

Subject: Studies in the News: (November 26, 2008)



Studies in the News for



California Department of Mental Health

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CHILDREN AND ADOLESCENT MENTAL HEALTH

“County Variation in Children’s and Adolescent’s Health Status and School District Performance in California.” By Susan I. Stone and Sunyoung Jung, University of California, Berkeley. IN: *American Journal of Public Health*, vol. 98, no. 12 (December 2008) pp. 2223-2228.

[“Objectives. We examined the association between county-level estimates of children’s health status and school district performance in California. Methods. We used 3 data sources: the California Health Interview Survey, district archives from the California Department of Education, and census-based estimates of county demographic characteristics. We used logistic regression to estimate whether a school district’s failure to meet adequate yearly progress goals in 2004 to 2005 was a function of child and adolescent’s health status. Models included district- and county-level fixed effects and

were adjusted for the clustering of districts within counties. Results. County-level changes in children's and adolescent's health status decreased the likelihood that a school district would fail to meet adequate yearly progress goals during the investigation period. Health status did not moderate the relatively poor performance of predominantly minority districts. Conclusions. We found empirical support that area variation in children's and adolescent's health status exerts a contextual effect on school district performance. Future research should explore the specific mechanisms through which area-level child health influences school and district achievement.”]

Full text at: <http://www.ajph.org/cgi/reprint/98/12/2223>

Related article: “Self-Criticism and Depressive Symptomatology Interact to Predict Middle School Academic Achievement.”

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=19121741&site=ehost-live>

Disseminating Evidence-Based Practice for Children and Adolescents: A Systems Approach to Enhancing Care. By Anne E. Kazak, University of Pennsylvania, and others. (American Psychological Association, Washington, D.C.) 2008. 116 p.

[“A new report from the American Psychological Association (APA) Task Force on Evidence-Based Practice for Children and Adolescents recommends ways to disseminate evidence-based practices to improve mental health services for children and adolescents, including those involved with the child welfare system. The task force defines evidence-based practice as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

The report recommends that providers should adhere to the following ideals when providing mental health services to children and families: Partnerships with other providers; Cultural responsiveness; A developmental approach; and, A socioecological framework

Systems-level strategies that can improve the provision of evidence-based practices include enhancing education and training for service providers, increasing funding for research, and revising policies and practices so that evidence-based services are available to all children and families.”]

Full text at: <http://www.apa.org/releases/EBPCAreport0608draftfinal.pdf>

Medicaid Early and Periodic Screening, Diagnosis, and Treatment Fact Sheet. By Jane Perkins, National Health Law Program. (The Program, Chapel Hill, North Carolina) October 2008. 10 p.

[“Low socioeconomic status carries with it numerous by-products: poor nutrition, fewer educational opportunities, greater exposure to environmental hazards, and inadequate housing, to name just a few. All of these disadvantages increase the likelihood that a poor child will be in poor health. Indeed, children living in poverty, particularly children of color, are more likely than other children to suffer from ill health, including vision, hearing and speech problems, dental problems, elevated lead blood levels, behavioral problems, anemia, asthma, and pneumonia. There is a growing body of evidence establishing that lifelong patterns of health and well-being are established during childhood. Early detection of health conditions, comprehensive treatment and health education are needed. Added to the Medicaid Act in 1967, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) entitles children and youth to preventive care and treatment services.”]

Full text at <http://www.healthlaw.org/library/attachment.134266.pdf>.

Pediatric Perspectives and Practices on Transitioning Adolescents with Special Needs to Adult Health Care. By Margaret McManus and others, National Alliance to Advance Adolescent Health. Fact Sheet Number 6. (The Alliance, Washington, D.C.) October 2008. 6 p.

[“The transition from pediatric to adult health care is a significant issue facing all adolescents, but it is of critical concern to the 17% of adolescents with special health care needs.¹ To make this transition smooth, these young people need assistance over a period of time to assume their new role as informed health care consumers. They also need developmentally appropriate support to understand and manage their condition and to negotiate the changes when they move from pediatric to adult health care systems.”]

