

Subject: Studies in the News: (April 30, 2008)



Studies in the News for



California Department of Mental Health

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](#)

How to Obtain Materials Listed in SITN:

- When available on the Internet, the URL for the full-text of each item is provided.
- **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.
- All other interested individuals should contact their local library-the items may be available there, or may be borrowed by your local library on your behalf.

The following are the Subject Headings included in this issue:

CHILDREN AND ADOLESCENT MENTAL HEALTH

[Alignment of family needs and services.](#)

DEPRESSION

[Risk factors of antenatal depression, postnatal depression, and parent stress.](#)

DISPARITIES

[Public health approach to eliminating disparities in health.](#)
[Conceptualizing racial and ethnic disparities in health.](#)
[Geographic and racial/ethnic disparities in child health.](#)

EVIDENCE BASED PRACTICE

[Integrated treatment model for HIV, mental illness and substance abuse.](#)
[Results of trial using supported employment for persons with schizophrenia.](#)
[Community-based program for American Indians and Alaskan natives.](#)
[State implementation of evidence-based practice for youths.](#)

MILITARY AND MENTAL HEALTH ISSUES

[Mental health and cognitive care needs of returning veterans.](#)
[Post-deployment stress: What families know and what families can do.](#)
[Post-deployment stress: What you know and what you can do.](#)

POLICY AND PROCEDURES

[States' roles in shaping high performance health systems.](#)

STIGMA

[Predictors of personal and perceived stigma associated with depression.](#)
[Reducing the stigma and discrimination of mental illness.](#)

SUICIDE PREVENTION

[Preventing suicide in a college student population.](#)
[Increasing use of antidepressants and decreasing suicide rates.](#)
[Families dealing with teen suicide.](#)
[Adolescents and suicide prevention programs.](#)

UNIVERSITY MENTAL HEALTH COUNSELING CENTERS

[2007 National survey of counseling center directors at colleges and universities.](#)

NEW WEB-BASED SEMINAR ON JUVENILE JUSTICE SYSTEMS

[Creative approaches to using Medicaid in juvenile justice systems.](#)

CHILDREN AND ADOLESCENT MENTAL HEALTH

Are Family Needs and Services Aligned? Evaluating the Bureau of Milwaukee Child Welfare. By Andrew W. Zinn, Chapin Hall Center for Children at the University of Chicago, and Mark E. Courtney, Partners for our Children. Chapin Hall Center for Children. (The Center, Chicago, Illinois) 2008. 14 p.

[“Public child welfare systems struggle to address the problems facing the families they serve in part because of the myriad reasons families come to the attention of child welfare authorities. Neglect, sexual abuse, and child behavior problems, to name a few, arise for different reasons and require equally different remedies.

Within this context, public child welfare systems must make decisions about how to allocate scarce resources, including which types of services merit their support. Often complicating those decisions is a lack of information about the populations served and the efficacy of different types of services. In an increasingly performance-based environment, in which states and local agencies are being held accountable for family

outcomes, it is imperative that the system gain a better understanding of who is served and how their needs can best be met.”]

Full text at: http://www.chapinhall.org/article_abstract.aspx?ar=1350

DEPRESSION

“Risk Factors for Antenatal Depression, Postnatal Depression, and Parenting Stress.” By Bronwyn Leigh, Austin Health, Victoria, Australia, and Jeannette Milgrom, University of Melbourne. IN: *BMC Psychiatry*, vol. 8, no. 24 (April 16, 2008) pp. 1-34.

[“Given that the prevalence of antenatal and postnatal depression is high, with estimates around 13%, and the consequences serious, efforts have been made to identify risk factors to assist in prevention, identification and treatment. Most risk factors associated with postnatal depression have been well researched, whereas predictors of antenatal depression have been less researched. Risk factors associated with early parenting stress have not been widely researched, despite the strong link with depression. The aim of this study was to further elucidate which of some previously identified risk factors are most predictive of three outcome measures: antenatal depression, postnatal depression and parenting stress and to examine the relationship between them.

