

**Subject:** Studies in the News: (March 28, 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

Studies in the News (SITN): California Department of Mental Health is a service provided to the Department of Mental Health by the California State Library. This service features articles focusing on mental health issues. Prior lists can be viewed from the California State Library's Web site at [California State Library - Studies in the News](#)

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- **California State Employees** may contact the Information Resources and Government Publications (916-654-0206; csinfo@library.ca.gov) with the SITN issue date and title of article.
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**CHILDREN AND ADOLESCENT MENTAL HEALTH**

**Critical Services for Our Children: Integrating Mental and Oral Health into Primary Care. By Grantmakers in Health. Issue Brief No. 30. (Grantmakers, Washington, DC) February 2008. 36 p.**

[“Critical Services for Our Children: Integrating Mental and Oral Health into Primary Care presents a summary of a discussion among grantmakers and health services researchers about improving the children's health care system by better integrating oral and mental health services into primary care. The issue brief is based on a Grantmakers in Health Issue Dialogue held on April 17, 2007, that focused on strategies for reducing fragmentation of services and explored opportunities for health funders. An overview of the issue, possible solutions, a conclusion, and references are provided. Topics include challenges to an integrated children's health system and examples of how health funders are addressing the problems.”]

Full text at: [http://www.gih.org/usr\\_doc/Issue\\_Brief\\_30.pdf](http://www.gih.org/usr_doc/Issue_Brief_30.pdf)

**“Effectively Addressing Mental Health Issues in Child Welfare Practice: The Family Connection.” By Elizabeth Pufahl, Tennessee Voices for Families. IN: Child Welfare, vol. 86, no. 5 (September/October 2007) pp. 75-91.**

[“Nonprofit family-run organizations, such as Tennessee Voices for Children (TVC), are providing leadership in advocating for and delivering services to children and families in need. Utilizing a family-driven approach and a staff partially comprised of parent-professionals, TVC's Nashville Connection and Family Connection programs have strengthened families by providing alternatives to state custody for children and families

living with serious emotional or behavioral problems. TVC's Nashville Connection and Family Connection programs did this by coordinating support services, building community bridges, and providing comprehensive in-home services.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31238332&site=ehost-live>

**Eyes on Bullying What Can You Do: A Toolkit to Prevent Bullying in Children’s Lives. By Kim Storey and others, Education Development Center, Inc. (The Center, Newton, Massachusetts) 2008. 43 p.**

[“In Children's Lives offers a variety of tools to help parents and other caregivers understand bullying in a new way, reexamine their knowledge and beliefs about bullying, and shape the beliefs and behaviors of the children in their care. The toolkit, created at Education Development Center, is designed especially for parents and other caregivers of Preschool- and school-age children and adolescents to use in child care programs, after-school programs, and camps. Topics include (1) the issue of bullying; (2) why bullying can sometimes be difficult to see; (3) the concepts of bully, victim, and bystander; (4) recommendations and strategies for addressing bullying when it occurs; (5) a strategic approach to creating an environment where everyone takes responsibility for preventing bullying; and (6) resources and references on bullying prevention.”]

Full text at: <http://www.eyesonbullying.org/pdfs/toolkit.pdf>

**"Frequency of Provider Contact after FDA Advisory on Risk of Pediatric Suicidality with SSRIs." by Elaine H. Morrato, University of Colorado, and others. IN: American Journal of Psychiatry, vol. 165, no. 1 (January 2008) pp. 42-50.**

[“The Food and Drug Administration (FDA) issued a public health advisory in October 2003 on the risk of suicide in pediatric patients taking antidepressants and advised maintaining "close supervision" of such patients. In this study, the authors compared trends in the frequency of provider contacts before and after the advisory were issued.... Conclusions indicated that contrary to expectations, the frequency of visits by patients with new episodes of depression treated with antidepressants did not increase after the October 2003 FDA advisory was issued." **NOTE: Journal is available for borrowing.**]

**The Mental Health of Adolescents: A National Profile 2008. By David Knopf and others, National Adolescent Health Information Center. (The Center, San Francisco, California) 2008. 15 p.**

[“Parents, practitioners, and policymakers are recognizing the importance of young people’s mental health. Youth with better mental health are physically healthier, demonstrate more socially positive behaviors and engage in fewer risky behaviors. Conversely, youth with mental health problems, such as depression, are more likely to engage in health risk behaviors. Furthermore, youths’ mental health problems pose a

significant financial and social burden on families and society in terms of distress, cost of treatment, and disability.

