

**Subject:** Studies in the News: (January 31, 2008)

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## Studies in the News for



## California Department of Mental Health

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### Introduction to Studies in the News

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## **CHILDREN AND ADOLESCENT MENTAL HEALTH**

**Who are Children with Special Health Care Needs? By the Data Resource Center for Children & Adolescent Health. Child and Adolescent Health Measurement Initiative. (U.S. Department of Health & Human Resources, Washington, DC) November 2007. 2 p.**

[“ The federal Maternal and Child Health Bureau defines children with special health care needs (CSHCN) as: ‘those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.’

This definition is used to guide the development of family-centered, coordinated systems of care children and families for children with special care needs served by the state Title V block grants administered by the Maternal and Child Care Bureau.”]

Full text at: <http://cshcndata.org/Viewdocument.aspx?item=153>

## **DEPRESSION**

**Reducing Maternal Depression and Its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework. By Jane Knitzer and others,**

**National Center for Children in Poverty. Project Thrive. Issue Brief No. 2. (The Center, New York, New York) January 2008. 28 p.**

[“This issue brief calls for policymakers to include much more serious attention to maternal depression as part of the larger efforts across the country to improve healthy developmental and school-readiness outcomes in young children.

The argument is simple: particularly for low-income children, maternal depression is a known barrier to ensuring that young children experience the kinds of relationships that will facilitate their success in the early school years. Investing in treatment and support for one generation will promote healthy development and school readiness for the next. Addressing maternal depression through a parenting and early childhood lens is in effect a ‘two-fer’: it can help parents, but importantly, it will also pay off for their children, both in the short term and in the longer term.

There are tough barriers, particularly fiscal barriers, to creating family focused interventions. It requires a framework shift that provides public incentives for a family-focused, namely multi-generational, culturally responsive, approach that brings together resources from multiple public systems. There is also a critical role as a catalyst and seeder of initiatives for private philanthropy.

The real message from this brief is clear. While there is much more to be known, we already have enough evidence about effective approaches to address a damaging condition that ripples throughout a family and a community, with lifelong implications for everyone it touches. We simply cannot afford not to respond with resources and commitment.”]

Full text at: [http://www.nccp.org/publications/pdf/text\\_791.pdf](http://www.nccp.org/publications/pdf/text_791.pdf)

**Treatment for Past Year Depression among Adults. By the Office of Applied Studies: Substance Abuse and Mental Health Services Administration (SAMSHA). The National Survey on Drug Use and Health (NSDUH) Report. (The Administration, Rockville, Maryland) January 3, 2008. 4 p.**

[“In 2005 and 2006, an annual average of 15.8 million adults aged 18 or older (7.3 percent) experienced a major depressive episode (MDE) in the past year. Several treatments for depression are available, including various psychotherapeutic approaches and antidepressant medications, although many adults who experience an MDE do not receive any treatment for their symptoms....

This issue of The NSDUH Report examines variation in the utilization of treatment for depression, types of treatment received, and satisfaction with that treatment among adults aged 18 or older who experienced at least one MDE in the past year. All findings presented in this report are based on combined 2005 and 2006 NSDUH data.”]

Full text at: <http://oas.samhsa.gov/2k8/depression/depressionTX.pdf>

**DISPARITIES**

**Assessment of State Capacity to Identify and Track Disparities in the Leading Health Indicators. By Allison Hedley Dodd and others, Mathematica Policy Research, Inc. (The Corporation, Washington DC) December 2007. 60 p.**

[“Our analysis sought to characterize the capacity of states to identify and track disparities in health across subgroups of the population (like race/ethnicity), using the leading health indicators (LHIs) from Healthy People 2010 (HP2010) as the basis for our work. Assessing health status is one of the three core functions of public health (along with formulating public policies and assuring that all populations have access to appropriate and cost-effective care). HP2010 lays out important goals and objectives for improving the health of the public, which are particularly relevant because they were developed through a collaborative process involving stakeholders at all levels—federal, state and the local community. HP2010 also makes the attainment of these goals and objectives, and the reduction of disparities among subgroups of the population, as key overall goals.