Primipara and multiparae women were recruited antenatally from two major hospitals as part of the beyondblue National Postnatal Depression Program. In this subsidiary study, 367 women completed an additional large battery of validated questionnaires to identify risk factors in the antenatal period at 26-32 weeks gestation. A subsample of these women (N = 161) also completed questionnaires at 10-12 weeks postnatally. Depression level was measured by the Beck Depression Inventory (BDI).

Regression analyses identified significant risk factors for the three outcome measures. (1) Significant predictors for antenatal depression: low self-esteem, antenatal anxiety, low social support, negative cognitive style, major life events, low income and history of abuse. (2) Significant predictors for postnatal depression: antenatal depression and a history of depression while also controlling for concurrent parenting stress, which was a significant variable. Antenatal depression was identified as a mediator between seven of the risk factors and postnatal depression. (3) Postnatal depression was the only significant predictor for parenting stress and also acted as a mediator for other risk factors.

Risk factor profiles for antenatal depression, postnatal depression and parenting stress differ but are interrelated. Antenatal depression was the strongest predictor of postnatal depression, and in turn postnatal depression was the strongest predictor for parenting stress. These results provide clinical direction suggesting that early identification and treatment of perinatal depression is important.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-8-24.pdf>

DISPARITIES

"The Public Health Approach to Eliminating Disparities in Health." By David Satcher and Eve J. Higginbotham, Morehouse School of Medicine. IN: American Journal of Public Health, vol. 98, no. 3 (March 2008) pp. 400-403

["Reducing and eliminating disparities in health is a matter of life and death. Each year in the United States, thousands of individuals die unnecessarily from easily preventable diseases and conditions. It is critical that we approach this problem from a broad public health perspective, attacking all of the determinants of health: access to care, behavior, social and physical environments, and overriding policies of universal access to care, physical education in schools, and restricted exposure to toxic substances. We describe the historical background for recognizing and addressing disparities in health, various factors that contribute to disparities, how the public health approach addresses such challenges, and two successful programs that apply the public health approach to reducing disparities in health. Public health leaders must advocate for public health solutions to eliminate disparities in health." **Note: A copy of this article can be obtained from the CA State Library.**]

"Toward a Policy Relevant Analysis of Geographic and Racial/Ethnic Disparities in Child Health." By Delores Acevedo-Garcia, Harvard School of Public Health, and others. IN: Health Affairs, vol. 27, no. 2 (2008) pp. 321-333.

["Extreme racial/ethnic disparities exist in children's access to "opportunity neighborhoods." These disparities arise from high levels of residential segregation and have implications for health and well-being in childhood and throughout the life course. The fact that health disparities are rooted in social factors, such as residential segregation and an unequal geography of opportunity, should not have a paralyzing effect on the public health community. However, we need to move beyond conventional public health and health care approaches to consider policies to improve access to opportunity-rich neighborhoods through enhanced housing mobility, and to increase the opportunities for healthy living in disadvantaged neighborhoods."]

Full text at: <http://content.healthaffairs.org/cgi/reprint/27/2/321>

"When does a Difference Become a Disparity? Conceptualizing Racial and Ethnic Disparities in Health." [Issue Theme: Disparities: Expanding the Focus] By Paul L. Hebert, Mt. Sinai School of Medicine, New York, and others. IN: Health Affairs, vol. 27, no. 2 (March/April 2008) pp. 374-382.

["Definitions of racial and ethnic disparities fall along a continuum from differences with little connotation of being unjust to those that result from overt discrimination. Where along this continuum one decides that a racial difference becomes a disparity is subjective, but the magnitude of the injustice is generally proportional to how much

control a person is perceived to have over the cause of the difference in health. The degree to which one sees environmental factors and social context as shaping choices has important implications for the measurement of disparities and ultimately for directing efforts to eliminate them.

