

**Subject:** Studies in the News: (April 15, 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**

**"Achieving the Promise: The Significant Role of Schools in Transforming Children's Mental Health in America." By DeAnn Lechtenberger, Texas Tech University, and others. IN: Teaching Exceptional Children, vol. 40, no. 4 (March/April 2008) pp. 56-64.**

["According to the U.S. Department of Education (2003), during the 2001 to 2002 school year, 476,908 American children and youth attending public schools received special services under the category of serious emotional disturbance (SED), which is also referred to as emotional and/or behavioral disorders (EBD) in the research literature. It has been estimated that there are as many as 9 million children in the United States identified with SED. This estimate is destined to climb within the next 50 years as the number of children and youth with mental disorders climbs from 20% to nearly 50%

(U.S. Department of Health and Human Services." **Note: Article can be obtained from CA State Library.**]

**“Establishing ongoing, Early Identification Programs for Mental Health Problems in our Schools.”** By Robin Nemeroff, William Paterson University, and others. **IN: Journal of the American Academy of Child & Adolescent Psychiatry, vol. 47, no. 3 (March 2008) pp. 328-338.**

[“The objective of this study is to investigate the feasibility of establishing ongoing, early identification services for mental health problems in school settings. School counselors and other mental health professionals in middle, junior, and high schools were given training and supervision in the administration of an evidence-based mental health assessment tool, the Voice Diagnostic Interview Schedule for Children IV, over the course of 1 1/2 school years....Use of a computerized evidence-based mental health assessment tool is a feasible strategy for providing early mental health identification services in schools and can help to bridge the gap between mental health providers and the unmet needs of children who are at risk for mental health problems within the community.” **Note: Article can be obtained from the CA State Library.**]

**Improving the Delivery of Health Care that Supports Young Children’s Health Mental Health Development: Update on Accomplishments and Lessons from a Five-State Consortium.** By Neva Kaye and Jill Rosenthal, National Academy for State Health Policy. (The Academy, Washington, DC) February 2008. 65 p.

[“Services that support young children's healthy mental development can reduce the prevalence of developmental and behavioral disorders. Unchecked, social, emotional, and behavioral development delays have high costs and long-term consequences for health, education, child welfare, and juvenile justice systems—and for children's futures.

In January 2004, the second Assuring Better Child Health and Development (ABCD II) Consortium was formed. It provided five states (California, Iowa, Illinois, Minnesota, and Utah) an opportunity to develop and test strategies for improving the delivery of developmental services to young children at risk for or with social or emotional development delays, especially those in need of preventive or early intervention services. The states sought, by different means, to improve the identification of children in need of developmental services and improve the likelihood that those identified with a potential need received appropriate follow-up services, including intensified surveillance, assessment, and treatment. By the end of the three-year consortium, all produced data indicating success.”]

Full text at:

[http://www.commonwealthfund.org/usr\\_doc/Kaye\\_improving\\_delivery\\_healthy\\_mental.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Kaye_improving_delivery_healthy_mental.pdf?section=4039)

**“Public Knowledge and Assessment of Child Mental Health Problems: Findings from the National Stigma Study-Children.”** By Bernice A. Pescosolido, Indiana

**University, and others. IN: Journal of the Academy of Child & Adolescent Psychiatry, vol. 47, no. 3 (March 2008) pp. 339-349.**

[“Child and adolescent psychiatry confronts help-seeking delays and low treatment use and adherence. Although lack of knowledge has been cited as an underlying reason, we aim to provide data on public recognition of, and beliefs, about problems and sources of help. The National Stigma Study-Children is the first nationally representative study of public response to child mental health problems. A face-to-face survey of 1,393 adults used vignettes consistent with diagnoses of attention-deficit/hyperactivity disorder (ADHD) and depression....

Americans have clear and consistent views of children’s mental health problems. Mental health specialists face challenges in gaining family participation. Unless systematically addressed, the public’s lack of knowledge, skepticism, and misinformed beliefs signal continuing problems for providers, as well as for caregivers and children seeking treatment.” **Note: Article can be obtained from the CA State Library.]**

**“Understanding the Agreements and Controversies Surrounding Childhood Psychopharmacology.” By Erik Parens and Josephine Johnson, The Hastings Center. IN: Child and Adolescent Psychiatry and Mental Health, vol. 2, no. 5 (February 8, 2008) pp. 1-9.**

[“The number of children in the US taking prescription drugs for emotional and behavioral disturbances is growing dramatically. This growth in the use of psychotropic drugs in pediatric populations has given rise to multiple controversies, ranging from concerns over off-label use and long-term safety to debates about the societal value and cultural meaning of pharmacological treatment of childhood behavioral and emotional disorders. This commentary summarizes the authors' eight main findings from the first of five workshops that seek to understand and produce descriptions of these controversies. The workshop series is convened by The Hastings Center, a bioethics research institute located in Garrison, New York, U.S.A.”]

