

**Subject:** Studies in the News: (July 30, 2008)

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## Studies in the News for



## California Department of Mental Health

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## **CHILDREN AND ADOLESCENT MENTAL HEALTH**

**2008 Fact Sheet: Demographics: Adolescents and Young Adults. By the National Adolescent Health Information Center. (The Center, San Francisco, California) 2008. 4 p.**

[“This report has the following highlights: The adolescent and young adult population is more diverse than the adult population. Poverty rates among children and adolescents have decreased in the past decade. Family structure varies by racial/ethnic group. School enrollment rates have increased in the past few decades and the median age of first marriage has increased in the past few decades.”]

Full text at: <http://nahic.ucsf.edu/downloads/Demographics08.pdf>

**Early Childhood Experiences: Laying the Foundation for Health across a Lifetime. By the Robert Wood Johnson Foundation. (The Foundation, Princeton, New Jersey) June 2008. 9 p.**

[“The earliest years of our lives are crucial in many ways, including how they set us on paths leading toward—or away from—good health. Family income, education, and neighborhood resources and other social and economic factors affect health at every stage of life, but the effects on young children are particularly dramatic. While all parents want the best for their children, not all parents have the same resources to help their children grow up healthy. Parents’ education and income levels can create—or limit—their opportunities to provide their children with nurturing and stimulating environments and to adopt healthy behaviors for their children to model. These opportunities and obstacles, along with their health impacts, accumulate over time and can be transmitted across generations as children grow up and become parents themselves.

As noted in an earlier Robert Wood Johnson Foundation report, a large body of evidence now ties experiences in early childhood with health throughout life, particularly in adulthood. Strong evidence also demonstrates that it is possible to turn vicious cycles into paths to health, by intervening early. Although effects of early childhood interventions are greatest for children who are at greatest social and economic disadvantage, children in families of all socioeconomic levels experience benefits from early childhood programs that translate into improved development and health.”]

Full text at: <http://www.rwjf.org/files/research/commissionearlychildhood062008.pdf>

**Related article: Little Hoover Commission Testimony on Children and Mental Illness.**

Full text at: <http://www.lhc.ca.gov/lhcdir/childmh/LandsverkOct00.pdf>

**“Low Academic Competence in First Grade as a Risk Factor for Depressive Cognitions and Symptoms in Middle School.” By Keith C. Herman, University of Missouri, and others. IN: Journal of Counseling Psychology, vol. 55, no. 3 (May 2008) pp. 400-410.**

[“The present study investigated the role of low academic competence in the emergence of depressive cognitions and symptoms. Structural equation modeling was conducted on a longitudinal sample of African American boys ( $n = 253$ ) and girls ( $n = 221$ ). Results supported the hypothesized path models from academic competence in 1st grade to depressive symptoms in 7th grade, controlling for a host of correlated constructs (conduct problems, inattention, social problems). Perceived control in 6th grade mediated the effect of academic competence on depressive symptoms.

Although the models fit the data well for both boys and girls, the path coefficients were notably larger for girls; in particular, multiple group analysis revealed a statistically stronger effect of low academic competence on perceptions of control for girls. The study and findings fit well with counseling psychologists’ commitment to prevention activities and to culture-specific research. Implications for designing interventions and prevention strategies for children with early academic problems are discussed.”]

Full text at: <http://www.apa.org/journals/releases/cou553400.pdf>

**Related article: Programs for Children and Adolescents with Emotional and Behavioral Disorders in the United States: A Historical Overview, Current Perspectives and Future Directions.**

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=19794225&site=ehost-live>

**Parental Incarceration and Child Wellbeing in Fragile Families. By Center for Research on Fragile Families. Fragile Families Research Brief (Princeton University, Princeton, New Jersey) April 2008. 3 p.**