Policymakers have long known that racial and ethnic differences in health exist, and the federal government has made eliminating disparities a high priority. But there is little consensus on what constitutes a disparity, or when a difference between two groups should be given the more charged term of *disparity*. To many, *disparity* implies an inequity or an injustice rather than a simple inequality. Determining when a difference becomes a disparity may be problematic because a disparity is not measured directly, but rather as a residual or a difference between two groups, often only after other factors that might contribute to that difference have been statistically controlled for. Because a person's "race" is correlated with a large number of such factors, including his or her socioeconomic position and living conditions, there are many decisions to make. Although some factors are fairly obvious to control for, such as differences in age when measuring mortality, and not to control for, such as measures of overt racism, there is a large gray area in between.”]

Full text at: <http://content.healthaffairs.org/cgi/reprint/27/2/374>

EVIDENCE-BASED PRACTICES

“An Integrated, Multidimensional Treatment Model for Individuals Living with HIV, Mental Illness, and Substance Abuse.” By Stephanie Bouis, Duke University Medical Center, and others. IN: Health & Social Work, vol. 32, no. 4 (November 2007) pp. 268-278.

[“The challenge of providing effective treatment services for the growing population of HIV-positive individuals who are also dually diagnosed with substance use and mental disorders has only recently been recognized as an important public health concern affecting both HIV treatment and prevention. This article describes a treatment model that was created for a study of integrated treatment for HIV-positive individuals with substance use and mental disorders. The treatment model was based on the transtheoretical model of behavior change as well as evidence-based practices that are widely used in the treatment of individuals dually diagnosed with substance use and mental disorders. The model involved collaboration between medical and behavioral health care professionals and emphasized the importance of goal reinforcement across disciplines. Furthermore, it included the development and enhancement of client motivation to modify medical and behavioral health-risk behaviors using individual readiness for change and offered comprehensive care addressing a continuum of client needs that may influence treatment outcomes. Treatment modalities included individual therapy, group therapy, and psychiatric medication management. This treatment intervention was associated with positive outcomes in the integrated treatment study and can be adapted for use in a variety of psychiatric or medical treatment settings.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=28087574&site=ehost-live>

“Effectiveness of Supported Employment for Individuals with Schizophrenia: Results of a Multi-Site Randomized Trial.” By Judith A. Cook, University of Illinois at Chicago, and others. IN: *Clinical Schizophrenia & Related Psychoses*, vol. 2, no. 1 (April 2008) pp. 37-46.

[“Background: Prior studies of supported employment efficacy for individuals with schizophrenia have yielded mixed results, with some finding poorer outcomes for those with this diagnosis and others finding no differences. Aims: This multi-site effectiveness trial examined the relative impact of diagnosis with schizophrenia and evidence-based practice supported employment on the likelihood of competitive employment.

Method: At seven U.S. sites, 1,273 outpatients with severe mental illness were randomly assigned to either an experimental supported employment program or to a comparison/services as usual condition and followed for two years. Data collection involved semi-annual, in-person interviews, and weekly recording of all paid employment by vocational and research staff. Mixed-effects random regression analysis was used to examine the effects of study condition, schizophrenia diagnosis, and their interaction, on the likelihood of competitive employment.

Results: Subjects in experimental group programs and those with diagnoses other than schizophrenia (predominantly bipolar disorder and major depression) were significantly more likely to be competitively employed than those in control programs and those with diagnoses of schizophrenia. However, an interaction effect between study condition and diagnosis was observed in which experimental group treatment ameliorated the negative effects of diagnosis on employment outcome.

Discussion: Evidence-based supported employment interventions are superior to services as usual/comparison programs in assisting individuals with schizophrenia to attain competitive employment. Given recent evidence of this model's effectiveness outside the U.S. and interest in its promotion internationally, it has global potential to further the recovery potential of individuals with psychiatric disabilities.”]

Full text:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31546795&site=ehost-live>

“The Native Telehealth Outreach and Technical Assistance Program: A Community Based Approach to the Development of Multimedia Focused Health Care Information.” By Rhonda Wiegman Dick, University of Colorado at Denver, and others. IN: *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, vol. 14, no. 2 (2007) pp. 49-66.