Full text at: <http://www.incenterstrategies.org/jan07/factsheet6.pdf>

Tracking Adolescent Health Policy: An Annotated List, 2008 Update: From the National Initiative to Improve Adolescent and Young Adult Health by the Year 2010. By the University of California, San Francisco. (The University, San Francisco, California) 2008. 13 p.

[“Adolescence represents a critical period of physical, social, psychological, and cognitive growth. As they become increasingly independent, adolescents take greater responsibility for health-related habits, such as diet and exercise. While not legally adults, many adolescents initiate adult behavior in areas such as driving, substance use and sexuality. These habits and behaviors have significant implications for health in the short and long term. Thus, adolescence presents an opportunity to promote a lifetime of health. Influences at the individual, family, school, community, and policy levels interact to shape the health and well being of adolescents.

Adolescent health priorities have been identified as part of *Healthy People 2010*, the nation's public health goals and objectives. A national expert panel selected 21 objectives as critical for adolescents and young adults, out of 107 *Healthy People 2010* objectives that pertain to this age group. These objectives address six areas: mortality, unintentional injury, violence, substance use and mental health, reproductive health, and the prevention of chronic disease. Many policies focus on these six areas, ranging from education programs that aim to influence individual behavior, to financing mechanisms to increase access to care, to structural reforms that shape the environment in which adolescents live.”]

Full text at: <http://policy.ucsf.edu/pubpdfs/TrackingPolicy2008.pdf>

Related article: Child Health in Complex Emergencies. (2006)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=19433666&site=ehost-live>

DISPARITIES

“Health Inequalities among Latinos: What do we know and what can we do?” By Lisa CaCari Stone, Harvard School of Public Health, and C.H.Hank Balderrama, Oregon Department of Health. IN: Health and Social Work, vol.33, no. 1 (February 2008) pp. 3-7

[“The author comments on the increasing health care inequalities experienced by Hispanic Americans in the U.S. According to the author, health care policy should address social determinants of health, including income, work and housing. She suggested enhancing the health care system in the country while improving living and social conditions. It is noted that Hispanic Americans are more likely to have low socioeconomic status.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=32185553&site=ehost-live>

Quality Improvement in the Indian Health Service. Quality Matters Newsletter. (The Commonwealth Fund, New York, New York) November/December 2008. 17 p.

[“Despite the fact that the Indian Health Service is underfunded, its federal, tribal, and urban health facilities have been making strides in quality improvement. It has achieved this in part by harnessing the clinical data available within its longstanding information system, and by reaching out to communities through partnerships with local tribes to promote health and prevent disease....

Based on a comparison with a federal employee's health benefit package, the Indian Health Service's budget is estimated to be funded at 54 percent of the level of need, says Robert G. McSwain, its director. The agency's chronic underfunding has forced it to ensure that the "resources we do have, which are limited, are used as a catalyst" to help providers deliver care in different ways than they have in the past, he says. This includes having clinic and hospital staffs learn how to work together in care teams and to make patients the focus of care.

McSwain's predecessor, Charles W. Grim, D.D.S., M.H.S.A., started down this path when he chose to reduce the director's priorities from up to a dozen initiatives to three: behavioral health, chronic care, and health promotion and disease prevention. The goal, which McSwain has continued to push in his year-long tenure, has been to integrate these three initiatives into a single effort across the Indian Health Service.”]

Full text at:

http://www.commonwealthfund.org/usr_doc/2008_11_12_QM.pdf?section=4039

JUVENILE OFFENDERS AND MENTAL ILLNESS

“Childhood Psychiatric Disorders and Young Adult Crime: A Perspective, Population Based Study.” By William E. Copeland and others, Duke University. IN: American Journal of Psychiatry, vol. 164, no. 11 (November 2007) pp. 1668-1675.