[“Incarceration is widespread in the United States. By the end of 2004, the United States had over 2.1 million people incarcerated in jails or prisons. The majority of these prisoners are parents. As of 2002, 1,150,200 parents with 2,413,700 minor children were incarcerated in State and Federal prisons. Previous literature has shown significant negative effects of incarceration on parental employment, earnings, and relationship stability. Despite the prevalence of incarceration among parents, and the association between incarceration and negative parental outcomes, we know very little about the relationship between imprisoned parents and child wellbeing. The literature on children of incarcerated parents is quite small and most existing studies are constrained by small or convenience samples, limited long-term follow-up, and the lack of an appropriate comparison sample.<sup>1</sup> However, these studies suggest that children with parents facing incarceration tend to live in high-risk environments, even without considering the

potential risk for poor child outcomes associated with parental imprisonment itself. Approximately one-half of fathers sent to state and federal prisons were not living with their children before their incarceration and most of these fathers have had children by multiple partners. Parents who spend time in prison or jail also tend to be poorly educated, lack material resources, and frequently have problems with drugs, alcohol, and mental illness, each of which has been linked to poor child outcomes even in the absence of incarceration. This literature has also pinpointed developmental challenges unique to the children of incarcerated parents. Young children (ages 2-6) of incarcerated parents have been observed to have emotional problems, while school-aged children are stigmatized by their peers and display poor academic performance and behavior problems. The extent to which these problems result from the incarceration, as opposed to other risk factors faced by the families of incarcerated individuals, remains unclear.”]

Full text at: <http://www.fragilefamilies.princeton.edu/briefs/ResearchBrief42.pdf>

**Related article: Effects of Parental Incarceration on Young Children**

Full text at: <http://aspe.hhs.gov/HSP/prison2home02/parke-stewart.htm>

**“Protective and Vulnerability Factors Predicting New-Onset Depressive Episode in a Representative of U.S. Adolescents.” By Benjamin W. Van Voorhees and others. IN: Journal of Adolescent Health, vol. 42 (2008) pp. 605-616.**

[“Depressive episodes cause considerable morbidity and mortality in adolescents. We sought to identify factors predicting new onset depressive episode in a representative sample of U.S. adolescents.

**Methods:** We conducted logistic regression analyses to identify baseline individual, family, school/ peer and community factors predicting new-onset depressive episode at a 1-year follow-up in a longitudinal cohort study of 4791 U.S. adolescents. Potential protective and vulnerability factors included individual (sociodemographics, general health and maturity, coping behavior, self-concept, and affect regulation), family (connectedness and conflict), school/peers (acceptance and performance), and community (engagement, delinquency, and adverse events).

African American and Hispanic ethnicity, female gender, and low-income status predicted higher risk of onset of a depressive episode. Active coping and positive self-concept, predicted lower risk, whereas poor affect regulation and greater depressed mood predicted higher risk. Family “connectedness,” parental warmth, peer acceptance, better school performance, and religious activities were protective, whereas parental conflict, delinquent activities, and greater numbers of adverse events increased risk of depressive episodes.

Female gender, nonwhite ethnicity, low-income status, poor health, and parental conflict, increase risk of a depressive episode. Physicians should consider recommending behaviors that enhance perceived fitness, favorable self-concept, family connectedness,

peer acceptance, and community engagement to youth as means a of mitigating this risk for developing a depressive episode.”]

Full text at: <http://download.journals.elsevierhealth.com/pdfs/journals/1054-139X/PIIS1054139X07004946.pdf>

**Related article: Early Onset Schizophrenia**

Full text at:

[http://www.nami.org/Content/ContentGroups/Helpline1/Early\\_Onset\\_Schizophrenia.htm](http://www.nami.org/Content/ContentGroups/Helpline1/Early_Onset_Schizophrenia.htm)

**DISABILITY AND HEALTH IN THE UNITED STATES, 2001-2005**

**Disability and Health in the United States, 2001-2005. By B. Altman and A. Bernstein, National Center for Health Statistics. (The Center, Hyattsville, Maryland) July 2008. 89 p.**

[“Disability and Health in the United States, 2001–2005 examines health-related differences between disabled and nondisabled noninstitutionalized adults aged 18 years and over using data from the National Health Interview Survey (NHIS). The basic actions difficulty measure of disability used in this report identifies noninstitutionalized adults with respondent-reported difficulties in movement or sensory, emotional, or cognitive functioning that is associated with some health problem. The complex activity limitation measure of disability identifies noninstitutionalized adults with respondent-reported limitations in self-care tasks (activities of daily living (ADL) or instrumental activities of daily living (IADL)) work limitations, or limitations or restrictions in the ability to participate fully in social activities.”]