[“The development and dissemination of culturally relevant health care information has traditionally taken a "top-down" approach. Governmental funding agencies and research institutions have too often dictated the importance and focus of health-related research and information dissemination. In addition, the digital divide has affected rural communities in such a way that their members often do not possess the knowledge or experience necessary to use technological resources. And, even when they do, their skills may be limited, adequate only for implementing applications and programs designed by others who live and work outside of these communities.

This need became the driving force in the creation of the Native Telehealth Outreach and Technical Assistance Program. The goal of the program is to equip Native community members, at both the lay and professional levels, with the means to use technology to address tribal health care needs. The transfer of relevant technical knowledge and skills enables participants to develop projects which enhance the community-wide dissemination of health care information. Nine community health advocates and professionals participated in the initial cohort. Eight of the participants successfully developed multimedia-based projects including Web sites, interactive CD-ROMs, and video focusing on a variety of health concerns. At the conclusion of the 18-month program period, projects were disseminated throughout rural communities. The NTOTAP staff continues to evaluate the use of these projects and their benefits within the rural communities.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=27563930&site=ehost-live>

“State Implementation of Evidence-Based Practice for Youths, Part I: Responses to the State of the Evidence.” By Eric J. Bruns, University of Washington school of Medicine, and Kimberly Eaton Hoagwood, Columbia University. IN: Journal of the American Academy of Child & Adolescent Psychiatry, vol. 47, no. 4 (April 2008) pp. 369-374.

[“The article describes a unique association of states in the U.S. that are investigating how administrators and stakeholders should create public policy through their statewide evidence-based practice implementation efforts for children and adolescents. The section presents background on such issue, significant theory and research, and descriptions of approaches followed by six of these U.S. states. It also provides a synthesis of these state approaches, including recommendations for state policy, federal policy, and future research.” **NOTE: A copy of this article can be obtained from the California State Library.**]

MILITARY AND MENTAL HEALTH ISSUES

Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans. By the Rand Center for Military Health Policy Research. (Rand Corporation, Santa Monica, CA) 2008. 7 p.

[“Since October 2001, approximately 1.64 million U.S. troops have deployed to support operations in Afghanistan and Iraq. Many have been exposed for prolonged periods to combat-related stress or traumatic events. Safeguarding the mental health of these service members and veterans is an important part of ensuring the future readiness of our military force and compensating and honoring those who have served our nation. In the wake of recent reports and media attention, public concern about the care of the war wounded is high. In response, several task forces, independent review groups, and a Presidential Commission have examined the care of the war wounded and recommended improvements. Policy changes and funding shifts are already under way.”]

Full text at: http://www.rand.org/pubs/research_briefs/2008/RAND_RB9336.pdf

Post Deployment Stress: What Families Should Know, What Families Can Do. By the Center for Military Health Policy Research. (The Rand Corporation, Santa Monica, California) 2008. 16 p.

[“Information is covered for families of veterans returning from deployment in Iraq or Afghanistan about post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and other emotional and behavioral problems that veterans may face. Before developing this pamphlet, companion to CP-534-IADIF (*Post-Deployment Stress: What You Should Know, What You Can Do*), RAND surveyed a couple hundred existing educational materials on these topics. The researchers then coded and classified these materials and reviewed them to identify gaps in information and to isolate the best materials from which to draw upon. Based on these refined materials, the booklet was further improved by feedback from RAND Corporation experts, other military mental health experts, and nine focus groups including service members and their families.”]

Full text at: http://rand.org/pubs/corporate_pubs/2008/RAND_CP535-2008-03.pdf

Post Deployment Stress: What You Should Know, What You Can Do. By the Center for Military Health Policy Research. (The Rand Corporation, Santa Monica, California) 2008. 16 p.

