/text_673.pdf

[Request #S07-102-683]

Child and Youth Emergency Mental Health Care: A National Problem. By Janice L. Cooper, Columbia University, and Rachel Masi, National Center for Children in Poverty. Unclaimed Children Revisited. Issue Brief No. 1. (The Center, New York, New York.) July 2007. 14 p.

[“Increases in emergency use rates for mental health care by children and youth are emblematic of problems with access to community-based mental health services and supports. These visits further stretch an overextended emergency health care system. Emergency departments are poorly equipped to address the mental health needs of children, youth, and their families who seek psychiatric attention. While they encounter challenges meeting the need for pediatric and adolescent services, they are even less prepared to provide pediatric and adolescent mental health care.

This issue brief reviews the state of mental health services for children and youth who visit hospital emergency departments for mental health-related reasons and provides an overview of the challenges associated with mental health-related emergency department visits. It discusses the policy implications of using emergency department services for mental health reasons for children and youth and makes recommendations for policy action.”]

Full text at: http://www.nccp.org/publications/pdf/text_750.pdf

[Request #S07-102-684]

Children’s Mental Health: States Reach Out to the Youngest Patients. By Jennifer Stedron, National Conference of State Legislatures. In Depth State Health Notes. Vol. 27, No. 473. (NCSL, Washington, DC) August 7, 2006. 3 p.

[“Eleven-year-old ‘Mia’s’ suicide threat was shocking, despite her increasing moodiness and acting out in school. Like many parents, her mother could trace the start of her problems back to toddlerhood; even at 18 months her violent mood swings had made her a ‘difficult’ child. With the situation now so dire, her mother agonized: could Mia’s serious depression have been prevented if she had received professional help in her early years?

According to a growing mound of research, the answer is: yes. Research suggests that early concerns, such as withdrawal or sleeplessness, can be predictors of later mental health problems. And early intervention for those concerns, such as parent-infant therapy, may ward off later depression or developmental delays—which can improve school readiness and academic success, in addition to overall child (and later, adult) well-being.

In an effort to prevent mental health problems, some states are launching innovative programs. In Vermont, the Children’s Upstream Services Initiative ([CUPS](#)) garnered national attention after [research](#) showed that it had significantly reduced parents’ stress and improved the developmental health of children. Wisconsin’s [Think Big, Start Small](#) program is designed to increase public awareness of early childhood issues, including infant mental health. And a pilot program in Massachusetts promotes identification of and intervention services for at-risk children.

But finding resources for programs whose payoff is not immediate can be difficult, especially when other programs are competing for funds. Says Vermont Sen. Jim Leddy, who headed a community mental-health center for 20 years, prevention programs are ‘the last to be funded and the first to be cut.’”]

Full text at: <http://www.ncsl.org/print/health/shn/id473.pdf>

[Request #S07-102-685]

“Stigma, Obesity, and the Health of the Nation’s Children.” By Rebecca M. Puhl, Yale University, and Janet D. Latner, University of Hawaii at Manoa. IN: Psychological Bulletin, vol. 133, no. 4 (July 2007) pp. 557-580.

[“Preventing childhood obesity has become a top priority in efforts to improve our nation’s public health. Although much research is needed to address this health crisis, it is important to approach childhood obesity with an understanding of the social stigma that

obese youths face, which is pervasive and can have serious consequences for emotional and physical health. This report reviews existing research on weight stigma in children and adolescents, with attention to the nature and extent of weight bias toward obese youths and to the primary sources of stigma in their lives, including peers, educators, and parents. The authors also examine the literature on psychosocial and physical health consequences of childhood obesity to illustrate the role that weight stigma may play in mediating negative health outcomes. The authors then review stigma-reduction efforts that have been tested to improve attitudes toward obese children, and they highlight complex questions about the role of weight bias in childhood obesity prevention. With these literatures assembled, areas of research are outlined to guide efforts on weight stigma in youths, with an emphasis on the importance of studying the effect of weight stigma on physical health outcomes and identifying effective interventions to improve attitudes.”]