Our intent in carrying out this study was to identify whether states, which play a vital role in efforts to achieve public health goals, have the data they need for assessment, a first step in action. We focused on the LHIs cited in HP2010 both because they are important and because they provided a way to focus the study. The 10 LHIs cover a range of broad public health issues (physical fitness and activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care). By searching the websites of the Centers for Disease Control and Prevention (CDC), federally standardized data sources, and state governments, we identified data sources that collect the data specified in the LHI objectives.

This project is the first phase of a two-phase study. The information presented in this paper describes what we learned about the availability of leading indicators in states, both overall and by population subgroup, including a review of findings for every state as of September 2007. The second phase, now underway, will involve case studies that seek to identify whether efforts to improve performance on leading indicators consider the issue of disparities, and what analytical, political, organizational or other factors enhance or impede such efforts. This effort also will provide an opportunity to learn more about how potential users at the state and local level view the value and adequacy data of disparities data of the type we examined for and within states and also how important they view data in driving the design of disparities.”]

Full text at: <http://www.mathematica-mpr.com/publications/pdfs/healthindicators.pdf>

**FOSTER CARE**

**Foster Care and School Mental Health. By Monique Vulin-Reynolds and others, Center for School Mental Health, University of Maryland School of Medicine. (The Center, Baltimore, Maryland) January 2008. 7 p.**

[“In a recent study of children and adolescents, who had previously been in foster care, 54% had one or more mental health problems in the past 12 months (compared with 22% of the general population) and 25% had Post-Traumatic Stress Disorder within the past 12 months (twice the rate of U.S. war veterans). Children in foster care are also more likely than the general population to have a special education classification of an emotional or behavioral disturbance.

Although children and youth in foster care are exposed to similar environmental stressors as those living in “high-risk” environments” (e.g., poverty, instability, caregivers with high levels of stress), children in foster care are more likely to have mental health problems or learning disabilities. Thus, helping children to adjust to life in the foster care system may be as important as addressing those issues that originally led to foster care placement.”]

Full text at: <http://csmh.umaryland.edu/resources.html/FosterCareBrief.pdf>

### **MENTAL HEALTH POLICIES AND PROCEDURES**

**NIMH Director’s Report to the National Advisory Mental Health Council –January 11, 2008. By Thomas R. Insel, National Institute of Mental Health. (The Institute, Bethesda, Maryland) January 11, 2008. 27 p.**

[“The National Advisory Mental Health Council (NAMHC) advises the Secretary of Health and Human Services; the Director, National Institutes of Health; and the Director, National Institute of Mental Health, on all policies and activities relating to the conduct and support of mental health research, research training, and other programs of the Institute.”]

Full text at: <http://www.nimh.nih.gov/about/advisory-boards-and-groups/namhc/reports/directors-report-to-the-national-advisory-mental-health-council-january-11-2008.shtml>

**Mental Health: Transforming Florida’s Mental Health System-Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development. By the Supreme Court of the State of Florida. (The Court, Tallahassee, Florida) November 2007. 170 p.**

[“The problems currently facing Florida’s mental health and, consequently, criminal justice systems relate to the fact that the community mental health infrastructure was developed at a time when most people with severe and disabling forms of mental illnesses resided in state hospitals. As such, the community mental health system was designed around individuals with more moderate treatment needs, and not around the needs of individuals who experience acute and chronic mental illnesses.

People who would have been hospitalized 40 years ago because of the degree to which mental illness has impaired their ability to function are now forced to seek services from an inappropriate, fragmented, and unwelcoming system of community-based care. The justice system was never intended to serve as the safety net for the public mental health system and is ill-equipped to do so. Florida’s jails and prisons have been forced to house an increasing number of individuals who are unable to access critically needed and competent care in the community....

In this report, recommendations are made for the development of a comprehensive and competent mental health system which will prevent individuals from entering the justice system to begin with and will respond to individuals who do become involved in the justice system quickly and effectively to link them to appropriate services and prevent recidivism. By designing an appropriate and responsive system of care for individuals with serious mental illnesses, severe emotional disturbances, and/or co-occurring substance use disorders, people who otherwise would continue to recycle through the justice system will be served more effectively and efficiently. Public safety will be improved and the rate of individuals accessing more costly services in forensic mental health and criminal justice systems will be reduced.”]