[**“OBJECTIVE:** While psychopathology is common in criminal populations, knowing more about what kinds of psychiatric disorders precede criminal behavior could be helpful in delineating at-risk children. The authors determined rates of juvenile psychiatric disorders in a sample of young adult offenders and then tested which childhood disorders best predicted young adult criminal status. **METHOD:** A representative sample of 1,420 children ages 9, 11, and 13 at intake were followed annually through age 16 for psychiatric disorders. Criminal offense status in young adulthood (ages 16 to 21) was ascertained through court records. **RESULTS:** Thirty-one percent of the sample had one or more adult criminal charges. Overall, 51.4% of male young adult offenders and 43.6% of female offenders had a child psychiatric history. The population-attributable risk of criminality from childhood disorders was 20.6% for young adult female participants and 15.3% for male participants. Childhood psychiatric profiles predicted all levels of criminality. Severe/violent offenses were predicted by comorbid diagnostic groups that included both emotional and behavioral disorders. **CONCLUSIONS:** The authors found that children with specific patterns of psychopathology with and without conduct disorder were at risk of later criminality. Effective identification and treatment of children with such patterns may reduce later crime.”]

Full text at: <http://ajp.psychiatryonline.org/cgi/reprint/164/11/1668>

Related article: “Critical Factors in Mental Health Programming for Juveniles in Corrections Facilities.” (2006)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=21388606&site=ehost-live>

Related article: A Cure for Crime: Can Mental Health Treatment Diversion Reduce Crime among Youth? (2006)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=19001283&site=ehost-live>

POLICIES AND PROCEDURES

Health News Coverage in U.S. Media: January 2007-June 2008. By the Kaiser Family Foundation and the Pew Research Center. (The Foundation, Menlo Park, California) December 2008. 14 p.

[“The purpose of this study is to take a broad look at how the news media covered one vital area—health and health policy—in 2007 and 2008. While there have been many studies that have taken a narrow look at news coverage of specific health issues (breast cancer, diabetes) or at coverage in one particular news medium (local television, print) this report takes a wider look at the broad spectrum of health issues, across a wide range of news media.

The report addresses the following questions: To what extent has health news been a part of the national news agenda? Which health topics get the most coverage? How does coverage vary from print to television, radio to online? And how big of an issue was health in coverage of the 2008 Presidential primary campaign?”]

Full text at: <http://www.kff.org/entmedia/upload/7839.pdf>

STIGMA

“Pathways between Internalized Stigma and Outcomes Related to Recovery in Schizophrenia Spectrum Disorders.” By Philip T. Yanos, City University New York, and others. IN: Psychiatric Services, vol. 59, no. 12 (December 2008) pp. 1437-1442.

[“The mechanisms by which internalized stigma affects outcomes related to recovery among people with severe mental illness have yet to be explicitly studied. This study empirically evaluated a model for how internalized stigma affects important outcomes

related to recovery. A total of 102 persons with schizophrenia spectrum disorders completed measures of internalized stigma, awareness of mental illness, psychiatric symptoms, self-esteem, hopefulness, and coping. Path analyses tested a predicted model and an alternative model for the relationships between the variables. *Results:* Results from model 1 supported the view that internalized stigma increases avoidant coping, active social avoidance, and depressive symptoms and that these relationships are mediated by the impact of internalized stigma on hope and self-esteem. Results from model 2 replicated significant relationships from model 1 but also supported the hypothesis that positive symptoms may influence hope and self-esteem. *Conclusions:* Findings from two models supported the hypothesis that internalized stigma affects hope and self esteem, leading to negative outcomes related to recovery. It is recommended that interventions be developed and tested to address the important effects of internalized stigma on recovery.”]

Full text at: <http://ps.psychiatryonline.org/cgi/reprint/59/12/1437>

“Reducing Stigma and Discrimination: Candidate Interventions.” By Graham Thornicroft and others, Kings College, London. IN: International Journal of Mental Health Systems, vol. 2, no. 3(April 13, 2008) pp. 1-7.