Full text at: <http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=bul-133-4-557&site=ehost-live>

[Request #S07-102-686]

Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma. By Janice L. Cooper, Columbia University Mailman School of Public Health, and others. Unclaimed Children Revisited. Working Paper No. 2. (National Center for Children in Poverty, New York, New York) July 2007. 102 p.

[“On 1982, Jane Knitzer’s seminal study, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, called attention to the desperate state of the mental health system for children and adolescents with mental health problems and their families. The study became a turning point in the mental health field and led to a series of reforms. Twenty-five years later, the National Center for Children in Poverty (NCCP) has undertaken a national initiative to reexamine the status of policies that impact the optimal well-being of children and adolescents with or at increased risk for mental health problems and their families. As part of that initiative, NCCP convened roundtable discussions to help us better understand critical issues that deeply impact the lives of children, youth, and families experiencing mental health problems.

This report, the second of five special reports, is based on a forum convened by the National Center for Children in Poverty with support from the Annie E. Casey Foundation.”]

Full text at: http://www.nccp.org/publications/pdf/text_737.pdf

[Request #S07-102-687]

Summaries of Research on Mental Health Services for Children and Adolescents and their Families. By the Research and Training Center for Family Support and

Children’s Mental Health, Portland State University. Data Trends. No. 146. (The Center, Portland, Oregon) June 2007. 2 p.

[In the article, *Qualities to Look for in Mental health Consultation for Early Childhood Settings*, (Green and others, 2006), the authors ‘sought to determine the most important characteristics of early childhood mental health consultants (MHCs) in predicting both positive child and staff outcomes within Head Start programs....’

This study examined several aspects of early childhood MHC, and their relation to the effectiveness of consultation. Overall, the individual characteristics of the MHC (race, degree, type of practice) are less important to the perceived effectiveness of their consultation than the frequency with which they provide services, and the quality of relationship between the consultant and staff. Ultimately, it is the quality of the relationship the MHC has with Head Start staff that is most predictive of positive perceived impact on child outcomes...the authors conclude that MHCs who were reported as being most effective were not considered ‘outside experts’ but instead integral members of a collaborative team. Ultimately ‘relationships are the foundation of effective early childhood intervention services.’”]

Full text at: <http://www.rtc.pdx.edu/PDF/dt146.pdf>

[Request #S07-102-688]

MATERNAL DEPRESSION

“Brief Maternal Depression Screening at Well-Child Visits.” By Ardis L. Olson, Dartmouth Medical School and others. IN: *Pediatrics*, vol. 118, no. 1 (July 2006) pp. 207-216.

[“The goals were (1) to determine the feasibility and yield of maternal depression screening during all well-child visits, (2) to understand how pediatricians and mothers respond to depression screening information, and (3) to assess the time required for discussion of screening results.

Implementation of brief depression screening of mothers at well-child visits for children of all ages was studied in 3 rural pediatric practices. Two screening trials introduced screening (1 month) and then determined whether screening could be sustained (6 months). Screening used the 2-question Patient Health Questionnaire. Practices tracked the proportions of visits screened and provided data about the screening process.

Practices were able to screen in the majority of well-child visits (74% in trial 1 and 67% in trial 2). Of 1398 mothers screened, 17% had 1 of the depressive symptoms and 6% ($n = 88$) scored as being at risk for a major depressive disorder. During discussion, 5.7% of all mothers thought they might be depressed and 4.7% thought they were stressed but not depressed. Pediatric clinicians intervened with 62.4% of mothers who screened positive and 38.2% of mothers with lesser symptoms. Pediatrician actions included discussion of

the impact on the child, a follow-up visit or call, and referral to an adult primary care provider, a mental health clinician, or community supports. Pediatrician time needed to discuss screening results decreased in the second trial. Prolonged discussion time was uncommon (5–10 minutes in 3% of all well-child visits and >10 minutes in 2%).

Routine, brief, maternal depression screening conducted during well-child visits was feasible and detected mothers who were willing to discuss depression and stress issues with their pediatrician. The discussion after screening revealed additional mothers who felt depressed among those with lesser symptoms. The additional discussion time was usually brief and resulted in specific pediatrician actions.”]