Full text at: <http://www.cdc.gov/nchs/data/misc/disability2001-2005.pdf>

**Related article: Frequently asked questions by educators about students with psychiatric disabilities.**

Full text at: <http://www.bu.edu/cpr/jobschool/>

**FOSTER CHILDREN AND MENTAL HEALTH**

**“Effects of Enhanced Foster Care on the Long-term Physical and Mental Health of Foster Care Alumni.” By Ronald C. Kessler, Harvard Medical School, and others. IN: Archives of General Psychiatry, vol. 65, no. 6 (June 2008) pp. 625-633.**

[“Child maltreatment is a significant risk factor for adult mental disorders and physical illnesses. Although the child welfare system routinely places severely abused and/or neglected children in foster care, no controlled studies exist to determine the effectiveness of this intervention in improving the long-term health of maltreated youth.

The objective of this report is to present results of the first quasi-experimental study, to our knowledge, to evaluate the effects of expanded foster care treatment on the mental and physical health of adult foster care alumni....

A representative sample of 479 adult foster care alumni who were placed in foster care as adolescents (14-18 years of age) between January 1, 1989, and September 30, 1998, in private (n = 111) or public (n = 368) foster care programs in Oregon and Washington were used. More than 80% of alumni were traced, and 92.2% of those traced were interviewed....

Private program alumni had significantly fewer mental disorders (major depression, anxiety disorders, and substance use disorders), ulcers, and cardio metabolic disorders, but more respiratory disorders, than did public program alumni.

Public sector investment in higher-quality foster care services could substantially improve the long-term mental and physical health of foster care alumni.”]

Full text at: <http://archpsyc.ama-assn.org/cgi/content/full/65/6/625>

**Related article: Young Children in Foster Care.**

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=16527283&site=ehost-live>

## **PRIMARY CARE**

**Health Centers: America’s Primary Care Safety Net- Reflections on Success, 2002-2007. By U.S. Department of Health and Human Services. (The Department, Rockville, Maryland) June 2008. 48 p.**

[“For more than 40 years, health centers in the United States have delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay. During that time, health center grantees have established a tradition of providing care for people underserved by America’s health care system: the poor, uninsured, and homeless; minorities; migrant and seasonal farm workers; public housing residents; and people with limited English proficiency....

In its 4 decades of existence, the national network of health centers has grown substantially—and so has the range of services offered. Today, more than 1,000 health centers operate 6,000 service delivery sites in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Besides primary health care, most of those sites now offer access to oral health, mental health, substance abuse services, and pharmacy services. Slightly more than half of all health center grantees—52 percent—serve rural America; the remainder are found in urban areas....

Academic researchers have highlighted health centers' success in increasing access to care, improving health outcomes for patients, reducing health disparities among U.S. population groups, and containing health care costs. The World Health Organization recognizes health centers as a model of primary care delivery and has encouraged its replication and expansion in industrialized and developing nations.”]

Full text at: [ftp://ftp.hrsa.gov/bphc/HRSA\\_HealthCenterProgramReport.pdf](ftp://ftp.hrsa.gov/bphc/HRSA_HealthCenterProgramReport.pdf)

**Related article: Reimbursement of Mental Health Services in Primary Care Settings.**

Full text at: <http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf>

**Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence Based Practice Guideline. By the New Zealand Guidelines Group. (The Group, Wellington, New Zealand) 2008. 216 p.**

[“The purpose of this guideline is to provide a summary of current New Zealand and overseas evidence about the identification of common mental disorders and the management of depression among young people and adults in the primary care setting. Among young people the focus is largely on adolescents as they are the most vulnerable. The guideline has been developed for health care practitioners in primary care, and for health service provider organizations and funders. The guideline identifies evidence-based practice for most people, in most circumstances. It thus forms the basis for decision-making by the health care practitioner in discussion with the person in developing an individualised care plan.”]

Full text at: [http://www.nzgg.org.nz/guidelines/0152/Depression\\_Guideline.pdf](http://www.nzgg.org.nz/guidelines/0152/Depression_Guideline.pdf)

## **POLICIES AND PROCEDURES**

**Colocating Health Services: A Way to Improve Coordination of Children’s Health Care? By Susanna Ginsberg, SG Associates Consulting. Commonwealth Fund Publication, No. 1153, Vol. 41. (The Fund, New York, New York) July 2008. 12 p.**

[“Pediatric practices are faced with a growing demand that they address the healthy development of their patients. As pediatric practices strengthen their role as medical homes for their patients, they need either to provide expanded services or enhance their capacity to coordinate that care. One option for enhancing the existing capacity of pediatric practices is collocation with other providers and services in the same setting.