Full text at: <http://mhlp.fmhi.usf.edu/web/mhlp/documents/Supreme-Court-Report-2007.pdf>

**“To Commit or Not to Commit: Virginia Overhauls its Mental Health System.” By Christina Kent, National Conference of State Legislatures. IN: State Health Notes, vol. 29, no. 507 (January 22, 2008) pp. 1-4.**

[“When a Virginia Tech student killed 33 students and professors last April 16, he drew national attention to a recurring, controversial subject: how to ensure that persons with mental illnesses get the help they need, when they need it. “Mental health will be a significant issue in the Commonwealth of **Virginia** during its 2008 session,” said Delegate Phil Hamilton. By January 9 (the deadline for introduction of legislation) lawmakers had proposed more than 100 bills pertaining to the issue. “I think there’s a consensus that we’re going to do something on these issues in particular,” Delegate Rob Bell told the *Hampton Roads Pilot*. “What is the actual shape it will take? I’m hesitant to predict.”

Virginia lawmakers have a jump on reforms. In 2006, the Chief Justice of the state Supreme Court appointed a Commission on Mental Health Law Reform to analyze the

existing system. Last December, the commission released a preliminary report of recommendations, and its members will continue framing other long-term reforms. “Six percent of Virginians have a serious mental illness, and one of every four citizens of the Commonwealth has a diagnosable mental illness of some type,” Governor Tim Kaine said. “...Due to chronic under-funding and an insufficient focus on the quality of care, our mental health system has not been measuring up to the needs of Virginia’s mentally ill.” He proposed increasing funding for the system by \$42 million, as well as issuing \$55 million in bonds to improve mental health facilities.”]

Full text at:

<http://www.ncsl.org/programs/health/shn/2008/sn507b.htm>

### **PRIMARY CARE AND THE UNDERSERVED**

**Health Literacy Practices in Primary Care Settings: Examples from the Field. By Sharon E. Barrett, Institute of Medicine Health Literacy Roundtable and others. (The Commonwealth Fund, New York, New York) January 2008. 36 p.**

[“Low health literacy is widespread among U.S. patients, yet limited research has been done to assess the effects of health literacy practices designed to combat the problem, particularly among safety-net providers in primary care settings. This report presents findings from a 2005 study in which the Association of Clinicians for the Underserved first did an online survey of health care facilities across the country and then followed it up with visits to five selected sites for staff and patient interviews. The study identified five health literacy practices that staff considered especially valuable for their group’s patients and potentially applicable to other clinics: a team effort, beginning at the front desk; use of standardized communication tools; use of plain language, face-to-face communication, pictorials, and educational materials; clinicians partner with patients to achieve goals; and organizational commitment to create an environment where health literacy is not assumed.”]

Full text at:

[http://www.commonwealthfund.org/usr\\_doc/Barrett\\_hltliteracypracticesprimarycaresettingexamplesfield\\_1093.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Barrett_hltliteracypracticesprimarycaresettingexamplesfield_1093.pdf?section=4039)

### **STIGMA**

**“Fleet Leaders’ Attitudes about Subordinates’ Use of Mental Health Services.” By Richard J. Westphal, Naval Medical Center. IN: Military Medicine, vol. 172, no. 11 (November 2007) pp. 1138-1143.**

[“Mental disorders are a significant source of medical and occupational morbidity for sailors. Stigma, fear of negative career impact, and subordinates concern about leaders' attitudes are significant barriers to the use of mental health services. Semi-structured interviews and military policies were data sources used to analyze the language,

knowledge, and attitudes of Navy surface fleet leaders about mental illness and mental health treatment using Foucault's concept of discourse analysis. A discourse is a system of knowledge that influences language, perceptions, values, and social practices. The results showed that leaders' concerns about sailors' mental combat readiness, not mental illness stigma, was the dominant discourse about mental illness and mental health services use. In particular, organizational differences between the surface warfare and the mental health communities may influence leaders' attitudes more than stigma. This study provides an elaborated view of mental health knowledge and power within a Navy community.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=27554862&site=ehost-live>