[“Information is covered for veterans returning from deployment in Iraq or Afghanistan about post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and other emotional and behavioral problems that veterans may face. Before developing this booklet, companion to CP-535-IADIF (*Post-Deployment Stress: What Families Should Know, What Families Can Do*), RAND surveyed a couple hundred existing educational materials on these topics. The researchers then coded and classified these materials and reviewed them to identify gaps in information and to isolate the best materials from which to draw upon. Based on these refined materials, the booklet was further improved by feedback from RAND Corporation experts, other military mental health experts, and nine focus groups including service members and their families.”]

Full text at: http://rand.org/pubs/corporate_pubs/2008/RAND_CP534-2008-03.pdf

POLICIES AND PROCEDURES

Identifying and Evaluating Equity Provisions in State Health Care Reform. By Brian Smedley, the Opportunity Agenda, and others. (The Commonwealth Fund, New York, New York) April 2008. 66 p.

[“Millions of people in the United States—principally racial and ethnic minorities, immigrants, and those who lack proficiency in English—face barriers to high-quality health care. Such problems are largely due to high numbers of uninsured individuals among these groups, though it persists even when they are insured. By expanding health insurance coverage and addressing issues of access to care, quality of care, patient empowerment, infrastructural reforms, and social and community-level determinants of health, states have the potential to achieve equity. This report seeks to identify state policies that promote equitable health care access and quality and to evaluate existing laws, regulations, or reform proposals in five states—Massachusetts, Washington, Illinois, Pennsylvania, and California. These states’ initiatives, all of which move toward universal health insurance coverage, also address other innovative strategies such as improving health care provider diversity, distribution, and cultural competence.”]

Full text at:

http://www.commonwealthfund.org/usr_doc/Smedley_identifyingequityprovisions_1124.pdf?section=4039

States’ Roles in Shaping High Performance Health Systems. By Catherine Hess and others, National Academy of State Health Policy. Publication No. 1115. (The Commonwealth Fund, New York, New York) April 2008. 44 p.

[“States shape the health system in many ways, influencing key components such as insurance coverage, quality of care, and information and provider infrastructures. This report presents findings from the State Health Policies Aimed at Promoting Excellent Systems project, undertaken by the National Academy for State Health Policy, with support from The Commonwealth Fund. After conducting surveys of multiple agencies in states across the country, as well as a review of related literature, this study found that states are pursuing system improvements across the full spectrum of their authority, including health care purchasing, regulation of providers, reporting of performance data, integration of public health with health care approaches, and improving the availability and affordability of health insurance. Despite this activity, this study finds room for states to do much more. Ongoing efforts to track, study and diffuse information on state activities could accelerate adoption of promising policies and practices.”]

Full text at:

http://www.commonwealthfund.org/usr_doc/Hess_statesrolesshapinghighperfhltsys_1115.pdf?section=4039

STIGMA

“Predictors of Depression Stigma.” By Kathleen M. Griffiths, Australian National University, and others. IN: BMC Psychiatry, vol. 8, no. 25 (April 18, 2008) pp. 1-36.

[“The objective of this study is to investigate and compare the predictors of personal and perceived stigma associated with depression.

Three samples were surveyed to investigate the predictors: a national sample of 1,001 Australian adults; a local community sample of 5,572 residents of the Australian Capital Territory and Queanbeyan aged 18 to 50 years; and a psychologically distressed subset (n=487) of the latter sample. Personal and Perceived Stigma were measured using the two subscales of the Depression Stigma Scale. Potential predictors included demographic variables (age, gender, education, country of birth, remoteness of residence), psychological distress, awareness of Australia’s national depression initiative beyondblue, depression literacy and level of exposure to depression. Not all predictors were used for all samples.

Personal stigma was consistently higher among men, those with less education and those born overseas. It was also associated with greater current psychological distress, lower prior contact with depression, not having heard of a national awareness raising initiative, and lower depression literacy. These findings differed from those for perceived stigma except for psychological distress which was associated with both higher personal and higher perceived stigma. Remoteness of residence was not associated with either type of stigma.

