

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



Studies in the News for



California Department of Mental Health

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NEW CONFERENCES

CHILDREN AND ADOLESCENT MENTAL HEALTH

“Issues in Measuring Child Health.” By Marie C. McCormick, Harvard School of Public Health. IN: Ambulatory Pediatrics, vol. 8, no. 2 (March 17, 2008) pp. 77-84.

[“Assessing child health is critical to a variety of child health, educational, and social programs, as well as to clinical research and practice. However, despite the apparent wealth of measures available in health, education, and legal and social welfare systems, little agreement exists as to what are the most important measures and for what domains of health. Development of improved measures may capitalize on advances in

conceptualization of child health, including the dynamic nature of the interplay of child health and development over time. The need for enhanced measures can be illustrated by consideration of various aspects of pediatric care: well-child care, acute illness care, and the management of children with special health care needs. In particular, the strong theoretical perspectives on aspects of development such as cognition and behavioral development need to be informed by the experience of various states of health and their developmental implications. If generalist academicians are to further their research and educational mission, they must engage, and urgently, in the development and measurement of child health.” **Note: An electronic copy of this article can be obtained from the CA State Library.]**

Related article: "Contribution of 'School Link' to an area mental health service.”(December 2005)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=19065676&site=ehost-live>

Related article: “Programs for children and adolescents with emotional and behavioral disorders in the United States: A historical overview, current perspectives, and future directions.” (Winter 2006)

Full text at:

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

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

[“Parents, practitioners, and policymakers are recognizing the importance of young people’s mental health. Youth with better mental health are physically healthier, demonstrate more socially positive behaviors and engage in fewer risky behaviors. Conversely, youth with mental health problems, such as depression, are more likely to engage in health risk behaviors. Furthermore, youths’ mental health problems pose a significant financial and social burden on families and society in terms of distress, cost of treatment, and disability.

Most mental health problems diagnosed in adulthood begin in adolescence. Half of lifetime diagnosable mental health disorders start by age 14; this number increases to three fourths by age 24. The ability to manage mental health problems, including substance use issues and learning disorders, can affect adult functioning in areas such as social relationships and participation in the workforce....To improve mental health, policy-makers and program administrators need accurate information about the issue. This brief highlights existing national data about adolescent mental health status.”]

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

Related article: “The effectiveness and quality of routine child and adolescent mental health care outreach clinics.” (November 2006)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=23485666&site=ehost-live>

Reducing Behavior Problems in the Elementary School Classroom. By Mark Epstein and others, the Institute of Education Sciences. (The Institute, Washington, D.C.) September 2008. 87 p.

[“This guide is intended to help elementary school educators as well as school and district administrators develop and implement effective prevention and intervention strategies that promote positive student behavior. The guide includes concrete recommendations and indicates the quality of the evidence that supports them. Additionally, we have described some, though not all, ways in which each recommendation could be carried out. For each recommendation, we also acknowledge roadblocks to implementation that may be encountered and suggest solutions that have the potential to circumvent the roadblocks. Finally, technical details about the studies that support the recommendations are provided in Appendix D.”]

Full text at: http://ies.ed.gov/ncee/wwc/pdf/practiceguides/behavior_pg_092308.pdf

CO-OCCURRING DISORDERS

“Public Conceptions of Serious Mental Illness and Substance Abuse, Their Causes and Treatments: Findings from the 1996 General Social Survey.” By Sara Kuppin, Columbia University, and Richard M. Carpiano, University of Wisconsin. IN: **American Journal of Public Health, vol. 98, Supplement (September 2008) pp. 120-125.**

[“We examined the degree to which lay beliefs about the causes of disorders may predict beliefs about what constitutes appropriate treatment. We analyzed randomized vignette data from the MacArthur Mental Health Module of the 1996 General Social Survey (n = 1010). Results indicated that beliefs in biological causes (i.e., chemical imbalance, genes) were significantly associated with the endorsement of professional, biologically focused treatments (e.g., prescription medication, psychiatrists, and mental hospital admissions). Belief that the way a person was raised was the cause of a condition was the only nonbiologically based causal belief associated with any treatment recommendations (talking to a clergy member). Conclusions were reached that lay beliefs about the biological versus nonbiological causes of mental and substance abuse disorders are related to beliefs regarding appropriate treatment. We suggest areas for further research with regard to better understanding this relationship in an effort to construct effective messages promoting treatment for mental health and substance abuse disorders.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=34060855&site=ehost-live>

DISPARITIES

Closing the Disparities Gap in Healthcare Quality with Performance Measurement and Public Reporting. By the National Quality Forum. Issue Brief Number 10. (The Forum, Washington, D.C.) August 2008. 6 p.

