

Subject: Studies in the News: (October 15, 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

Cultural Competency

Depression

First Episode Psychosis

Juvenile Justice and Mental Illness

Law and Mental Illness

**Mental Health Policies and Procedures
Mental Illness and Prisons
Suicide Prevention**

The following studies are currently on hand:

CHILDREN AND ADOLESCENT MENTAL HEALTH

A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children. By the Center on the Developing Child. (Harvard University, Cambridge, Massachusetts) August 2007. 36 p.

[“It is widely recognized that the path in our nation’s future prosperity and security begins with the well-being of all our children. To this end, one of the most important tasks facing policymakers is to choose wisely among strategies that address the needs of our youngest children and their families. Until now, confusing messages about which strategies actually can improve children’s life chances have presented enormous challenges to this decision-making process. As scientists, we believe that advances in the science of early childhood and early brain development, combined with the findings of four decades of rigorous program evaluation research, can now provide a strong foundation upon which policymakers and civic leaders with diverse political values can design a common, effective, and politically viable agenda. With this goal in mind, we describe in this report the process by which brain architecture is formed in very young children, with special attention to the important influence of early experiences on the production of a weak or sturdy foundation for future development, and integrate this scientific knowledge with the identification of those factors from the program evaluation literature that appear to offer the best course toward positive outcomes for children. We believe that this combination of neuroscience; child development research, and program evaluation data can provide an informed and pragmatic framework for those engaged in policy design and implementation.”]

Full text at:

http://www.developingchild.harvard.edu/content/downloads/Policy_Framework.pdf

[Request# S07-111-933]

Child Mental Health and Human Capital Accumulation: The Case of ADHD Revisited. By Jason Fletcher, Yale University, and Barbara L. Wolfe, University of Wisconsin. Working Paper. Number 13474. (National Bureau of Economic Research, Cambridge, Massachusetts) October 2007. 30 p.

[“Currie and Stabile (2006) (hereafter, JCMS) made a significant contribution to our understanding of the influence of ADHD (Attention Deficit Hyperactivity Disorder) symptoms on a variety of school outcomes including participation in special education, grade repetition and test scores. They did so using samples of children ages 4-12 who are

then tracked for 6 years, in the United States and Canada. Their contributions include using a broad sample of children, including symptoms rather than only diagnosed cases of ADHD and estimating sibling fixed effects models to control for unobserved family effects. In this paper we extend their findings by looking at a sample of slightly older children and confirm and extend many of the JCMS findings in terms of a broader set of measures of human capital.

Our contribution is to explore the issue of the impact of ADHD on a sample of somewhat older children and examine educational outcomes that occur somewhat later in life. We also explore family effects: that is, does having a sibling with ADHD play a role in human capital accumulation? We first report on the consistency of our results with those of JCMS using both a full sample and then a sibling or fixed effects approach. We then ask if the effect of ADHD on outcomes of older children is as negative as those on younger children. Finally we report on findings relating to family effects; that is, is the human capital accumulation of children who have a sibling with ADHD negatively affected? Following JCMS we also use responses to a set of symptoms of ADHD rather than focusing only on children with ADHD diagnosis.

As noted in JCMS, ADHD is the most common mental illness among young children. Children with ADHD may be hyperactive, inattentive or both. As such, they are more likely to have difficulties in concentrating and carrying out tasks in school, may be disorderly at home and in school and may be disruptive to those around them. With the exception of JCMS and recent papers by Fletcher and Wolfe (2007) and Fletcher and Lehrer (2007), most studies of the outcomes of ADHD on children do not control for other factors which may be associated with both the frequency of ADHD and these poor outcomes, such as living in disadvantaged communities and/or having parents with low levels of human capital. We follow these studies in using family fixed effects in an attempt to control for unobserved factors that might lie behind the prevalence of ADHD and negative outcomes.”]

Full text at: <http://www.nber.org/papers/w13474.pdf>

[Request# S07-111-934]

“Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample.” By William Gardner, Ohio State University, and others. IN: Journal of American Academy of Child and Adolescent Psychiatry, vol. 46, no. 5 (May 2007) pp. 611-618.

[“The objective of this study was to validate the 17-item version of the Pediatric Symptom Checklist (PSC-17) as a screen for common pediatric mental disorders in primary care. The patients were 269 children and adolescents (8-15 years old) whose parents completed the PSC-17 in primary care waiting rooms. Children were later assessed using the Schedule for Affective Disorders and Schizophrenia for School-age Children-Present and Lifetime version (K-SADS-PL). The PSC-17’s subscales were

compared with K-SADS-PL diagnoses and measures of anxiety, depression, general psychopathology, functioning, and impairment.