This issue brief examines what is currently known about the use of collocation and its benefits. The literature and interviews used as information resources for the brief suggest that collocation of services is not a single strategy but rather a complex set of relationships, organizational structures, and other features meant to help practices deliver

effective care. However, more thorough examination of current colocation approaches is needed before advice can be provided to practices considering this option.

Pediatric practices are facing increased demands to address more fully the myriad requirements of children and their families. These requirements include: assessing and addressing the developmental and behavioral needs of children; treating chronic conditions, obesity, and substance abuse; and helping families navigate the complex and fragmented health care delivery system to obtain services. In order to meet such varied and complex needs, a number of leaders in health care have advanced the “medical home” model of primary care to optimize the coordination of patient services, among other functions. The medical home model has been a focal point for guidance from the American Academy of Pediatrics (AAP), 1 from newly developed accreditation standards by the National Committee for Quality Assurance, and from the Commonwealth Fund’s vision of a high-performing well-child system of care.”]

Full text at:

[http://www.commonwealthfund.org/usr\\_doc/Ginsburg\\_Colocation\\_Issue\\_Brief.pdf?section=4039](http://www.commonwealthfund.org/usr_doc/Ginsburg_Colocation_Issue_Brief.pdf?section=4039)

**Coverage for All: Inclusion of Mental Illness and Substance Use Disorders In State Healthcare Reform Initiatives. By Mary Giliberti, National Alliance on Mental Illness, and others. (The Alliance, Arlington, Virginia) June 2008. 72 p.**

[“Frustrated by inaction at the federal level to address the growing number of uninsured Americans, states are increasingly moving forward on healthcare reform. Although state initiatives have been the subject of front page news, no one has examined the impact of their programs on people with mental illnesses and substance use disorders.

This analysis by the National Alliance on Mental Illness (NAMI) and the National Council for Community Behavioral Healthcare (National Council) examines benefits for mental illness and substance use disorders for adults in state plans that cover the uninsured. The paper, which is based on research on 18 states’ initiatives and proposals, includes important findings on the following topics: The scope of the problem; The history of financing for mental health and substance use treatment; Analysis of state benefit packages; and, Issues for future exploration.”]

Full text at: <http://healthcareforuninsured.org/wp-content/uploads/Full.pdf>

**Mental Health and Universal Coverage. By Deborah Lee and Gwen Foster, California Endowment. (The Endowment, Los Angeles, California) January 2008. 21 p.**

[“Cumulatively mental health disorders cost taxpayers more than \$150 billion each year, including the costs of treatment, social service and disability payments, lost productivity

and premature death. The annual loss of productivity in the U.S. due to mental illness is estimated at \$63 billion. An estimated 60 percent of employee absences are due to psychological problems and decreased productivity related to mental and substance-use disorders cost employers approximately \$17 billion annually.

There are multiple barriers to access to high-quality mental health services, including stigma, lack of information about mental illnesses, lack of adequate numbers of providers, lack of insurance coverage or inadequate coverage. One in five Californians has no health insurance, and most are employed. Of those Californians who have insurance, many are underinsured. Hispanics, Asians, adults with the lowest incomes and less educated adults are most likely to be uninsured or underinsured for behavioral health coverage....

The report covers the following areas: incidence and consequences of untreated mental illness; access to effective mental health services; access to mental health coverage; public funding streams for mental health services; and status of the mental health parity debate. This executive summary synthesizes important findings and recommendations.”]

Full text at:

[http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Access/Mental\\_Health/Mental%20Health%20and%20Universal%20Coverage.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Access/Mental_Health/Mental%20Health%20and%20Universal%20Coverage.pdf)

**Related article: Mental Health Policy, Plans, and Programmes.**

Full text at: [http://www.who.int/mental\\_health/policy/en/policy\\_plans\\_revision.pdf](http://www.who.int/mental_health/policy/en/policy_plans_revision.pdf)

## **RESILIENCE**

**"Major Life Events: Their Personal Meaning, Resolution, and Mental Health Significance." By John R. Reynolds and R. Jay Turner, Florida State University. IN: Journal of Health and Social Behavior, vol. 49, no. 2 (June 2008) pp. 223-237.**