**“A Qualitative Analysis of the Perception of Stigma among Latinos Receiving Antidepressants.” By Alejandro Interian, Robert Wood Johnson Medical School and others. IN: Psychiatric Services, vol. 58, no. 12 (December 2007) pp. 1591-1594.**

[“This study sought to describe the role of stigma in antidepressant adherence among Latinos. The study utilized data generalized data generated from six focus groups of Latino outpatients receiving antidepressants. By using a grounded theory approach, qualitative analysis focused specifically on the role of stigma in antidepressant treatment, as well as salient Latino values. Results indicated that perceptions of stigma were related to both the diagnosis of depression and use of antidepressant medication. Qualitative analyses showed that antidepressant use was seen as implying more severe illness, weakness or failure to cope with problems, and being under the effects of a drug. Reports of stigma were also related to social consequences. Also, the perceived negative attributes of antidepressant use were at odds with self-perceived cultural values. In conclusion, stigma was a prominent concern among Latinos receiving antidepressants, and stigma often affected adherence. Furthermore, culture is likely to play an important role in the communication of stigma and its associated complications.” **NOTE: Contact the California State Library for copy of this article.]**

### **SUICIDE PREVENTION**

**“Cultural Considerations in Adolescent Suicide Prevention and Psychosocial Treatment.” By David B. Goldston, Duke University, and others. IN: American Psychologist, vol. 63, no. 1 (January 2008) pp. 14-31.**

[“Ethnic groups differ in rates of suicidal behaviors among youths, the context within which suicidal behavior occurs (e.g., different precipitants, vulnerability and protective factors, and reactions to suicidal behaviors), and patterns of help-seeking. In this article, the authors discuss the cultural context of suicidal behavior among African American, American Indian and Alaska Native, Asian American and Pacific Islander, and Latino

adolescents, and the implications of these contexts for suicide prevention and treatment. Several cross-cutting issues are discussed, including acculturative stress and protective factors within cultures; the roles of religion and spirituality and the family in culturally sensitive interventions; different manifestations and interpretations of distress in different cultures; and the impact of stigma and cultural distrust on help-seeking. The needs for culturally sensitive and community-based interventions are discussed, along with future opportunities for research in intervention development and evaluation.”]

Full text at: <http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=amp-63-1-14&site=ehost-live>

**"Preventing Suicide: A Resource for the Family." By Sergio A. Perez Barrero, Medical University of Granma, Cuba. IN: Annals of General Psychiatry, vol. 7, no. 1 (January 24, 2008) pp. 1-12.**

["Suicide is one of the 10 major causes of death in most countries. The family can play an important role in its prevention, as it is an avoidable cause of death. In order to be able to prevent suicide among its members, the family should rid itself of some myths associated with suicidal behavior.

Myths can be defined as culturally accepted phenomena rooted in the minds of people that do not reflect any scientific truth; in the case of suicide they are erroneous judgments concerning the act itself and the person who takes their own life. Such myths need to be removed if people at risk can be helped.

Myths tend to justify their advocates' attitudes and become a hindrance in the prevention of suicide. There are many myths in relation to suicide and the suicides. We will consider some of these, and also explain some scientific criteria that should be taken into consideration by the family in order to help prevent suicide among its members."]

Full text at: <http://www.annals-general-psychiatry.com/content/pdf/1744-859X-7-1.pdf>

**“Suicide Attempt Characteristics, Diagnoses, and Future Attempts: Comparing Multiple Attempters to Single Attempters and Ideators.” By Regina Miranda, City University of New York, and others. IN: Journal of the American Academy of Child & Adolescent Psychiatry, vol. 47, no. 1 (January 2008) pp. 32-40.**

[“Objective of this study is to compare psychiatric diagnoses and future suicide attempt outcomes of multiple attempters (MAs), single attempters (SAs) and ideators. Two hundred twenty-eight teens who reported recent ideation or a lifetime suicide attempt in a screening of 1, 729 high school students completed the Adolescent Suicide Interview, which provided information on attempt number and characteristics and mood, anxiety, and substance use disorder modules of the Diagnostic Interview Schedule for Children...MAs more strongly predict later suicidality and diagnosis than SAs and ideation. Forms that assess past suicide attempts should routinely inquire about frequency of attempts. The similarity between the present findings and those of clinical

samples suggest that screening may yield a representative sample of suicide attempters and ideators.” **Note: This Journal is available for loan.]**