Full text at: <http://pediatrics.aappublications.org/cgi/reprint/118/1/207>

[Request #S07-102-689]

MENTAL HEALTH POLICIES

“Benefits for Employees with Children with Special Needs: Findings from the Collaborative Employee Benefit Study.” By James M. Perrin, Harvard Medical School, and others. IN: Health Affairs, vol. 26, no. 4 (2007) pp. 1096-1104.

[“Approximately 13 – 15 percent of children and adolescents in the United States have chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required by children generally. For about half of these children, the condition causes disability or limits their ability to do what other children can do. In 1960 this rate was just 2 percent, which indicates more than a threefold increase over the past few decades. Some growth represents increased survival for a number of rare childhood conditions, although more reflects major growth in relatively common conditions such as asthma, obesity, and mental health conditions (for example, attention deficit hyperactivity disorder [ADHD] and depression). Children with chronic health conditions or special health care needs require more health services than other children do, often unpredictably. They also may require specialized or adaptive care from other service systems, especially the education system or specialized caregivers.

These increases in the number of children with special needs have coincided with a shift in U.S. population and workplace demographics. Increases in the number of working mothers and in both single-parent and dual-earner households have altered the boundary between the workplace and home. For many families, new economic realities have created competing demands between work and family responsibilities. Caring for children with special health care needs amplifies these work-family challenges.”]

Full text at: <http://content.healthaffairs.org/cgi/content/full/26/4/1096>

[Request #S07-102-690]

REPORT TO THE PRESIDENT ON ISSUES RAISED BY THE VIRGINIA TECH TRAGEDY

Report to the President on Issues Raised by the Virginia Tech Tragedy. By Michael Leavitt, Department of Health and Human Services, Margaret Spellings, Department of Education and Attorney General Alberto Gonzales, Department of Justice. (Department of Health and Human Services, Washington, DC) June 13, 2007. 26 p.

[“The Virginia Tech tragedy was deeply felt throughout America. People everywhere we traveled extended their hearts and prayers to the families and friends of the victims. The tragedy also raised issues with which our society has long grappled....

This report does not seek to investigate the specifics of the Virginia Tech tragedy itself. That work is currently being done by the Virginia Tech Review Panel appointed by Governor Kaine. Instead, this report summarizes the major recurring themes we heard in our visits across the country. It includes critical steps state and local leaders identified to address school violence and mental illness at the community level.

The report includes recommended actions the federal government can take to support state and local communities and ensure that the federal government and federal law are not obstacles to achieving these goals. The recommended action items are not, individually or together, a panacea for the many complex issues our society confronts in trying to prevent another tragedy. Rather, they are an attempt to frame the issues and identify tangible steps we can take over time to prevent events like the Virginia tragedy.”]

Full text at: <http://www.hhs.gov/vtreport.pdf>

[Request #S07-102-691]

SUICIDE PREVENTION

Healthcare Inspection: Implementing VHA’s Mental Health Strategic Plan Initiatives for Suicide Prevention. By Department of Veteran Affairs Office of Inspector General. Report No.06-03706-126. (VA Office of Inspector General, Washington, DC) May 10, 2007. 79 p.

[“In response to a request from a member of the U.S. House of Representatives, Committee on Veteran’s Affairs, The Office of the Inspector General (OIG) undertook an assessment of Veterans Health Administration’s (VHA’s) progress in implementing initiatives for suicide prevention from *A Comprehensive VHA Strategic Plan for Mental Health Services*. Centers for Disease Control and Prevention (CDC) data indicate that in 2004 there were 32,439 known completed suicides in the United States, which accounted for 1.4 percent of overall deaths....

There are approximately 25 million veterans in the United States, and 5 million veterans who receive care within VHA. Based on CDC data indicating suicide rates in men between 20 and 65 approximating 20 per 100,000 per year and not controlling for VHA population specific epidemiologic factors, VHA mental health officials estimate 1,000 suicides per year among veterans receiving care within VHA and as many as 5,000 per year among all living veterans.

In this report we review what is known about the characteristics, nature, and rates of suicide. We also summarize related reports from the Surgeon General of the United States, the Institute of Medicine, and the President's New Freedom Commission on Mental Health, as well as *A Comprehensive VHA Strategic Plan for Mental Health Services*, known generally as VHA's Mental Health Strategic Plan (MHSP)."]