[“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 behavior (discrimination). From a literature review, a series of candidate interventions are identified which may be effective in reducing stigmatization 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>

“Reducing the Stigma of Mental Illness.” By P. Tognazzini and others, University of British Columbia School of Nursing. IN: The Canadian Nurse, vol. 104, no. 8 (October 2008) pp. 30-33.

[“A national report on mental health, produced by the Standing Senate Committee on Social Affairs, Science and Technology, indicates that Canada lags behind other developed countries in awareness of mental health and mental disorders. The report points out that health-care professionals are among the groups that perpetuate the stigma associated with mental illness. The authors, representing the Canadian Federation of Mental Health Nurses education committee, advocate psychiatric/mental health courses and clinical practicums in undergraduate nursing education. They call on students and nurses alike to reflect on attitudes and beliefs that might prevent them from intervening effectively with people living with mental illness.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=18979863&site=ehost-live>

“Stigma of Depression is more severe in Chinese Americans than Caucasian Americans.” By George L.K.Hsu, Tufts-New England Medical Center, and others. IN: *Psychiatry: Interpersonal & Biological Processes*, vol. 71, no. 3 (Fall 2008) pp. 210-218.

[“Stigma of mental illness is a major obstacle to its diagnosis and treatment and may be worse among Asians than Caucasians. This study compared the stigma of depression in 50 Chinese Americans (CA) and 50 Caucasian Americans (WA). Subjects were asked to read 5 case vignettes in the following order: diabetes mellitus (DB), major depressive disorder (MDD), somatoform depression (SD), psychotic depression (PD), and fever of unknown origin (HA). Diagnosis of each case was not revealed. Subjects then rated their response to each case, on a Likert scale from "strongly disagree" to "strongly agree," to 25 statements that contained 6 stigma factors: fear, shame, cognitive distortion, social consensus, discrimination, and sanction. Composite scores constructed from ratings of each factor were used to calculate the severity of stigma. Stigma of all 5 cases was worse in CA than WA. Both groups ranked DB and HA to be least and PD to be most stigmatizing. CA rated SD to be less stigmatizing than MDD but not WA. We concluded that stigma formation and severity were determined by fear, shame, cognitive distortion, social communication, consensus, and sanction. Mental symptoms, particularly psychotic symptoms, were more stigmatizing than physical symptoms, especially for CA. Belief that depression was like a physical illness did not diminish its stigma.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=34880465&site=ehost-live>

“A Visual Culture of Stigma: Critically Examining Representations of Mental Illness.” By Jennifer Eisenhauer, Ohio State University. IN: *Art Education*, vol. 61, no. 5 (September 2008) pp.13-18.

[“The article presents information about an incident involving a controversial teddy bear manufactured by the Vermont Teddy Bear Company in 2005. The bear, which came out for Valentine's Day, was titled the "Crazy for You" bear and wore a straight jacket with a tag labeled "commitment report." The bear was criticized by mental health advocates and became a collector's item. The article examines this incident in light of other mental health stereotypes in popular culture and explores the term "visual culture of stigma." Information about the medical history of mental illnesses is included and the portrayal of mental health in children's media is also examined.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=f5h&AN=34160311&site=ehost-live>

SUICIDE PREVENTION

“Communication of Suicide Intent by Schizophrenic Subjects: Data from the Queensland Suicide Register.” By Diego De Leo and Helen Klieve, Griffith University, Queensland, Australia. IN: International Journal of Mental Health Systems, vol. 1, no. 6 (October 2007) pp. 1-7.

[“Background: Suicide in mentally ill subjects, like schizophrenics, remains unbearably frequent in Australia and elsewhere. Since these patients are known to constitute a high-risk group, suicide in them should be amongst the most preventable ones. The objective of this study is to investigate the frequency of suicide communication in subjects with reported history of schizophrenia that completed suicide.

The Queensland Suicide Register (QSR) was utilized to identify suicide cases. Frequency of suicide communication was examined in subjects with schizophrenia, and compared with persons with other psychiatric conditions and with subjects with no reported diagnosis. Sociodemographic variables, history of suicidal behavior, pharmacological treatment and mental health service utilization were also compared among the three groups.