The findings highlight the importance of treating the concepts of personal and perceived stigma separately in designing measures of stigma, in interpreting the pattern of findings in studies of the predictors of stigma, and in designing, interpreting the impact of and disseminating interventions for stigma.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-8-25.pdf>

“Reducing Stigma and Discrimination: Candidate Interventions.” By Graham Thornicroft and others, King’s College London. IN: International Journal of Mental Health Systems, vol. 2, no. 3 (April 13, 2008) pp.1-22.

[“This paper proposes that stigma in relation to people with mental illness can be understood as a combination of problems of knowledge (ignorance), attitudes (Prejudice) and behaviour (discrimination). From a literature review, a series of candidate interventions are identified which may be effective in reducing stigmatisation and discrimination at the following levels: individuals with mental illness and their family members; the workplace; and local, national and international. The strongest evidence for effective interventions at present is for (i) direct social contact with people with mental illness at the individual level, and (ii) social

marketing at the population level.”]

Full text at: <http://www.ijmhs.com/content/pdf/1752-4458-2-3.pdf>

SUICIDE PREVENTION

"An Empirically Supported Program to Prevent Suicide in a College Student Population." By Paul Joffe, University of Illinois, Urbana-Champaign. IN: *Suicide & Life-Threatening Behavior*, vol. 38, no. 1 (February 2008) pp. 87-103.

["In the fall of 1984, the University of Illinois instituted a formal program to reduce the rate of suicide among its enrolled students. At the core of the program is a policy that requires any student who threatens or attempts suicide to attend four sessions of professional assessment. The consequences for failing to comply with the program include withdrawal from the university. In the 21 years that the program has been in effect, reports on 2,017 suicide incidents have been submitted to the Suicide Prevention Team. The rate of suicide at locations within Champaign County (where the university is located) have decreased from a rate of 6.91 per 100,000 enrolled students during the 8 years prior to the program's start to a rate of 3.78 during the first 21 years of the program. This represents a reduction of 45.3 percent. This reduction occurred against a backdrop of stable rates of suicide both nationally and among 11 peer institutions within the Big Ten. The implications for programs and policies at institutions of higher education are discussed."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31446620&site=ehost-live>

“Increased Use of Antidepressants and Decreasing Suicide Rates: A Population-Based Study Using Danish Register Data.” By A. Erlangsen, University of Aarhus, Denmark, and others. IN: *Journal of Epidemiology and Community Health*, vol. 62 (April 24, 2008) pp. 448-454.

[“Objective: The objective of the present study was to examine if the change in the suicide rate is associated with individuals’ use of antidepressants as has been suggested by ecological studies. Participants in the study were individuals aged 50 years and older living in Denmark between 1 January 1996 and 31 December 2000 (N = 2 100 808).

Main outcome measures: Suicide rates are calculated according to current antidepressant treatment status (no treatment, tricyclic antidepressants (TCA), selective serotonin reuptake inhibitors (SSRI), other antidepressants). The change in the suicide rate during 1996–2000 was decomposed by treatment group.

Results: Only one in five older adults dying by suicide was in treatment at the time of death. Whereas the male suicide rate declined by 9.7 suicides per 100 000, recipients of antidepressants contributed to the decline by 0.9 suicides. Women redeeming

antidepressant prescriptions accounted for 0.4 suicides of the observed reduction of 3.3 per 100 000. The average suicide rates for men receiving TCA and SSRI were 153.3 and 169.0 per 100 000 person-years, respectively. Among older women, both TCA and SSRI users had an average suicide rate of 68.8 per 100 000 over the period examined.

Conclusions: Just a small proportion of older adults dying by suicide were found to be in treatment with antidepressants at the time of death. Individuals in active treatment with antidepressants seem to account for 10% of the decline in the suicide rate. Nevertheless, suicides might be prevented by more effective treatment.”]