["Compared to whites, racial and ethnic minorities in America today face disproportionately higher rates of disease, disability, and mortality, resulting in part from disparities in the quality of healthcare they receive from U.S. healthcare delivery systems. The same is true of low-income populations compared to those who are more affluent. But there are systematic public and private efforts underway to address disparities and deliver measurable improvements in healthcare quality to poorly served groups. The ultimate goal is for all Americans—regardless of their ethnicity, gender, socioeconomic position, or insurance status—to have access to healthcare that meets the Institute of Medicine (IOM) criteria for quality: It must be safe, timely, effective, efficient, patient centered, and equitable. This National Quality Forum (NQF) Issue Brief highlights the challenges our healthcare system faces as a result of disparities in care. It summarizes important initiatives that are under way at the national, regional, and local levels and also benchmarks notable progress that has been made to improve disparities through data collection, measurement, public reporting, intervention, education, and incentives. Although progress in reducing the disparities gap has been disappointing during the first half of this decade, the future looks more promising. Multistakeholder groups are tackling serious challenges through the use of data collection and the development of innovative new approaches to close the gap."]

<http://www.rwjf.org/files/research/3479.34094.issuebrief.pdf>

One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations. By Amy Wilson-Stronks and others, The Joint Commission. Hospitals, Language and Culture: A Snapshot of the Nation. (The Commission, Oakbrook Terrace, Illinois) 2008. 60 p.

["Racial and ethnic health disparities are linked to poorer health outcomes and lower quality care. Language and cultural issues can have a significant impact on these disparities when not addressed by health care organizations. As the diversity of our nation continues to grow, hospitals are encountering more patients with language and cultural barriers. The multiplicity of languages, dialects, and cultures can be overwhelming to hospitals and their staff. The *Hospitals, Language, and Culture* (HLC) study set out to better understand how the challenges associated with cultural and language (C&L) barriers are being addressed at 60 hospitals across the country."]

Full text at: http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B49BD7F756CF/0/HLC_One_Size_PrePub.pdf

FAMILIES OF ADULTS WITH MENTAL ILLNESS

“Unmet Needs of Families of Adults with Mental Illness and Preferences Regarding Family Services.” By Amy L. Drapalski, Department of Veterans Affairs, Maryland Healthcare System, and others. IN: *Psychiatric Services*, vol. 59, no. 6 (June 2008) pp. 655-662.

[“This study used a survey to assess the information and educational needs of family members of adults with mental illness and their preferences regarding how to address those needs... On average, family members reported a substantial number of unmet needs, often despite prior receipt of information. Family members' experiences of stigma and having an ill relative with a more recently occurring condition (for example, a younger relative or a shorter length of illness) or with a disabling condition (for example, recent hospitalization) were significantly associated with a greater number of unmet needs. Family members preferred that a mental health provider (63%) address their needs on an as-needed basis (58%).

The needs and preferences of family members of adults with mental illness are diverse and varied. Consequently, these families may benefit from ongoing provision of information and support tailored to meet the families' individual needs. Continued efforts should be made to understand and address consumer and family needs, potential barriers to participation in family services, and the relationship between stigma and family need.”]

Full text at: <http://ps.psychiatryonline.org/cgi/reprint/59/6/655>

Related article: Elderly parents of adults with severe mental illness: Group work interventions. (2004)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=16843819&site=ehost-live>

HOUSING FOR SERIOUS MENTALLY ILL

"Housing for Persons with Serious Mental Illness: Consumer and Service Provider Preferences." By Myra Piatt, McGill University, and others. IN: *Psychiatric Services*, vol. 59, no. 9 (September 2008) pp. 1011-1017.