**“Suicide Ideation, Plan, and Attempt in the Mexican Adolescent Mental Health Survey.” By Guilherme Borges, National Institute of Psychiatry, Mexico City, and others. IN: Journal of the American Academy of Child & Adolescent Psychiatry, vol. 47, no. 1 (January 2008) pp. 41-52.**

[“No representative data among adolescents in Mexico exist on the prevalence and risk factors for suicide ideation, plan, and attempt despite a recent increase in suicide deaths. Data, in this study, are presented from the Mexican Adolescent Mental Health Survey, a representative household survey of 3,005 adolescents ages 12 to 17 in metropolitan Mexico City who were gathered in 2005, regarding lifetime prevalence and age-of-onset distributions of suicide ideation, plan, and attempt and demographic and psychiatric disorders risk factors. Lifetime ideation was reported by 11.5% of respondents, whereas 3.9% reported a lifetime plan and 3.1% a lifetime suicide attempt. Onset of suicidality attempt within the first year of onset of ideation. Suicidality was more likely to occur among females. The presence of one or more mental disorders was strongly related to suicide ideation, plan, and attempt. Among ideators only dysthymia was consistently related to a plan and attempt. Conclusions reached were that intervention efforts should focus on assessment and target adolescents with mental disorders, particularly mood disorders, to be effective in prevention.” **Note: This Journal is available for loan.]**

**United Kingdom: Suicides. By the Office for National Statistics. (The Office, London, England) January 28, 2008. 2 p.**

[“The suicide rate in men aged 15 and over showed a downward trend during the 1990s until a sharp increase in 1998. Since this peak, the rate has again fallen, stabilising in 2006. Rates in women were lower than those seen in men throughout 1991 to 2006, and have shown an overall decline. The rates seen in 2006 for both men and women were the lowest seen across the period at 17.4 and 5.3 per 100,000 population, respectively. In 2006, there were 5,554 suicides in adults aged 15 and over in the UK, which represented almost one per cent of the total of all deaths at ages 15 and over. Three-quarters of these suicides were among men and this division between the sexes was broadly similar throughout the period 1991-2006.”]

Full text at: <http://www.statistics.gov.uk/cci/nugget.asp?id=1092>

### **TRAUMA AND PTSD**

**"Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq." By Charles W. Hoge, Walter Reed Army Institute of Research, and others. IN: New England Journal of Medicine, vol. 358, no. 4(January 30, 2008) pp. 453-463**

[“An important medical concern of the Iraq war is the potential long-term effect of mild traumatic brain injury, or concussion, particularly from blast explosions. However, the epidemiology of combat-related mild traumatic brain injury is poorly understood.

We surveyed 2525 U.S. Army infantry soldiers 3 to 4 months after their return from a year-long deployment to Iraq. Validated clinical instruments were used to compare soldiers reporting mild traumatic brain injury, defined as an injury with loss of consciousness or altered mental status (e.g., dazed or confused), with soldiers who reported other injuries.

Of 2525 soldiers, 124 (4.9%) reported injuries with loss of consciousness, 260 (10.3%) reported injuries with altered mental status, and 435 (17.2%) reported other injuries during deployment. Of those reporting loss of consciousness, 43.9% met criteria for post-traumatic stress disorder (PTSD), as compared with 27.3% of those reporting altered mental status, 16.2% with other injuries, and 9.1% with no injury. Soldiers with mild traumatic brain injury, primarily those who had loss of consciousness, were significantly more likely to report poor general health, missed workdays, medical visits, and a high number of somatic and postconcussive symptoms than were soldiers with other injuries. However, after adjustment for PTSD and depression, mild traumatic brain injury was no longer significantly associated with these physical health outcomes or symptoms, except for headache.

Mild traumatic brain injury (i.e., concussion) occurring among soldiers deployed in Iraq is strongly associated with PTSD and physical health problems 3 to 4 months after the soldiers return home. PTSD and depression are important mediators of the relationship between mild traumatic brain injury and physical health problems.”]

Full text at: <http://content.nejm.org/cgi/content/full/NEJMoa072972>