Subjects with a reported diagnosis of schizophrenia comprised 7.2% (n = 135) of the 1,863 suicides included in this study. Subjects with schizophrenia and those with other psychiatric disorders communicated their suicide intent more frequently than those with no psychiatric diagnosis, and persons with schizophrenia communicated their intent more than those with other psychiatric diagnoses. Seventy one per cent of schizophrenia subjects had contact with a mental health professional within the three months prior to suicide.

The fact that subjects with schizophrenia had the highest prevalence of suicide intent communication could offer concrete opportunities for suicide prevention.”]

Full text at: <http://www.ijmhs.com/content/pdf/1752-4458-1-6.pdf>

VETERAN’S AND MENTAL ILLNESS

“Canadian Military Personnel’s Population Attributable to Fractions of Mental Disorders and Mental Health Service Use Associated with Combat and Peacekeeping Operations.” By Jitender Sareen, University of Manitoba, Winnipeg, and others. IN: American Journal of Public Health, vol. 98, no. 12 (December 2008) pp. 2191-2198.

[“We investigated mental disorders, suicidal ideation, self-perceived need for treatment, and mental health service utilization attributable to exposure to peacekeeping and combat operations among Canadian military personnel. Methods. With data from the Canadian Community Health Survey Cycle, Canadian Forces Supplement, a cross-sectional population-based survey of active Canadian military personnel (N=8441), we estimated population attributable fractions (PAFs) of adverse mental health outcomes. Results. Exposure to either combat or peacekeeping operations was associated with posttraumatic stress disorder (men: PAF=46.6%; 95% confidence interval [CI]=27.3, 62.7; women: PAF=23.6%; 95% CI=9.2, 40.1), 1 or more mental disorder assessed in the survey (men: PAF=9.3%; 95% CI=0.4, 18.1; women: PAF=6.1%; 95% CI=0.0, 13.4), and a perceived need for information (men: PAF=12.3%; 95% CI=4.1, 20.6; women: PAF=7.9%; 95% CI=1.3, 15.5). Conclusions. A substantial proportion, but not the majority, of mental health– related outcomes were attributable to combat or peacekeeping deployment. Future studies should assess traumatic events and their association with physical injury during deployment, premilitary factors, and post deployment psychosocial factors that may influence soldiers’ mental health.”]

Full text at: <http://www.ajph.org/cgi/content/abstract/98/12/2191?etoc>

NEWCONFERENCE

WORKING FAMILIES POLICY SUMMIT - 2009

**Tuesday, January 13, 2009
8:30 a.m. - 4:30 p.m.
Sacramento Convention Center**

**Registration Materials will be available
December 8, 2008 at www.ccrwf.org
There is no cost to attend the Summit, but you must register.**

Hosted by
California Center for Research on Women and Families

The 6th Working Families Policy Summit will feature the state’s leading advocates presenting their legislative agendas for the upcoming year. Issues include health care, economic security, child care, preschool, after-school care, workplace issues and more!

Also featuring Senate President pro Tempore-elect Darrell Steinberg as our luncheon keynote speaker.

CCRWF is a program of the Public Health Institute
Kate Karpilow, Ph.D., CCRWF Executive Director
Cathy Murnighan, Summit Coordinator

Questions?

Contact Cathy Murnighan at e-mail Summit@ccrwf.org
or call (916) 944-4935.

**Feel free to pass this along to interested colleagues and place on your
community calendar.**

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NEWPODCASTS

Racial Disparities in Mental Health: Psychiatrist, Dr. Stephen McLeod-Bryant discusses racial disparities in mental health care and how often it's more than a racial issue but is often tied to behaviors, economic resources, and adverse incidents earlier in ones lifetime and cultural differences. From the Medical University of South Carolina.

Podcast:

<http://www.muschealth.com/multimedia/Podcasts/displayPod.aspx?podid=141&autostart=false>