Most mental health problems diagnosed in adulthood begin in adolescence. Half of lifetime diagnosable mental health disorders start by age; this number increases to three fourths by age. The ability to manage mental health problems, including substance use issues and learning disorders, can affect adult functioning in areas such as social relationships and participation in the workforce....

This brief also assesses shortcomings of current data and offers recommendations to address these limitations. We hope this brief helps strengthen systems that monitor the mental and emotional health of young people at national, state and local levels. Monitoring systems are an important component of efforts to promote mental health, and prevent and treat mental health problems. Such efforts promote a healthy adolescence and lay the groundwork for healthy adulthood.”]

Full text at: <http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf>

## **DISPARITIES**

**Racial and Ethnic Disparities in U. S. Health Care: A Chartbook. By Holly Mead, George Washington University, and others. Publication No. 1111. (The Commonwealth Fund, New York, New York) March 2008. 113 p.**

[“The goal of this chartbook is to create an easily accessible resource that can help policy makers, teachers, researchers, and practitioners begin to understand disparities in their communities and to formulate solutions. Given the magnitude of the body of disparities research, we do not intend to create an exhaustive report that simply presents existing data. Rather we seek to prompt thinking about why these disparities may exist, and more importantly, what may be done to eliminate these gaps. Our hope is to offer a systematic set of data coupled with a discussion that we hope can educate a broad audience about the challenges and opportunities to improve the health and health care of all Americans.

This chartbook also incorporates an evolving understanding of the nature and etiology of disparities. Many studies have pointed to the role of bias, miscommunication, lack of trust, and financial and access barriers in allowing disparities to occur. This chartbook also reflects emerging evidence that disparities may be a function of the overall performance of the health system where one lives, or of the quality of providers that care for many minorities. Hence, some disparities observed in national analyses may be due to failures in the health care system that result in barriers to care for minorities. Other disparities may be due to minorities disproportionately living in regions where quality is suboptimal or receiving care from providers whose quality similarly needs improvement. Understanding these underlying dynamics will help policy makers and health professionals design the most effective strategies for reducing disparities.”]

Full text at:

[http://www.commonwealthfund.org/usr\\_doc/Mead\\_raceethnicdisparities\\_chartbook\\_1111.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Mead_raceethnicdisparities_chartbook_1111.pdf?section=4039)

### **FOSTER CARE**

**“Mental Health Assessment of Infants in Foster Care.” By Judith Silver, Children’s Hospital, Philadelphia, and Sheryl Dicker, New York Permanent Judicial Commission on Justice for Children. IN: Child Welfare, vol. 86, no. 5 (September/October 2007) pp. 36-55.**

[“Infants placed in foster care are at high risk for emotional and behavioral problems. Assessment of their mental health must account for their often-adverse life experiences prior to placement and the involvement of multiple systems that shape their lives in lieu of parents' authority. This article presents practice guidelines for infant mental health evaluations with consideration of legal requirements and the unique issues conferred by foster care.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31238330&site=ehost-live>

**“Reducing Transfers of Children in Family Foster Care through Onsite Mental Health Interventions.” By Carmen Collado and Paul Levine, Jewish Board of Family and Children’s Services. IN: Child Welfare, vol. 86, no. 5 (September/October 2007) pp. 133-150.**

[“Mental health is a critical issue in the foster care system. Craven and Lee (2006) found that 30% of children in the system suffer from emotional/behavioral/developmental problems. Austin (2004) cites Stephen Hornberger, Director of Behavioral Health at CWLA, in noting that 40-85% of children in foster care have mental health disorders, depending on the study. Burns and colleagues (2004) reported that 47.9% of children in the child welfare system had significant emotional or behavioral problems; the incidence increased for children in nonrelative foster care or group homes. Lyons and Rogers (2004) indicate that half of children in the system have clinically significant emotional or behavioral problems, and postulate that this high level of mental health problems makes the child welfare system in fact a behavioral health care system....This article describes a successful pilot project in New York City that effectively reduced the number of transfers or replacements of children in family foster care through the placement of mental health clinicians onsite at two foster care agencies.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31238335&site=ehost-live>