Full text at: <http://www.capmh.com/content/pdf/1753-2000-2-5.pdf>

## **DEPRESSION**

**“Long-term Cost Effects of Collaborative Care for Late-life Depression.” By Jurgen Unutzer, University of Washington School of Medicine, and others. IN: The American Journal of Managed Care, vol. 14, no. 2 (February 2008) pp. 95-100.**

[“Major depression and dysthymic disorder (chronic depression) are common in older adults. In addition to causing impairment of functioning and quality of life, depression in late life has been associated with substantial increases in total healthcare costs. The Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) trial<sup>3</sup> enrolled 1801 depressed older primary care patients from 8 healthcare systems in a randomized controlled trial of a collaborative care management program for depression

compared with care as usual. Participants from each organization were randomly assigned to collaborative care or to care as usual.

Earlier findings from the IMPACT study<sup>3</sup> reported that the collaborative care program was substantially more effective than care as usual in reducing depression and in improving physical and social function. Intervention patients continued to have significantly less depression than patients in usual care even at the 24-month follow-up, 12 months after the end of the intervention program.<sup>4</sup> Analyses from the IMPACT trial<sup>5</sup> found the collaborative care program to be substantially more cost-effective than care as usual. IMPACT participants experienced 107 more depression-free days during a 24-month period than patients assigned to care as usual. During the initial study year, total healthcare costs (including the costs of the IMPACT intervention) were slightly higher among the intervention group than among control subjects, but a slight decrease in costs among the intervention group compared with usual care patients was observed in the second year, suggesting that an initial investment in better depression care may result in long-term cost savings.

In this article, we report long-term (4-year) effects of collaborative care for late-life depression on total healthcare costs from a payer's perspective. Our findings are based on cost data available from 2 participating group-model health maintenance organizations."  
**Note: Copy of article can be obtained from California State Library.]**

**"Treating Tobacco Dependence in Clinically Depressed Smokers: Effect of Smoking Cessation on Mental Health Functioning." By Judith J. Prochaska, University of California, San Francisco, and others. IN: American Journal of Public Health, vol. 98, no. 3 (March 2008) pp.446-448.**

["Data was analyzed from a randomized trial of 322 actively depressed smokers and the effect of smoking cessation on their mental health functioning was examined. Only 1 of 10 measures at 4 follow-up time points was significant: participants who successfully stopped smoking reported less alcohol use than did participants who continued smoking. Depressive symptoms declined significantly over time for participants who stopped smoking and those who continued smoking; there were no group differences. Individuals in treatment for clinical depression can be helped to stop smoking without adversely affecting their mental health functioning." **NOTE: This article can be obtained from the California State Library.]**

### **DISASTER MENTAL HEALTH**

**Disaster Mental Health. [Issue Theme] By Julia Johnsen, University of Minnesota. IN: Healthy Generations, vol. 8, no. 1 (Center for Education in Maternal and Child Public Health, Minneapolis, Minnesota) Winter 2008. 3 p.**

[“Disasters have mental health implications for a significant proportion of people who experience them. These effects are multifaceted and frequent: they begin early and often last a long time. Why do many disasters have such pervasive and lasting consequences for mental health? The reasons span biological, psychological, and social domains.”

**Note: Articles can be obtained from the California State Library.]**

### **DISPARITIES**

**“Access to Mental Health Treatment by English Proficiency and Race/Ethnicity.”  
By T. Sentell and others, University of California, San Francisco. IN: *Journal of General Internal Medicine*, vol. 22, no. 2 (November 2007) pp. 289-293.**

[“Limited English proficiency (LEP) may contribute to mental health care disparities, yet empirical data are limited. The objective of this study was to quantify the language barriers to mental health care by race/ethnicity using a direct measure of LEP. A cross-sectional analysis of the 2001 California Health Interview Survey was conducted with adults aged 18 to 64 who provided language data (n = 41,984).

Participants were categorized into three groups by self-reported English proficiency and language spoken at home: (1) English-speaking only, (2) Bilingual, and (3) Non-English speaking. Mental health treatment was measured by self-reported use of mental health services by those reporting a mental health need.