Results showed in receiver operating characteristics analyses, the PSC-17 subscales performed as well as competing screens...The instrument was less successful with anxiety. None of the screens were highly sensitive, many were insensitive, and all would have low positive predictive value in low-risk primary care populations.

Conclusions were that the PSC-17 and its subscales are briefer than alternative questionnaires but performed as well as those instruments in detecting common mental disorders in primary care. Continued research is needed to develop brief yet sensitive assessment instruments appropriate for primary care.” **NOTE: Journal is available for loan.]**

[Request# S07-111-953]

“Family Breakup and Adolescents’ Psychosocial Maladjustment: Public Health Implications of Family Disruptions.” By Christelle Roustit, Université Pierre et Marie Curie-Paris, and others. IN: Pediatrics, vol. 120, no. 4 (October 2007) pp. 984-991.

[“Recent changes in family structure are associated with an increase in psychosocial maladjustment in adolescents. We examined, from a public health intervention perspective, the association between family breakup and psychosocial maladjustment in adolescents and assessed the mediating role of family-functioning variables....

All 4 of the indicators of psychosocial maladjustment were significantly associated with family breakup. The association between family breakups and internalizing disorders was mediated by parental psychological distress and low paternal emotional support. Independently, the witnessing of interparental violence was also strongly associated with internalizing disorders. For the other 3 outcomes, that is, externalizing disorders, substance abuse, and alcohol consumption, family breakup and family-functioning variables had independent effects. The conclusion reached was that family-based interventions and social approaches are complementary support modalities for adolescents experiencing family disruptions.”]

Full text at: <http://pediatrics.aappublications.org/cgi/reprint/120/4/e984>

[Request# S07-111-957]

CULTURAL COMPETENCY

Building Culturally Competent Health Care Systems in California. By the California Endowment. (The Endowment, Los Angeles, California) 2007. 40 p.

[“On March 28-29, 2007, the California Endowment hosted a convening, ‘Building Culturally Competent Health Systems in California,’ held in Los Angeles. The

participants of this convening included more than 130 individuals from California's public and nonprofit hospital systems and other organizations working on issues of language access, cultural competency, health disparities and work force diversity. This document is a summary of the convening's proceedings, sessions and panel discussions.”]

Full text at: <http://www.calendow.org/Article.aspx?id=2282#>

[Request# S07-111-958]

DEPRESSION

“Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes.” By Phillip S. Wang, Harvard Medical Center, and others. IN: Journal of the American Medical Association, vol. 298, no. 12 (September 26, 2007) pp. 1401-1411.

[“Context for the study: Although guideline-concordant depression treatment is clearly effective, treatment often falls short of evidence-based recommendations. Organized depression care programs significantly improve treatment quality, but employer purchasers have been slow to adopt these programs based on lack of evidence for cost-effectiveness from their perspective.

Objective of the study was to evaluate the effects of a depression outreach-treatment program on workplace outcomes, a concern to employers.

Design, Setting, and Participants: A randomized controlled trial involving 604 employees covered by a managed behavioral health plan were identified in a 2-stage screening process as having significant depression. Patient treatment allocation was concealed and assessment of depression severity and work performance at months 6 and 12 was blinded. Employees with lifetime bipolar disorder, substance disorder, recent mental health specialty care, or suicidality were excluded.

Interventions included a telephonic outreach and care management program encouraged workers to enter outpatient treatment (psychotherapy and/or antidepressant medication), monitored treatment quality continuity, and attempted to improve treatment by giving recommendations to providers. Participants reluctant to enter treatment were offered a structured telephone cognitive behavioral psychotherapy....

Conclusions reached were that a systematic program to identify depression and promote effective treatment significantly improves not only clinical outcomes but also workplace outcomes. The financial value of the latter to employers in terms of recovered hiring, training, and salary costs suggests that many employers would experience a positive return on investment from outreach and enhanced treatment of depressed workers.”

Journal available for loan.]

[Request# S07-111-960]

FIRST EPISODE PSYCHOSIS

“Effect of Age at Onset on the Course of Major Depressive Disorder.” By Sidney Zisook, University of California, San Diego, and others. IN: American Journal of Psychiatry, vol. 164 (October 2007) pp. 1539-1546.

[“This report assesses whether age at onset defines a specific subgroup of major of major depressive disorder in 4,041 participants who entered the Sequenced treatment Alternatives to Relieve Depression (STAR*D) study.