## **HOMELESSNESS AND MENTAL HEALTH**

**Voices from the Street: A Survey of Homeless Youth by Their Peers. By Nell Bernstein and Lisa K. Foster, California Research Bureau, California State Library. CRB 08-004. (The Bureau, Sacramento, California) March 2008. 133 p.**

[“Homeless youth are a hidden population. To shed light on this group of vulnerable young people, CRB conducted a survey in which homeless and formerly homeless youth completed over 200 interviews with their homeless peers across the state. The youth interviewed describe their experiences – how they became homeless, what life on the street is like, their interactions with police, their education and aspirations, their mental health experiences, how they go about getting help – the services they need, and the changes they would like to see happen in policy or law. The majority come from the hardest-to-reach and least-studied homeless populations: youth who sleep on the streets or in cars, squat in abandoned buildings, or "couch-surf." Most left their families because of violence or abuse or were kicked out, and many are surviving on the streets in the neighborhoods in which they grew up. This report presents the survey responses and findings. It is a primary component of the California Homeless Youth Project, a major research and policy initiative undertaken by the CRB and California Council on Youth Relations, with support from The California Wellness Foundation, to bring attention to the serious issues facing homeless youth in the state.”]

Full text at: <http://www.library.ca.gov/crb/08/08-004.pdf>

## **JUVENILE JUSTICE**

**“Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta Analysis.” By Gina M. Vincent, University of Massachusetts Medical School, and others. IN: Journal of American Academy of Adolescent Psychiatry, vol. 47, no. 3 (March 2008) pp. 282-290.**

[“Studies have suggested a high prevalence of mental health symptoms among youths in the juvenile justice system, with the highest prevalence among girls and whites compared to boys and other races. This multisite, archival study examined whether sex and race differences, when they exist, were consistent across U.S. juvenile justice programs. The data included scores on the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2) for 70,423 youths from 283 juvenile justice probation, detention, or corrections programs....

At the aggregate level, 72% of girls and 63% of boys had a clinical elevation on at least one MAYSI-2 scale. Our meta-analytic technique indicated that the sex differences across sites were even larger than these numbers imply. Conversely and counter to existing evidence, race-related differences were generally small or nonexistent. Whites were more likely to have alcohol and drug problems and suicide ideation, but not more likely to have symptoms of depression, anxiety, or thought disturbance than blacks or

Hispanics.” **Note: A copy of this article can be obtained from the California State Library.]**

### **MILITARY AND MENTAL HEALTH**

**Army Report of Mental Health of Soldiers in Afghanistan and Iraq. By the Mental Health Advisory Team (MHAT) V (The Team, Washington, DC) February 14, 2008. 6 p.**

[“This US Army report, produced by the fifth Mental Health Advisory Team, discusses the mental health and morale of soldiers deployed in Afghanistan and Iraq in fall, 2007.

The fifth Mental Health Advisory Team (MHAT) V was established by the Office of the U.S. Army Surgeon General. Historically, teams have been formed to support requests from the Commanding General, Multi-National Force-Iraq (MNF-I); however, for MHAT V the request from MNFI-I was augmented by a request from the Service Chief, Army Central Command(ARCENT) to examine Soldiers in Afghanistan and Kuwait. Therefore, unlike previous years, the current MHAT report contains two separate reports - one for Operation Iraqi Freedom (OIF) which includes a section on Soldiers in Kuwait, and one for Operation Enduring Freedom (OEF).”]

Full text at: [http://www.armymedicine.army.mil/news/mhat/mhat\\_v/Redacted1-MHATV-4-FEB-2008-Overview.pdf](http://www.armymedicine.army.mil/news/mhat/mhat_v/Redacted1-MHATV-4-FEB-2008-Overview.pdf)

### **OTHER MENTAL HEALTH ISSUES**

**The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center. By E. Fuller Torrey and others, The Treatment Advocacy Center. (The Center, Arlington, Virginia) 2008. 17 p.**

[“Since the 1960s there has been a mass exodus of patients from public psychiatric hospitals. Data are available on the number of patients in such hospitals in 1955 and in 2004–2005.

The data show that: In 2005 there were 17 public psychiatric beds available per 100,000 population compared to 340 per 100,000 in 1955. Thus, 95 percent of the beds available in 1955 were no longer available in 2005. The states with the fewest beds were Nevada (5.1 per 100,000), Arizona (5.9), Arkansas (6.7), Iowa (8.1), Vermont (8.9), and Michigan (9.9). The states with the most beds were South Dakota (40.3) and Mississippi (49.7).