Non-English speaking individuals had lower odds of receiving needed services than those who only spoke English, when other factors were controlled. The relationship was even more dramatic within racial/ethnic groups: non-English speaking Asian/PIs and non-English speaking Latinos had significantly lower odds of receiving services compared to Asian/PIs and Latinos who spoke only English.

LEP is associated with lower use of mental health care. Since LEP is concentrated among Asian/PIs and Latinos, it appears to contribute to racial/ethnic disparities in mental health care. Heightened attention to LEP is warranted in both mental health practice and policy.”]

Full text at:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=17957413>

**“Decades of Work to Reduce Disparities in Health Care Produce Limited Success.”  
By Rebecca Voelker. IN: *Journal of the American Medical Association*, vol. 299, no. 12 (March 28, 2008) pp. 1411-1413.**

[“The early weeks of 2008 brought discouraging news for advocates working to narrow health care disparities among racial and ethnic groups. In rapid succession, several studies published in January in peer-reviewed journals showed that despite decades of

efforts to raise awareness about disparities and to reduce them, the gaps in some key treatment areas have not budged.

The latest findings build on years of research that has established the extent of inequalities in treatment for cancer, heart disease, diabetes, and many other conditions. Cancer, for example, has been the focus of dozens of studies and a number of federal initiatives to document and reduce treatment disparities. However, a new analysis of 143 512 Medicare patients with breast, colorectal, lung, and prostate cancers shows that from 1992 to 2002, not only did treatment disparities persist, the magnitude of the disparities did not diminish.” **Note: Article can be obtained from the California State Library.]**

**“Inequitable Access for Mentally Ill Patients to Some Medically Necessary Procedures.” By Stephen Kesley and others, Dalhousie University. IN: Canadian Medical Association Journal, vol. 176, no. 6 (March 13, 2007) pp. 779-784.**

[“Although universal health care aims for equity in service delivery, socioeconomic status still affects death rates from ischemic heart disease and stroke as well as access to revascularization procedures. We investigated whether psychiatric status is associated with a similar pattern of increased mortality but reduced access to procedures. We measured the associations between mental illness, death, hospital admissions and specialized or revascularization procedures for circulatory disease (including ischemic heart disease and stroke) for all patients in contact with psychiatric services and primary care across Nova Scotia.

We carried out a population-based record-linkage analysis of related data from 1995 through 2001 using an inception cohort to calculate rate ratios compared with the general public for each outcome (n = 215,889). Data came from Nova Scotia's Mental Health Outpatient Information System, physician billings, hospital discharge abstracts and vital statistics. We estimated patients' income levels from the median incomes of their residential neighbourhoods, as determined in Canada's 1996 census.

The rate ratio for death of psychiatric patients was significantly increased (1.34), even after adjusting for potential confounders, including income and comorbidity (95% confidence interval, which was reflected in the adjusted rate ratio for first admissions. Their chances of receiving a procedure, however, did not match this increased risk. In some cases, psychiatric patients were significantly less likely to undergo specialized or revascularization procedures, especially those who had ever been psychiatric inpatients. In the latter case, adjusted rate ratios for cardiac catheterization, percutaneous transluminal coronary angioplasty and coronary artery bypass grafts were 0.41, 0.22 and 0.34, respectively, in spite of psychiatric inpatients' increased risk of death.

Psychiatric status affects survival with and access to some procedures for circulatory disease, even in a universal health care system that is free at the point of delivery. Understanding how these disparities come about and how to reduce them should be a priority for future research.”]

Full text at:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=17353530>

**“New Evidence Regarding Racial and Ethnic Disparities in Mental Health: Policy Implications.”** By Thomas G. McGuire, Harvard Medical School, and Jeanne Miranda, University of California, Los Angeles. IN: *Health Affairs*, vol. 27, no. 2 (March/April 2008) pp. 393-402.

[“Minorities have, in general, equal or better mental health than white Americans, yet they suffer from disparities in mental health care. This paper reviews the evidence for mental health and mental health care disparities, comparing them to patterns in health. Strategies for addressing disparities in health care, such as improving access to and quality of care, should also work to eliminate mental health care disparities. In addition, a diverse mental health workforce, as well as provider and patient education, are important to eliminating mental health care disparities.” **Note: Article can be obtained from the CA State Library.**]

### **EVIDENCE-BASED PROGRAMS**

**Creating a Center for Evidence-Based Medicine: A Study Conducted by Staff from the American Institutes for Research for the Medicare Payment Advisory Committee.** By Marilyn Moon and others, the American Institutes for Research. (The Institute, Washington, DC) February 2008. 34 p.