Full text at: <http://jech.bmj.com/cgi/reprint/62/5/448>

“In the Aftermath of Teenage Suicide: A Qualitative Study of the Psychosocial Consequences for the Surviving Family Members.” By Per Lindquist, Karolinska Institute, Sweden, and others. IN: BMC Psychiatry, vol. 8, no. 26 (April 21, 2008) pp. 1-25.

[“Studies of family reactions following teenage suicide are hampered by the psychological difficulties of approaching families and recruiting an unbiased sample of study subjects. By using a small but consecutive series of cases, we examined the qualitative aspects of losing a teenage family member due to suicide. Such an understanding is important for future organisation of proper programs that provide professional support in the grief process.

From a large project on teenage unnatural death in northern Sweden 1981-2000 (n = 88), 13 cases from 1995 through 1998 were retrospectively identified and consecutively analysed. Ten families agreed to participate. The open interviews took place 15 to 25 months after the suicide. The information gathered was manually analysed according to a grounded theory model, resulting in allocation of data into one of three domains: post-suicidal reactions, impact on daily living, and families' need for support.

Teenager suicide is a devastating trauma for the surviving family and the lack of sustainable explanations for the suicide is a predominant issue in the grief process. The prolonged social and psychological isolation of the families in grief should be challenged. At the time of the interview, the families were still struggling with explaining why the suicide occurred, especially since most suicides had occurred without overt premonitory signs. The bereaved family members were still profoundly affected by the loss, but all had returned to an ostensibly normal life. Post-suicide support was often badly timed and insufficient, especially for younger siblings.

Family doctors can organise a long-term, individually formulated support scheme for the bereaved, including laymen who can play a most significant role in the grief process. There is also a need for better understanding of the families who have lost a teenager whom committed suicide and for the development and testing of treatment schemes for the bereaved family.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-8-26.pdf>

"What Prevents Adolescents from Seeking Help After a Suicide Education Program." By Konstantin Cigularov, Colorado State University, and others. IN: Suicide & Life-Threatening Behavior, vol. 38, no. 1 (February 2008) pp. 74-86.

["Perceived barriers to help-seeking among adolescents attending a suicide education program were examined. A total of 854 high school students in Colorado completed one of two questionnaires, measuring barriers to help-seeking for self or friend. The most prominent barriers for self were: inability to discuss problems with adults, self-overconfidence, fear of hospitalization, and lack of closeness to school adults. The most prominent barriers for troubled friends were: friendship concerns, unapproachability of school adults, fear of friend's hospitalization, and underestimating friend's problems. Results reveal multiple constraints limiting the program's utilization, supporting the need for comprehensive system approaches to suicide prevention."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31446619&site=ehost-live>

UNIVERSITY MENTAL HEALTH COUNSELING CENTERS

2007 National Survey of Counseling Center Directors. By Robert P. Gallagher, University of Pittsburg. (International Association of Counseling Directors, Inc.) 2008. 53 p.

["The National Survey of Counseling Center Directors has been conducted since 1981 and includes data provided by the administrative heads of college and university counseling centers in the United States and Canada. The survey attempts to stay abreast of current trends in counseling centers and to provide counseling center directors with ready access to the opinions and solutions of colleagues to problems and challenges in the field. The areas addressed cover a range of concerns including budget trends, current concerns, innovative programming, and a number of other administrative, ethical and clinical issues."]

Full text at: http://iacsinc.org/NsccdSurveyFinal_v2.pdf

NEW WEB-BASED SEMINAR ON JUVENILE JUSTICE SYSTEMS

The National Academy for State Health Policy will be presenting a web-based seminar on creative approaches to using Medicaid in juvenile justice systems on **May 14th, from 2:00-3:30 Eastern Time**. This seminar will convene experts from across the country to discuss how juvenile justice agencies can use Medicaid and other federally funded services. For additional information about the seminar or to register, visit http://www.nashp.org/_docdisp_page.cfm?LID=17F87464-CC6A-4874-A37E2A7F579B99DD