A consensus of experts polled for this report suggests that 50 public psychiatric beds per 100,000 population is a minimum number. Thus, 42 of the 50 states had less than half the minimum number needed, and Mississippi was the only state to achieve this goal.

The total estimated shortfall of public psychiatric beds needed to achieve a minimum level of psychiatric care is 95,820 beds.

The consequences of the severe shortage of public psychiatric beds include increased homelessness; the incarceration of mentally ill individuals in jails and prisons; emergency rooms being overrun with patients waiting for a psychiatric bed; and an increase in violent behavior, including homicides, in communities across the nation.

The consequences of the severe shortage in public psychiatric beds could be improved with the widespread utilization of PACT (Program of Assertive Community Treatment) programs and assisted outpatient treatment (AOT), both of which have been proven to decrease hospitalization. It could also be improved with greater flexibility in federal and state regulations allowing for the development of alternatives to hospitalization.”]

Full text at:

<http://www.treatmentadvocacycenter.org/documents/TheShortageofPublicHospitalBeds.pdf>

### **SUICIDE PREVENTION**

**“Reduction in Young Male Suicide Rates in Scotland.” By Cameron Stark, University of Aberdeen, Scotland, and others. IN: BMC Public Health, vol. 8 (February 29, 2008) pp. 1-21.**

[“Rates of suicide and undetermined death increased rapidly in Scotland in the 1980’s and 1990’s. The largest increases were in men, with a marked increase in rates in younger age groups. This was associated with an increase in hanging as a method of suicide. National suicide prevention work has identified young men as a priority group. Routinely collected national information suggested a decrease in suicide rates in younger men at the beginning of the 21st century. This study tested whether this was a significant change in trend, and whether it was associated with any change in hanging rates in young men....

There was a 42% reduction in rates in 15 – 29 year old men, from 42.5/100,000 in 2000 to 24.5/100,000 in 2004. A join point analysis confirmed that this was a significant change. There was also a significant change in trend in hanging in men in this age group, with a reduction in rates after 2000. No other male age group showed a significant change in trend over the period 1980 - 2004. There was a smaller reduction in suicide rates in women in the 15 - 29 year old age group, with a reduction in hanging from 2002. There has been a reduction in suicide rates in men aged 15 - 29 years, and this is associated with a significant reduction in deaths by hanging in this age group. It is not clear whether this is related to a change in method preference, or an overall reduction in suicidal behaviour, and review of self-harm data will be required to investigate this further.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2458-8-80.pdf>

**Veterans' Suicide. By the National Conference of State Legislatures. (NCSL, Washington, DC) February 19, 2008. 2 p.**

[“New research from the Department of Veterans Affairs (VA) finds that the majority of veterans from the Iraq and Afghanistan wars who commit suicides are from the National Guard or Reserves. From 2001, when the conflict in Afghanistan commenced, until to the end of 2005, Guard or Reserve members accounted for 53 percent of suicides. Although these members make up only 28 percent of American armed forces, they comprise nearly half the troops in Iraq. Veterans’ groups attribute the high rate to the stress experienced by soldiers who normally serve in their home state, but must deploy and then re-adjust to civilian life when they return, the *Associated Press* reports. This is the first demographic study of suicide among veterans from the wars in Afghanistan and Iraq. In November, President Bush signed the [Joshua Omvig Veterans Suicide Prevention Act](#), which directed the VA to improve its mental health training for staff and to increase screening and treatment of veterans.”]

Full text at: <http://www.ncsl.org/programs/health/shn/2008/hl509.htm>

**PODCASTS**

**NEW! Podcast/Video Mental Health Online Workshop for Parents of University Students.**

Full access to audio/video workshop: [http://www.parent.umn.edu/mental\\_health.php](http://www.parent.umn.edu/mental_health.php)

[“This online workshop features University of Minnesota experts addressing some of the most common mental health concerns they hear about from parents of University students. The audio, video, and podcasts of the workshop are posted online. Parents are encouraged to view the materials presented here as introductory, and to consult with the resources found here at the University of Minnesota or in their own communities for more in-depth information or to address any specific concerns. This workshop is made possible in part by a grant from The Jed Foundation.”]