[“This paper considers what might be done as first steps toward a more comprehensive and systematic approach to using evidence for improving health care. In doing so, we consider some of the barriers and challenges facing such an effort, what a structure for an organization to promote evidence-based applications might look like, and lessons and cautions for moving forward.

In particular, we consider the necessary components of an organization that might be established, drawing on lessons both from Britain’s National Institute for Health and Clinical Excellence (NICE) and from a recent federal government effort, the National Registry of Effective Programs (NREP) developed by the Federal Center for Substance Abuse Prevention under the Substance Abuse and Mental Health Services Administration. The last section of the paper examines a range of practical considerations in creating a center for healthcare improvement. Finally, an appendix to the paper examines some of the measures used in comparative and cost effectiveness studies; an additional barrier to establishing an organization to promote more analysis is the lack of firm consensus on the specific measures that should be used.”]

Full text at:

[http://www.medpac.gov/documents/Feb08\\_Center\\_EvidenceBased\\_CONTRACTOR\\_N\\_R.pdf](http://www.medpac.gov/documents/Feb08_Center_EvidenceBased_CONTRACTOR_N_R.pdf)

## **FOSTER CARE AND MENTAL HEALTH**

**A Reason, A Season, or A Lifetime: Relational Permanence among Young Adults with Foster Care Backgrounds.** By Gina Miranda Samuels, Chapin Hall Center for Children at the University of Chicago. (The Center, Chicago, Illinois) 2008. 96 p.

[“The phenomenon called “aging out” includes approximately 20,000 young people who enter adulthood directly from foster care each year. Internationally, growing attention is afforded to this population as research continues to indicate a startling range of risks to their adulthood success. Few studies examine social support networks and relational well-being among this population. This interpretive study conducted in-depth interviews and created personal network maps with twenty-nine young adults participating in a program offering resources to help them make successful transitions to adulthood. The aim of this study was to explore their social support networks and examine how foster care might constrain or facilitate supportive relationships into adulthood. This study is informed by a conceptualization of foster care as embedded in “ambiguous loss.” The report’s key findings describe the members of their support networks and discuss unique aspects of these relationships including: (1) the distinctions participants make between the role of adult versus peer support, (2) the multiple roles and supports of inner-circle members, and (3) the participants’ understanding of what sustains or threatens the permanence of their most important relationships. This report introduces the concept of familial support, providing a sense of family connection, as an important support provided by some participants’ inner-circle network members. Ultimately, these findings indicate that experiencing and learning to cope with ambiguous loss shapes and informs how participants interpret their social worlds and affects their sense of some relationships as seasonal, and others as permanent or enduring across the life course. The report closes with implications for practice and policy.”]

Full text at: [http://www.chapinhall.org/article\\_abstract.aspx?ar=1466](http://www.chapinhall.org/article_abstract.aspx?ar=1466)

## **HOMELESSNESS**

**“Collaborative Mental Health Care for the Homeless: The Role of Psychiatry in Positive Housing and Mental Health Outcomes.”** By Vicky Stergiopoulos, University of Toronto, and others. IN: *Canadian Journal of Psychiatry*, vol. 53, no. 1 (January 2008) pp. 61-67.

[“Factors associated with positive outcomes for homeless men referred to a shelter-based collaborative mental health care teams were examined. A chart review of 73 clients referred over 12 months was completed. Two outcome measures were examined, clinical status and housing status, 6 months after their referral to the program.

Result: Among the referred clients, the prevalence of severe and persistent mental illness and substance use disorders was 76.5% and 48.5%, respectively. At 6 months, 24 clients (35.3%) had improved clinically, and 33 (48.5%) were housed. Logistic regression identified 2 factors associated with clinical improvement: the number of visits with a

psychiatrist and treatment adherence. The same 2 factors were associated with higher odds of housing, and presence of substance use disorder was associated with lower odds of housing at 6-month follow-up.