The study enrolled outpatients 18-75 years of age with nonpsychotic major depressive disorder from both primary care and psychiatric care practices. At study entry, participants estimated the age at which they experienced the onset of their first major depressive episode. This report divides the population into five-age-at-onset groups: childhood onset (ages <12), adolescent onset (ages 12-17), early adult onset (ages 18-44), middle adult onset (ages 45-59), and late adult onset (ages >60).

No group clearly stood out as distinct from the others. Rather the authors observed an apparent gradient, with earlier ages at onset associated with never being married, more impaired social and occupational function, poorer quality, greater medical and psychiatric comorbidity, a more negative view of life and the self, more lifetime depressive episodes and suicide attempts, and greater symptom severity and suicidal ideation in the index episode compared to those with later ages at onset of major depressive disorder. Although age at onset does not define distinct depressive subgroups, earlier onset is associated with multiple indicators of greater illness burden across a wide range of indicators.”]

Full text at: <http://ajp.psychiatryonline.org/cgi/reprint/164/10/1539>

[Request# S07-111-961]

JUVENILE JUSTICE AND MENTAL ILLNESS

Healthy Returns Initiative Strengthens Mental Health Services in the Juvenile Justice System. By the Center for Healthy Communities. Centerscene. (California Endowment, Los Angeles, California) Fall 2007. 8 p.

[“The Fall 2007 issue of centerscene explores issues of the prison system and mental health and highlights The California Endowment's Healthy Returns Initiative, a project to strengthen the capacity of probation departments to provide mental health services to youth in detention facilities...

According to national estimates, as many as 70 percent of adolescents in juvenile justice systems struggle with mental health or co-occurring disorders, 20 percent have a serious mental disorder, and at least 10 percent have a serious medical condition. Many have come through the foster care system, and as a population are among the most at-risk with the least access to services. ‘Kids in the juvenile justice system have lots and lots of

potential that's often restricted by their behavioral and emotional problems,' says Gwen Foster, senior program officer who oversees The Endowment's statewide grant-making in the area of mental health and manages the Healthy Returns Initiative. 'Although being held in juvenile detention facilities is a negative experience, it also affords opportunities to provide services for youths in detention and when they return to the community.']

Full text at:

http://www.calendow.org/chc/newsletter/pdfs/CHC_CenterSceneFA07_final.pdf

[Request# S07-111-962]

LAW AND MENTAL ILLNESS

“Law and Psychiatry: Issues Related to Possession of Firearms by Individuals with Mental Illness: An Overview Using California as an Example.” By Joseph R. Simpson, University of Southern California. IN: Journal of Psychiatric Practice, vol. 13, no. 2 (March 2007) pp. 1-6.

[“Since 1968, federal law has prohibited individuals with a history of certain types of mental health adjudications from purchasing or possessing firearms. The implementation of a nationwide system of background checks in 1989, following passage of the Brady Handgun Violence Prevention Act, has, at least to some degree, facilitated the identification of individuals who are federally banned from owning firearms. An increasing number of states also have their own laws in this area, making the issue relevant to more clinicians. In some states, including California, the criteria for being barred from possessing firearms are more stringent than those provided for by federal statute.

This column uses California as an example to illustrate laws and practices relating to firearm possession by individuals with a history of psychiatric illness. Federal laws and court decisions and the laws of other states have recently been reviewed elsewhere. Mental health professionals should be aware of the potential ramifications of firearm laws for their patients and be prepared to respond to requests to render an opinion regarding an individual's suitability for restoration of the ability to possess firearms. This last issue, although little explored to date, has the potential to develop into a new area of expertise within forensic psychiatry.”]

Full text at: <http://www.reidpsychiatry.com/columns/Simpson%2003-07.pdf>

[Request# S07-111-964]

MENTAL ILLNESS AND PRISONS

Creating New Options: Training for Corrections Administrators and Staff on Access to Federal Benefits for People with Mental Illnesses Leaving Jail or Prison. By Chris Koyanagi and Elaine Alfano, Judge David L. Bazelon Center for Mental Health Law. (The Center, Washington, DC) 2007. 76 p.

[“This manual describes the needs of individuals with mental illnesses who are incarcerated in jail and prison and explains how correctional staff can help them access the federal benefits that can enable them to make a successful transition to the community. It offers a general understanding of the federal benefit programs, what they provide and how someone leaving jail or prison can qualify for them....