[“ Researchers have employed varying strategies in an effort to better understand variation in responses to stress. This article argues that crisis theory makes a useful contribution to these efforts, particularly when studying variable response to major life events that are of high threat potential. Regression analyses of depressive symptomatology, mastery, and self-esteem in a community sample of adults provide preliminary support for the central tenets of crisis theory that specify the conditions under which experienced events are minimally and maximally hazardous. The results can also offer mixed support for the proposition that successfully resolved crises can even yield emotional and coping benefits. Longitudinal models and further development of survey-based measures for distinguishing the occurrence<sup>3</sup> of a crisis and assessing the adequacy of its resolution are needed to more thoroughly test crisis theory.” **NOTE: This journal may be borrowed from the California State Library.]**

**“Resilience and Vulnerability among Refugee Children of Traumatized and Non-Traumatized Parents.” By Atia Daud, Children’s’ Hospital, Stockholm, and others.**

**IN: Child and Adolescent Psychiatry and Mental Health, vol. 2, no. 7 (March 2008) pp. 1-11.**

[“The aim of the study was to explore resilience among refugee children whose parents had been traumatized and were suffering from Post-Traumatic Stress Disorder (PTSD). The study comprised 80 refugee children (40 boys and 40 girls, age range 6–17 yrs), divided into two groups. The test group consisted of 40 refugee children whose parents had been tortured in Iraq before coming to Sweden. In accordance with DSM-IV criteria, these children were further divided in two sub-groups, those who were assessed as having PTSD-related symptoms (n = 31) and those who did not have PTSD-related symptoms (n = 9). The comparison group consisted of 40 children from Egypt, Syria and Morocco whose parents had not been tortured....

Children without PTSD/PTSS in the traumatized parents group had more favorable values (ITIA and SDQ) with respect to *total scores, emotionality, relation to family, peer relations* and *prosocial behavior* than the children in the same group with PTSD/PTSS and these values were similar to those the children in the comparison group (the non-traumatized parents group). The children in the non-traumatized parents group scored significantly higher on the IQ test than the children with traumatized parents, both the children with PTSD-related symptoms and those without PTSD related symptoms.

Adequate emotional expression, supportive family relations, good peer relations, and prosociality constituted the main indicators of resilience. Further investigation is needed to explore the possible effects of these factors and the effects of IQ. The findings of this study are useful for treatment design in a holistic perspective, especially in planning the treatment for refugee children, adolescents and their families.”]

Full text at: <http://www.capmh.com/content/pdf/1753-2000-2-7.pdf>

**Related article: Resilience in Children-at-Risk**

Full text at: <http://cehd.umn.edu/carei/Reports/Rpractice/Spring97/resilience.html>

**Related article: The Road to Resilience**

Full text at: [http://apahelpcenter.org/dl/the\\_road\\_to\\_resilience.pdf](http://apahelpcenter.org/dl/the_road_to_resilience.pdf)

**SAMHSA REPORT ON DRUG ABUSE AND MENTAL HEALTH**

**Sub-state Estimates from 2004-2006: National Surveys on Drug Use and Health. By the Substance Abuse and Mental Health Services Administration. (SAMHSA, Rockville, Maryland) June, 2008. 302 p.**

[“This report presents estimates of the prevalence of substance use or mental health problems in sub state regions based on data from the combined 2004-2006 National Surveys on Drug Use and Health (NSDUHs). An annual survey of the civilian, noninstitutionalized population aged 12 or older, NSDUH is sponsored by the Substance

Abuse and Mental Health Services Administration (SAMHSA). It collects information from persons residing in households, noninstitutionalized group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases. In 2004-2006, NSDUH collected data from 203,870 respondents aged 12 or older and was designed to obtain representative samples from all 50 States and the District of Columbia. The survey was planned and managed by SAMHSA's Office of Applied Studies (OAS), and data collection was conducted under contract with RTI International.”]