[**OBJECTIVE:** This study evaluated the housing preferences of a representative sample of consumers with serious mental illness living in seven types of housing in Montreal, Quebec, and compared these with their case managers' housing preferences for them. **METHODS:** An inventory of all housing for this population was developed in consultation with administrators of three psychiatric hospitals and the regional health board. The inventory included seven categories: housing in a hospital setting, hostels, group homes, foster homes, supervised apartments, social housing (low-income housing or cooperative), and private rooming homes. A stratified random sample of 48 consumers was selected in each category. In all, 315 consumers and their case managers completed the Consumer Housing Preference Survey. **RESULTS:** Most consumers preferred living in housing that offered them more autonomy than the housing in which they were currently living. Case managers preferred housing that offered some structure, such as supervised apartments. Forty-four percent of consumers preferred to live in their own apartment. More than a third of consumers preferred to live in their current housing. **CONCLUSIONS:** When evaluating housing preferences, it is important to elicit the viewpoints of mental health consumers as well as their case managers. Special attention should be given to the type of housing where consumers currently live. A variety of housing, not just autonomous housing, is needed to meet the specific housing preferences of individuals with serious mental illness."]

Full text at;

<http://ps.psychiatryonline.org/cgi/reprint/59/9/1011>

Related article: Housing as a social integration factor for people classified as mentally ill. (May 2005)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=17385375&site=ehost-live>

JUVENILE JUSTICE ISSUES

“Examining the Impact of Gender, Race/Ethnicity and Family Factors on Mental Health Issues in a Sample of Court-Involved Youth.” By Stephen M. Gavazzi, Ohio State University, and others. IN: Journal of Marital and Family Therapy, vol. 34, no. 3 (July 2008) pp. 353-368.

[“Faced with anywhere between one half and two thirds of its youth having a diagnosable mental illness, the identification and treatment of mental health concerns is a critically important endeavor for professionals working with youth who have contact with the juvenile justice system. In addition, the literature suggests that factors related to both the family and to the gender of the adolescent must be incorporated into any approach to assessment and intervention within this special population. Further, prior work that has documented the interaction of gender and family issues with adolescent race/ethnicity warrants further empirical attention, as does the intermediary role that the family may play in the development of both internalizing and externalizing behaviors.

The present study extends this literature by examining factors related to gender, race/ethnicity, family factors, and mental health issues in a sample of 2,549 Caucasian and African American youth coming to the attention of juvenile courts. Multivariate analysis of variance results indicated significant main effects for gender and race/ethnicity, as well as a significant gender \times race/ethnicity interaction for the family and externalizing variables. A multiple group structural equation modeling procedure was employed in order to test the hypothesis that family environment mediates the relationship between gender and mental health problems, as well as to test for potential differences in these relationships as a function of race/ethnicity. Results indicated support for the mediation model in the sample of African American youth but not in the sample of Caucasian youth.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=33246382&site=ehost-live>

"Psychiatric Disorders among Detained Youth: A Comparison of Youths Processed in Juvenile Court and Adult Criminal Court." By Jason Washburn, Northwestern University Feinberg School of Medicine, and others. IN: Psychiatric Services, vol. 59 (September 2008) pp. 965-973.

["All 50 states and the District of Columbia have legal mechanisms to try juveniles as adults in criminal court. This study examined the prevalence of psychiatric disorders among youths transferred to adult criminal court and youths processed in the juvenile court.

Participants were a stratified random sample of 1,829 youths, ten to 18 years of age, who were arrested and detained in Chicago. Data from version 2.3 of the Diagnostic Interview Schedule for Children are presented for 1,715 youths, 13 to 18 years of age, including 1,440 youths processed in juvenile court and 275 youths processed in adult criminal court.

Males, African Americans, Hispanics, and older youths had greater odds of being processed in adult criminal court than females, non-Hispanic whites, and younger youths, even after the analyses controlled for felony-level violent crime. Among youths processed in adult criminal court, 68% had at least one psychiatric disorder and 43% had two or more types of disorders. Prevalence rates and the number of comorbid types of disorders were not significantly different between youths processed in adult criminal court and those processed in juvenile court. Among youths processed in adult criminal court, those sentenced to prison had significantly greater odds than those receiving a less severe sentence of having a disruptive behavior disorder, a substance use disorder, or comorbid affective and anxiety disorders.