Full text at: <http://www.va.gov/oig/54/reports/VAOIG-06-03706-126.pdf>

[Request #S07-102-692]

North Dakota Program Decreases Youth Suicides. By Matthew Gever, National Conference of State Legislatures. State Health Notes. Vol. 27, No. 481 (NCSL, Washington, DC) December 11, 2006. 2 p.

[“After reaching frightening heights in the 1990s, youth suicide rates in **North Dakota** have steadily decreased in the 2000s. State and tribal leaders attribute much of the progress to the [North Dakota Adolescent Suicide Prevention Project](#).

Launched in 2000, the Project focuses on teens and young adults because of their disproportionate rates of suicide. During the 1990s, suicide rates for the 15-24 age group averaged 20.0 per 100,000 residents, almost twice the national average of 12.5 per 100,000 for the same age group. For teens and young adults, suicide “is our number two cause of death,” said Mark LoMurray, director of the Project.

The program has proven to be so successful that it received a national award from the American Public Health Association. From 2000 to 2004, youth suicides fell by 47 percent, according to LoMurray.

Project leaders work with dozens of tribal and rural communities to develop strategies such as training professionals and peers to recognize and help troubled youth, establishing mentoring programs and increasing access to treatment. (A survey showed that about 70 percent of youth and young adults who had contact with medical professionals due to a suicide attempt in rural and tribal North Dakota had received no services two weeks later.)”]

Full text at: <http://www.ncsl.org/programs/health/shn/2006/sn481b.htm>

[Request #S07-102-693]

“Utah Youth Suicide Study: Barriers to Mental Health Treatment for Adolescents.”
By M.A. Moskos, University of Utah School of Medicine, and others. IN: **Suicide & Life Threatening Behavior**, vol. 37, no. 2 (April 2007) pp. 179-186.

[“Forty-nine suicide cases were drawn from an original sample of 151 consecutive youth suicide deaths. We used information from 270 interviews with parents and other survivors to evaluate mental health treatment sought for and by the decedent and barriers to mental health treatment. Participants reported the same primary barriers for the decedent: belief that nothing could help, seeking help is a sign of weakness or failure, reluctance to admit to having mental health problems, denial of problems, and too embarrassed to seek help. It is suggested that the stigma of mental illness is a considerable barrier to mental health treatment.” NOTE: Journal available for loan.]

[Request #S07-102-694]

TRAUMA/POSTTRAUMATIC STRESS DISORDER

“Dissemination of Evidence-Based Mental Health Interventions: Importance to the Trauma Field.” By Wayne J. Katon and others. IN: **Journal of Traumatic Stress**, vol. 19, no. 5 (October 2006) pp. 611-623.

[“Randomized controlled trials have established the efficacy of psychotherapy and medication treatments for posttraumatic stress disorder (PTSD). Despite these advancements, many individuals do not receive guideline-concordant PTSD care. In an effort to advance dissemination of evidence-based PTSD treatments, the authors review several examples of dissemination efforts of mental health interventions. The first examples describe the dissemination of multifaceted collaborative care interventions for patients with depressive disorders and evidence-based interventions for patients with severe mental illness. The final example explores evolving efforts to adapt and disseminate interventions to acutely injured trauma survivors. For each example, the authors describe the problem with prior clinical approaches, the program to be disseminated, the barriers and levers to implementation and the progress in overcoming these barriers.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=22980427&site=ehost-live>

[Request #S07-102-695]

Facts about Trauma for Policymakers: Children’s Mental Health. By Janice L. Cooper, Columbia University Mailman School of Public Health. (National Center for Children in Poverty, New York, New York) July 2007. 4 p.

[“Trauma can result in long-and short-term problems. Research suggests that these can include physical and emotional health conditions and put those exposed to trauma at

increased risk for chronic ill health and premature death. For children and youth, in addition to health problems, other consequences of trauma included difficulties with learning, ongoing behavior problems, impaired relationships and poor social and emotional competence. Children and youth exposed to trauma, especially violence, experience more learning and academic difficulties and behavioral and mood-related problems. Research also shows that the younger children are when they experience trauma; the more vulnerable they are to its effects in brain development.”]