Conclusion: Care by a mental health specialist is positively associated with improved outcomes. Strategies to improve treatment adherence, access to mental health specialists, and innovative approaches to treatment of substance use disorders should be considered for this population. Having a psychiatrist as a member of a shelter-based collaborative care team is one possible way of addressing the complex physical and mental health needs of homeless individuals.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=29995307&site=ehost-live>

### **JUVENILE JUSTICE AND MENTAL HEALTH**

**“Perceived Barriers to Mental Health Services among Youths in Detention.” By Karen M. Abram, Northwestern University Feinberg School of Medicine, and others. IN: Journal of the Academy of Child & Adolescent Psychiatry, vol. 47, no. 3 (March, 2008) pp. 301-308.**

[“The objective of this study is to examine perceived barriers to mental health service use among male and female juvenile detainees. The sample used included 1,829 juveniles newly detained in Chicago. The Diagnostic Interview Schedule for Children and Children’s Global Assessment Scale were used to determine the need for services. Service use and barriers to services were assessed with the Service Utilization and Risk Factors interview. Approximately 85% of youths with psychiatric disorders reported at least one perceived barrier to services. Most common was the belief that problems would go away without help. Generally, attitudes toward services were remarkable similar across sex and race. Among females, significantly more youths with past service use of referral to services reported this barrier than did youths who had never received or been referred to services. Among males, significantly more youths who had been referred, but never received, services were unsure about where to go for help than youths with past service use...

Despite the pervasive need for mental health services, the findings of this study suggest that detained youths do not perceive the mental health system as an important or accessible resource.” **Note: This article can be obtained from the CA State Library.]**

**“Reading Problems, Attention Deficits, and Current Mental Health Status in Adjudicated Adolescent Males.” By Natalie O’Brien and others. IN: Journal of Correctional Education, vol. 58, no. 3 (September 2007) pp.293-315.**

[“This study examined the prevalence of reading problems and self-reported symptoms of attentional deficits in a sample of adjudicated adolescent males (N = 101) aged 12 to 18

years who were residing in an alternative sentencing residential program. Thirty- four percent of the youth had reading problems while only 9% of the boys had self- reported attentional deficits. An additional 10% of the youth reported experiencing both reading problems and attentional difficulties. Results indicated that male offenders with attentional deficits reported greater depression, reduced self-concept~ and a more external locus of control at intake than male offenders with reading difficulties. Furthermore, male youth offenders with reading and attentional problems reported more depression, less positive self-concepts and a more external locus of control than did youth with reading problems only, but did not differ significantly from the group who only reported attentional problems. Overall, these findings exemplify the need for both educational and psychological interventions for youth entering the juvenile justice system. Psychological interventions for male offenders who self-report attentional difficulties may be particularly warranted.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=27945844&site=ehost-live>

### **MILITARY AND MENTAL HEALTH**

**“Characteristics of Deployed Operation Iraqi Freedom Military Personnel Who Seek Mental Health Care.” By Bradford Felker, Department of Veteran’s Affairs Puget Sound Health Care System, and others. IN: Military Medicine, vol. 173, no. 2 (February 2008) pp. 155-158.**

[“Introduction: This study reports on the feasibility of using validated mental health screening instruments for deployed Operation Iraqi Freedom military personnel. Methods: For a 3-month period in 2005, all service members (N = 296) who initially presented to the U.S. Military Hospital Kuwait mental health clinic completed an intake questionnaire that gathered demographic information and contained validated instruments to screen for mental disorders and functional impairment. Results: A total of 19% of the sample subjects screened positive for post-traumatic stress disorder-related symptoms, 35% for a major depressive disorder, and 11% for severe misuse of alcohol. Significant levels of distress and functional impairment were reported by 58% of the sample. Women represented a disproportionately high percentage of those presenting for care (27%). Conclusions: Screening instruments were well accepted and useful in detecting psychopathological conditions and functional impairment. Female service members might represent a high-risk group. These results are useful for those caring for service members during or after deployment.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=30001903&site=ehost-live>

### **PRIMARY CARE**

**“Beyond the Limits of Clinical Governance? The Case of Mental Health in English Primary Care.” By Linda Gask and others, University of Manchester, England. IN: BMC Health Services Research, vol. 8, no. 63 (March 28, 2008) pp. 1-27**

[“Little research attention has been given to attempts to implement organisational initiatives to improve quality of care for mental health care, where there is a high level of indeterminacy and clinical judgements are often contestable. This paper explores recent efforts made at an organisational level in England to improve the quality of primary care for people with mental health problems through the new institutional processes of clinical governance.

Framework analysis, based on the Normalisation Process Model (NPM), of attempts over a five year period to develop clinical governance for primary mental health services in Primary Care Trusts (PCTs). The data come from a longitudinal qualitative multiple case-study approach in a purposive sample of 12 PCTs, chosen to reflect a maximum variety of organisational contexts for mental health care provision.