One way to reduce the number of people with mental illnesses in a jail or prison is to close the revolving door through which they keep coming back. Improving their access to benefits on release is an important piece of a strategy to reduce such recidivism. However, federal benefit programs are confusing. There are many programs, each with its own rules and requirements. While jail and prison administrators, correctional officers and others in the criminal justice system need not become experts on these programs, they will find it helpful to have a general understanding of the benefits that individuals with mental illnesses need as they leave jail or prison. They can use this information to help inmates recognize the importance of these benefits and to help them apply.

This manual is designed for use by correctional facilities, or mental health advocates can use it to help administrators and staff of jails and prisons better understand the histories and needs of incarcerated individuals with mental illnesses and encourage them to start a benefit initiative at their facility.”]

Full text at: <http://www.bazelon.org/pdf/NewOptions.pdf>

[Request# S07-111-965]

MENTAL HEALTH POLICIES AND PROCEDURES

“The Future of Psychiatric Services in General Hospitals.” By Benjamin Liptzin, Baystate Medical Center, and others. IN: American Journal of Psychiatry, vol. 164 (October 2007) pp. 1468-1472.

[“General hospitals are the largest providers of inpatient psychiatric services in the United States on the basis of admissions and the number of psychiatrists employed. According to data from the Center for Mental Health Services, general hospitals accounted for 49.9% of admissions to 24-hour hospital and residential treatment centers in 2002 and employed 4,348 psychiatrists in 2000. Many general hospitals also provide ambulatory and emergency psychiatric care. Medical and surgical inpatients often have psychiatric conditions that require psychiatric consultation. Most leading academic departments of psychiatry are based in general hospitals and perform the bulk of federally funded psychiatric research, the training of psychiatric residents, and the education of medical students. The top 10 medical school departments of psychiatry by National Institutes of Health funding are all based in general hospital-linked academic medical centers. Despite these critical functions, psychiatric services in general hospitals are vulnerable. Reimbursement and operating margins for hospital and physician psychiatric services lag behind those of other medical services. This article will review the current state of

psychiatric services in general hospitals, outline current challenges, and make recommendations for their future.”]

Full text at: <http://ajp.psychiatryonline.org/cgi/content/full/164/10/1468?etoc>

[Request# S07-111-966]

Characteristics of Frequent Emergency Department Users. By Elizabeth M. Peppe and others, Actuarial Research Corporation, and Eric Becker and Bianca DiJulio, the Henry J. Kaiser Family Foundation. (The Foundation, Menlo Park, California) October 2007. 19 p.

[“The increased use of U.S. hospital emergency departments has received considerable attention from both the health care community and policymakers in recent years. This analysis from the Kaiser Family Foundation examines the demographic and health characteristics of people who frequently visit the emergency room to help understand why their utilization is so high.

Using data from the nationally representative Medical Expenditures Panel Survey, the analysis finds that high emergency department users (those who made four or more visits during a two-year period) are more likely to be in poor health and have higher anticipated needs for health care —specifically the elderly, the poor, and those living with chronic conditions. The findings also reveal that these individuals do not obtain care exclusively in the emergency room, but also use outpatient services at a greater rate than people who rarely visit emergency departments.

In terms of health insurance coverage, the analysis finds that the uninsured are not more likely to frequently visit emergency departments than those who are insured. High emergency department users are far more likely to have Medicare or Medicaid coverage, likely due to the poor health and age of these populations, whereas the majority of low users and non users are privately insured.”]

Full text at: <http://www.kff.org/insurance/upload/7696.pdf>

[Request# S07-111-967]

SUICIDE PREVENTION

“Self-Injurious Thoughts and Behaviors Interview: Development, Reliability, and Validity in an Adolescent Sample.” By Matthew K. Nock and others, Harvard University. IN: Psychological Assessment, vol. 19, no. 3 (September 2007) pp. 309-317.

[“The authors developed the Self-Injurious Thoughts and Behaviors Interview (SITBI) and evaluated its psychometric properties. The SITBI is a structured interview that assesses the presence, frequency, and characteristics of a wide range of self-injurious thoughts and behaviors, including suicidal ideation, suicide plans, suicide gestures,

suicide attempts, and nonsuicidal self-injury (NSSI). This initial study, based on the administration of the SITBI to 94 adolescents and young adults, suggested that the SITBI has strong interrater reliability and test-retest reliability, intraclass correlation coefficient over a 6-month period. Moreover, concurrent validity was demonstrated via strong correspondence between the SITBI and other measures of suicidal ideation, suicide attempt, and NSSI.

The authors concluded that the SITBI uniformly and comprehensively assesses a wide range of self-injury-related constructs and provides a new instrument that can be administered with relative ease in both research and clinical settings.”]

Full text: <http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=pas-19-3-309&site=ehost-live>

[Request# S07-111-968]