Full text at: <http://oas.samhsa.gov/substate2k8/substate.pdf>

### **SCHOOL-BASED MENTAL HEALTH PROGRAMS**

**Preparing *All* Education Personnel to Address Barriers to Learning & Teaching. By the Center for Mental Health in Schools. (The Center, Los Angeles, California) Summer, 2008. 41 pp.**

[“The next decade must mark a turning point for how schools and communities address the many barriers to learning experienced by children and youth. Needed in particular are initiatives to transform how schools work to prevent and ameliorate these barriers which lead to so many students being designated as learning, behavior, and emotional problems. Such a transformation is essential to enhancing achievement for all, closing the achievement gap, reducing dropouts, and increasing the opportunity for schools to be valued as treasures in their neighborhood. An end product must be schools where everyone – staff, students, families, and community stakeholders – feels supported. To this end, schools, districts, and state departments around the country will have to reshape the functions of *all* school personnel and enhance capacity for addressing barriers to learning and teaching. Accomplishing all this will require transforming policy and practice related to school improvement and personnel development.

With a view to clarifying implications for policy and practice, this report represents our Center’s first efforts to explore the frequently asked question: *How are pre-service preparation programs for teachers, support staff, and administrators focusing on addressing barriers to learning and teaching?*”]

Full text at: <http://smhp.psych.ucla.edu/pdfdocs/preparingall.pdf>

### **STIGMA**

**“Effects of School-Based Interventions on Mental Health Stigmatization: A Systematic Review.” By Howard M. Schachter, University of Ottawa, and others. IN: *Child and Adolescent Psychiatry and Mental Health*, vol. 2, no. 18 (July 21, 2008) pp. 1-43.**

[“Stigmatizing, or discriminatory, perspectives and behaviour, which target individuals on the basis of their mental health, are observed in even the youngest school children. We

conducted a systematic review of the published and unpublished, scientific literature concerning the benefits and harms of school-based interventions, which were directed at students 18 years of age or younger to prevent or eliminate such stigmatization. Forty relevant studies were identified, yet only a qualitative synthesis was deemed appropriate.

Five limitations within the evidence base constituted barriers to drawing conclusive inferences about the effectiveness and harms of school-based interventions: poor reporting quality, a dearth of randomized controlled trial evidence, poor methods quality for all research designs, considerable clinical heterogeneity, and inconsistent or null results. Nevertheless, certain suggestive evidence derived both from within and beyond our evidence base has allowed us to recommend the development, implementation and evaluation of a curriculum, which fosters the development of empathy and, in turn, an orientation toward social inclusion and inclusiveness.

These effects may be achieved largely by bringing especially but not exclusively the youngest children into direct, structured contact with an infant and likely only the oldest children and youth into direct contact with individuals experiencing mental health difficulties. The possible value of using educational activities, materials and contents to enhance hypothesized benefits accruing to direct contact also requires investigation. Overall, the curriculum might serve as primary prevention for some students and as secondary prevention for others.”]

Full text at: <http://www.capmh.com/content/pdf/1753-2000-2-18.pdf>

**Related article: Stigma: The feelings and experiences of 46 people with mental illness.**

Full text at: <http://bjp.rcpsych.org/cgi/reprint/184/2/176>

**Related article: The Stigma Scale: development of a standardized measure of the stigma of mental illness.**

Full text at: <http://bjp.rcpsych.org/cgi/reprint/190/3/248>

## **NEW WEBCASTS**

### **The Road to Recovery 2008 Multimedia Series**

*The Road to Recovery 2008* series will air eight Webcasts supporting the 19th annual observance of *National Alcohol and Drug Addiction Recovery Month (Recovery Month)*. In addition to the Webcasts, visitors can pose questions about each Webcast to an expert in the field through our interactive feature-Ask the Expert.

<http://www.recoverymonth.gov/2008/multimedia/default.aspx>

## **NEW PODCASTS**

### **Royal College of Psychiatrists, London, England**

Each month Dr Raj Persaud will be broadcasting the very latest breakthroughs and discoveries in neurosciences, psychiatry and psychology.

<http://www.rcpsych.ac.uk/pressparliament/podcasts.aspx>

## **NEW CONFERENCES**

*School Mental Health for All Students: Building a Shared Agenda  
for Youth, Families, Schools, and Communities*

**September 25-27, 2008**

Hyatt Regency Phoenix

122 North Second Street

Phoenix, AZ 85004

[http://csmh.umaryland.edu/conf\\_meet/AnnualConference/download\\_files/FinalAnnualConferenceBrochure.pdf](http://csmh.umaryland.edu/conf_meet/AnnualConference/download_files/FinalAnnualConferenceBrochure.pdf)