The constant change within the English NHS provided a difficult context in which to attempt to implement clinical governance. In the absence of clear evidence or direct guidance about what primary mental health care should be, and a lack of actors with the power or skills to set about realising it, the actors in clinical governance had little shared knowledge or understanding of their role in improving the quality of mental health care although some success was achieved in the monitoring of prescribing practice. There was a lack of ownership of mental health as an integral, normalised part of primary care.

Despite some achievements in regard to monitoring and standardisation of prescribing practice, mental health care in primary care seems to have so far largely eluded the gaze of clinical governance. Clinical governance in English primary mental health care has not yet become normalised. We make some policy recommendations which we consider would assist in the process normalisation and suggest other contexts to which our findings might apply.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1472-6963-8-63.pdf>

## **POLICIES AND PROCEDURES**

**Facing Deficits, Many States are Imposing Cuts that Hurt Vulnerable Residents. By Iris J. Lav and Elizabeth Hudgins, Center on Budget and Policy Priorities. (The Center, Washington, DC) March 13, 2008. 6 p.**

[“When the economy weakens, state and local revenues *decline* but the need for public programs *increases*, as residents lose jobs, income, and health insurance. Already, more than half the states are projecting deficits for the upcoming fiscal year or beyond. In the 21 states (plus the District of Columbia) for which specific estimates are available, the

combined deficits are expected to total at least \$37 billion for fiscal 2009. (In most states, fiscal year 2009 starts July 1 of this year.)

Virtually all states are required to balance their budgets each year or each biennium. Unlike the federal government, states cannot maintain services during an economic downturn by running a deficit. Thus, states will have to close the deficits now being reported with a combination of actions: drawing down reserves, raising taxes, or cutting expenditures.

Some states have already begun drawing on their rainy day funds and reserves. But if the economy remains weak or falls into recession, states' reserve funds will be depleted and many more states will likely turn to harmful budget cuts to balance their budgets. In addition, two states have already enacted significant tax increases, and a few other states are considering them. The federal government, which can — and arguably *should* — run deficits during troubled economic times, can help states minimize damaging budget cuts by providing assistance to the states, as it did in the recession in the early part of this decade.”]

Full text at: <http://www.cbpp.org/3-13-08sfp.pdf>

### **NEW MAY 2008 CONFERENCES**

**5-8 2008 CA WIC Association Annual Conference — San Diego**

[http://www.calwic.org/spring\\_conference.aspx](http://www.calwic.org/spring_conference.aspx)

**7–9 2008 California Mental Health Advocates for Children and Youth Conference: Promoting Wellbeing**

**Through Partnerships — Pacific Grove** (<http://www.cmhacy.org/conf-conference-overview.html>)

**12 Care Notebook Training — Los Angeles (for information, Contact Yolanda Casillas** [ycasillas@chla.usc.edu](mailto:ycasillas@chla.usc.edu))

**19–22 2008 National Conference, Prevent Child Abuse America, Connecting the Dots: Turning Knowledge**

**into Action — Milwaukee, WI** (<http://www.preventchildabuse.org/events/conference/index.shtml>)

**24–26 AAP CA Chapter 1, Pediatric Best Practices, Annual Spring Post Graduate Course — Monterey**

<http://www.aap-ca.org/meetings.html>

### **NEW JUNE 2008 CONFERENCES**

**4–5 Center for Prevention and Early Intervention Early Starts Institutes: Cognition and Early Learning — Anaheim** <http://www.wested.org/cs/cpei/print/docs/211>

**17–18 California Head Start Association Summer Health Institute — Riverside**  
<http://www.caheadstart.org/conference.html>

**NEWJULY 2008 CONFERENCES**

**8-Autism Spectrum Disorder and Employment**  
(sponsored by CRP-RCEP) —webcast  
<http://www.crp-rcep.org/training/webcastDetails.cfm/115>

**16–18 UIC MCH Leadership Program, A Retreat to Advance Maternal and Child Health Scholarship and Practice — Chicago**  
[http://www.uic.edu/sph/mch/mch\\_leadership\\_conference.htm](http://www.uic.edu/sph/mch/mch_leadership_conference.htm)

**16–20 Georgetown University Training Institutes 2008: Developing Local Systems of Care for Children and Adolescents with Mental Health Needs and their Families — Nashville, TN**  
[http://gucchd.georgetown.edu/programs/ta\\_center/TrainingInstitutes/](http://gucchd.georgetown.edu/programs/ta_center/TrainingInstitutes/)