Community and correctional systems must be prepared to provide psychiatric services to youths transferred to adult criminal court and especially to youths sentenced to prison. When developing and implementing services, psychiatric service providers must also

consider the disproportionate representation of individuals from racial-ethnic minority groups in the transfer process."]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/59/9/965>

Related article: “Teens caught in the middle: Juvenile justice and treatment.” (December 2005)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=19792980&site=ehost-live>

Related article: “Mental health and juvenile arrests: Criminality, criminalization, or compassion.” (August 2006)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=22172462&site=ehost-live>

POLICIES AND PROCEDURES

“Jump-Starting Collaboration: The ABCD Initiative and the Provision of Child Development Services through Medicaid and Collaborators.” By Carolyn Berry, New York University, and others. IN: *Public Administration Review*, vol. 68, no. 3 (May/June 2008) pp. 480-490.

[“What does it take for government agencies to overcome the hurdles of limited time and resources, fragmentation, and bureaucracy and work together? A recent study addressing that question pointed to The Commonwealth Fund-supported Assuring Better Child Health and Development (ABCD) program as an example of successful collaboration among Medicaid and other state agencies.

In the initial phase of the ABCD program, which ran from 2000 to 2003, the Fund provided grants to four states—North Carolina, Utah, Vermont, and Washington—to enhance the delivery of developmental services to low-income children. In "Jump-Starting Collaboration: The ABCD Initiative and the Provision of Child Development Services Through Medicaid and Collaborators" (*Public Administration Review*, May/June 2008), researchers led by Carolyn Berry, Ph.D., of New York University find that the program was successful: all states made changes to their policies, regulations, or reimbursement mechanisms to achieve their goals. Beyond just paying for developmental services, the four state Medicaid agencies took active roles in partnering with child health professionals.

According to Berry and her coauthors, the states' successes were due to their willingness to work across agencies, including the departments of health, public health, and social services, as well as with professional medical groups. The analysis was based on an

external evaluation of the ABCD program that was also supported by the Fund. The analysis included informant interviews and site visits, document reviews, and observation of meetings and conference calls among participants.” **NOTE: This journal is available for loan from the CA State Library or a hard copy of the article can be requested.]**

“Mental Health in the Context of Health Disparities.” By Jeanne Miranda, University of California, Los Angeles, and others. IN: American Journal of Psychiatry, vol. 165, no. 9 (September 2008) pp. 1102-1108.

[“A long standing theme of mental health policy has been the tension between the integration of mental health into general health policy and exceptionalism. Integration is represented by policies such as parity in health insurance coverage, and exceptionalism by “carve-outs” of mental health care to behavioral health care organizations. Frank and Glied (1) have argued that policies based on exceptionalism in mental health are waning and that integration has had salutary effects on persons with mental illness through mainstreaming into general social and health programs (notably Medicaid). Mental health status and mental health care disparities can also be framed within the exceptionalism/integration debate, in both a traditional and new sense. In the traditional sense, one may question whether policies promoting general purpose interventions to reduce health status or health care disparities will also address disparities in mental health. In the new sense, one may question whether policies should differ when poor health status or poor health care is correlated with certain racial groups. Should we take an integrationist perspective and address poor health status and low quality of care in general or take an exceptionalist perspective and promote policies focused on disparities? From a health policy perspective, disparities in health status or health care may not deserve special focus over and above the problems of poor health status and poor quality of care in general. Concern for social justice, however, argues for a focus on disparity. For example, the goal of equal opportunity is to provide a social environment in which no one is excluded from the activities of society, such as education, employment, or health care, on the basis of immutable traits”]

Full text at: <http://ajp.psychiatryonline.org/cgi/reprint/165/9/1102>

“We're not Short of People telling us what the Problems are. We're short of People telling us what to do": An Appraisal of Public Policy and Mental Health.” By Mark P. Petticrew, London School of Hygiene and Tropical Medicine, and others. IN: BMC Public Health, vol. 8, no. 314 (September 15, 2008) pp. 1-33.