Full text at: http://www.nccp.org/publications/pdf/text_746.pdf

[Request #S07-102-696]

“The Impact of Resource Loss and Traumatic Growth on Probable PTSD and Depression Following Terrorist Attacks.” By S.E. Hobfoll, Kent State University, and others. IN: *Journal of Traumatic Stress*, vol. 19, no. 6 (December 2006) pp. 867-878.

[“The authors interviewed by phone 2,752 randomly selected individuals in New York City within 6 to 9 months after the attacks of September 11, 2001 on the World Trade Center, and 1,939 of these were reinterviewed at a 12- to 16-month follow-up. It was hypothesized that resource loss would significantly predict probable posttraumatic stress disorder (PTSD) and probable depression since September 11, and that resource loss's impact would be independent of previously identified predictors relating to individuals' demographic characteristics, history of stressful event exposure, prior trauma history, peritraumatic experience, and social support. Second, it was predicted that reported traumatic growth would be related to greater, not lesser, psychological distress. The authors' findings supported their hypotheses for resource loss, but traumatic growth was unrelated to psychological outcomes when other predictors were controlled.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=17195971&site=ehost-live>

[Request #S07-102-697]

“Posttraumatic Stress Disorder, Anger, and Partner Abuse among Vietnam Combat Veterans.” By Casey T. Taft, Veterans Affairs Boston Healthcare System, and others. IN: *Journal of Family Psychology*, vol. 21, no. 2 (June 2007) pp. 270-277.

[“The authors examined interrelationships among posttraumatic stress disorder (PTSD) symptomatology, anger, and partner abuse perpetration among a sample of 60 combat veterans. Compared with PTSD-negative participants, PTSD-positive participants reported higher state anger across time and neutral and trauma prime conditions and higher anger reactivity during the trauma prime condition. PTSD-positive participants also exhibited more anger reactivity during the trauma prime than during the neutral condition. The same pattern of results was not found for anxiety reactivity during *trauma*

memory activation. PTSD symptoms were associated with physical assault and psychological aggression perpetration, and trait anger mediated these relationships. Findings indicate a heightened anger response among PTSD-positive veterans and suggest the salience of dispositional components of anger in abuse perpetration in this population.”]

Full text at: <http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=fam-21-2-270&site=ehost-live>

[Request #S07-102-698]

**“Use of Mental Health Services among Disaster Survivors: Predisposing Factors.”
By Dirk-Jan Den Ouden, Netherlands Institute for Health Services Research, and others. IN: BioMedical Central Public Health, vol. 7 (2007) pp. 1-34.**

[“Given the high prevalence of mental health problems after disasters it is important to study health services utilization. This study examines predictors for mental health services (MHS) utilization among survivors of a man-made disaster in the Netherlands (May 2000).

Electronic records of survivors (n=339; over 18 years and older) registered in a mental health service (MHS) were linked with general practice based electronic medical records (EMRs) of survivors and data obtained in surveys. EMR data were available from 16 months pre-disaster until 3 years post-disaster....

In multiple logistic models, adjusting for demographic and disaster related variables, MHS utilization was predicted by demographic variables (young age, immigrant, public health insurance, and unemployment), disaster-related exposure (relocation and injuries), self-reported psychological problems and pre- and post-disaster physician diagnosed health problems (chronic diseases, musculoskeletal problems). After controlling for all health variables, disaster intrusions and avoidance reactions, hostility, pre-disaster chronic diseases, injuries as a result of the disaster, social functioning problems and younger age predicted MHS utilization within 18 months post-disaster. Furthermore, disaster intrusions and avoidance reactions and hostility predicted MHS utilization following 18 months post-disaster.

This study showed that several demographic and disaster-related variables and self-reported and physician diagnosed health problems predicted post-disaster MHS-use. The most important factors to predict post-disaster MHS utilization were disaster intrusions and avoidance reactions and symptoms of hostility (which can be identified as symptoms of PTSD) and pre-disaster chronic diseases.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2458-7-173.pdf>

[Request #S07-102-699]