[“There is sustained interest in public health circles in assessing the effects of policies on health and health inequalities. We report on the theory, methods and findings of a project which involved an appraisal of current Scottish policy with respect to its potential impacts on mental health and wellbeing.

We developed a method of assessing the degree of alignment between Government policies and the 'evidence base', involving: reviewing theoretical frameworks; analysis of policy documents, and nineteen in-depth interviews with policymakers which explored influences on, and barriers to cross-cutting policymaking and the use of evidence.

Most policy documents did not refer to mental health; however most referred indirectly to the determinants of mental health and well-being. Unsurprisingly research evidence was rarely cited; this was more common in health policy documents. The interviews highlighted the barriers to intersectoral policy making, and pointed to the relative value of qualitative and quantitative research, as well as to the imbalance of evidence between "what is known" and "what is to be done".

Healthy public policy depends on effective intersectoral working between government departments, along with better use of research evidence to identify policy impacts. This study identified barriers to both these. We also demonstrated an approach to rapidly appraising the mental health effects of mainly non-health sector policies, drawing on theoretical understandings of mental health and its determinants, research evidence and policy documents. In the case of the social determinants of health, we conclude that an evidence-based approach to policymaking and to policy appraisal requires drawing strongly upon existing theoretical frameworks, as well as upon research evidence, but that there are significant practical barriers and disincentives. “[

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2458-8-314.pdf>

STEADY EMPLOYMENT AND MENTAL HEALTH

Steady Employment and Mental Health-Is There a Connection? By the Center for Addiction and Mental Health. (The Center, Toronto, Ontario) September 15, 2008. 2 p.

[“Despite low overall unemployment, Canada’s manufacturing industry has cut 88,000 jobs this year, with nearly all the losses occurring in Ontario. Also, part-time employment has grown by 3.5 per cent in 12 months, much faster than the 0.9 per cent growth in full time work. A new report from the World Health Organization (WHO) on the social determinants of health demonstrates that these kinds of employment changes can affect more than your wallet. Research from the Centre for Addiction and Mental Health (CAMH)’s Dr. Carles Muntaner in the WHO report highlights the profound impact of employment conditions on health.

Dr. Muntaner and his research team found that poor mental health outcomes are associated with precarious employment (e.g. temporary contracts or part-time work with low wages and no benefits). When compared with those with full-time work with benefits, workers who report employment insecurity experience significant adverse effects on their physical and mental health.” Visit [WHO | Commission on Social Determinants of Health - Final Report](#) for more information.

Full text at:

http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounds/WHO_work_report_muntaner.html

Related article: “Perspectives on benefits and costs of work from individuals with psychiatric disabilities.” (2007)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=24417868&site=ehost-live>

SUICIDE PREVENTION

“A Community Intervention Trial of Multimodal Suicide Prevention Program in Japan: A Novel Multimodal Community Intervention Program to Prevent Suicide and Suicide Attempt in Japan, NOCOMIT-J. By Yutaka Ono, Keio University, Tokyo, and others. IN: BMC Public Health, vol.8, no. 315 (September 15, 2008) pp. 1-26.

[“To respond to the rapid surge in the incidence of suicide in Japan, which appears to be an ongoing trend, the Japanese Multimodal Intervention Trials for Suicide Prevention (J-MISP) have launched a multimodal community-based suicide prevention program, NOCOMIT-J. The primary aim of this study is to examine whether NOCOMIT-J is effective in reducing suicidal behavior in the community.

This study is a community intervention trial involving seven intervention regions with accompanying control regions, all with populations of statistically sufficient size. The program focuses on building social support networks in the public health system for suicide prevention and mental health promotion, intending to reinforce human relationships in the community. The intervention program components includes a primary prevention measures of awareness campaign for the public and key personnel, secondary prevention measures for screening of, and assisting, high-risk individuals, after-care for individuals bereaved by suicide, and other measures. The intervention started in July 2006, and will continue for 3.5 years. Participants are Japanese and foreign residents living in the intervention and control regions (a total of population of 2,120,000 individuals).

The present study is designed to evaluate the effectiveness of the community-based suicide prevention program in the seven participating areas.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2458-8-315.pdf>

“Family and Racial Factors Associated with Suicide and Emotional Distress among Latino Students.” By Carolyn Garcia, University of Minnesota, and others. IN: Journal of School Health, vol. 78, no. 9 (September 2008) pp. 487-495.

[“Background: Latino youth experience disproportionate rates of mental health problems including suicide and depression. Better understanding of underlying risk and protective factors on the part of school-based health professionals, teachers, and health care providers in their lives is warranted.

The aims of this secondary analysis of 2004 Minnesota Student Survey data were to (1) describe the mental health status of a statewide sample of Latino 9th- and 12th-grade students; (2) explore relationships of family protective factors (communication, caring, and connection) with suicidal ideation, suicidal attempts, and emotional distress; and (3) highlight similarities and differences in family protective factors among subgroups of Latino students. Parallel analyses were completed for Latino-only and Latino-mixed students. Bivariate logistic regression models were used to examine associations between each family variable and each study outcome.

Nearly 1 in 5 Latino high school students have had suicidal thoughts in the past year; past year suicide attempts ranged from 6% to 18.5% across grade and gender subgroups. Most concerning are ninth-grade Latino girls, a group in which 30-40% reported suicidal thoughts and 14-19% reported attempting suicide in the past year. An important study finding is the high rate of suicidal ideation, suicide attempts, and emotional distress among students who self-identified as being of mixed ethnicity. Study findings can be used to inform mental health promotion initiatives and culturally tailor interventions with Latino students.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=33533366&site=ehost-live>

Related article: The Role of child and adolescent mental health services in suicide prevention in New Zealand. (December 2006)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=23115802&site=ehost-live>

“Guns and Suicide in the United States.” By Matthew Miller and David Hemenway, Harvard School of Public Health. IN: The New England Journal of Medicine, vol. 359, no. 10 (September 4, 2008) pp. 989-991.

[“This past June, in a 5-to-4 decision in *District of Columbia v. Heller*, the Supreme Court struck down a ban on handgun ownership in the nation's capital and ruled that the District's law requiring all firearms in the home to be locked violated the Second Amendment. But the Supreme Court's finding of a Second Amendment right to have a handgun in the home does not mean that it is a wise decision to own a gun or to keep it easily accessible. Deciding whether to own a gun entails balancing potential benefits and

risks. One of the risks for which the empirical evidence is strongest, and the risk whose death toll is greatest, is that of completed suicide.

In 2005, the most recent year for which mortality data are available, suicide was the second-leading cause of death among Americans 40 years of age or younger. Among Americans of all ages, more than half of all suicides are gun suicides. In 2005, an average of 46 Americans per day committed suicide with a firearm, accounting for 53% of all completed suicides. Gun suicide during this period accounted for 40% more deaths than gun homicide.” **Note: An electronic copy of this article can be obtained from the CA State Library.]**

Full text at: <http://content.nejm.org/cgi/content/full/359/10/989>

“Protecting Urban American Indian Young People from Suicide.” By Sandra H. Pettingell and others, University of Minnesota. IN: American Journal of Health Behavior, vol. 32, no. 5 (September/October 2008) pp. 465-476.

[“Objective: To examine the likelihood of a past suicide attempt for urban American Indian boys and girls, given salient risk and protective factors. Methods: Survey data from 569 urban American Indian, ages 9-15, in-school youths. Logistic regression determined probabilities of past suicide attempts. Results: For girls, suicidal histories were associated with substance use (risk) and positive mood (protective); probabilities ranged from 6.0% to 57.0%. For boys, probabilities for models with violence perpetration (risk), parent prosocial behavior norms (protective), and positive mood (protective) ranged from 1.0% to 38.0%. Conclusions: Highlights the value of assessing both risk and protective factors for suicidal vulnerability and prioritizing prevention strategies.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=34058216&site=ehost-live>

NEW CONFERENCES

Evidence-Based Child and Teen Mental Health Conference: The First National Institute for Primary Care Providers. Oct 8-10, 2008; Scottsdale, Arizona.

<http://nursing.asu.edu/ace/courses/ebpctmh/index.htm>

<http://nursing.asu.edu/ace/courses/ebpctmh/brochure.pdf>