

Subject: Studies in the News: (December 15, 2008)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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NEWPODCASTS

CHILDREN AND ADOLESCENT MENTAL HEALTH

Bipolar Disorder in Children and Teens. By the National Institute of Mental Health. (The Institute, Bethesda, Maryland) 2008. 8 p.

[“Bipolar disorder is a serious brain illness. It is also called manic-depressive illness. Children with bipolar disorder go through unusual mood changes. Sometimes they feel very happy or “up,” and are much more active than usual. This is called **mania**. And sometimes children with bipolar disorder feel very sad and “down,” and are much less active than usual. This is called **depression**.

Bipolar disorder is not the same as the normal ups and downs every kid goes through. Bipolar symptoms are more powerful than that. The illness can make it hard for a child to do well in school or get along with friends and family members. The illness can also be dangerous. Some young people with bipolar disorder try to hurt themselves or attempt suicide.

Children and teens with bipolar disorder should get treatment. With help, they can manage their symptoms and lead successful lives.”]

Full text at: <http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens-brochure.pdf>

Bullying: States Try to Rein in Ugly Behavior. By Lamar Baily, National Conference of State Legislatures (NCSL). (NCSL, Washington, D. C.) December 8, 2008. 4 p.

[“In February of this year, a California teen, Lawrence King, was shot two times in the head by a classmate in a school computer lab; he died a few days later. The killing followed weeks of harassment after King told classmates he was gay.

Bullies have verbally and physically harassed other kids since time immemorial. But these days, harassment too often turns deadly. Since 1979, there have been more than 30 fatal shootings at schools, many of which later turned out to be connected to bullying. Legislators have passed laws to curb the behavior, but critics are skeptical, saying bullying can't be defined, much less controlled by laws.

The definitions of bullying vary, but it generally includes verbal and physical abuse or ostracizing someone over a period of time. It's estimated that up to 25 percent of U.S. students are bullied regularly; another 15 percent to 20 percent of kids report that they harass others with some frequency.

Children who are bullies are more likely to get into fights, vandalize property, be truant and drop out of school, according to [Stop Bullying Now](#), a part of the federal Health Resources and Services Administration.”]

Full text at: <http://www.ncsl.org/programs/health/shn/2008/sn529c.htm>

“Effects of Social Development Intervention in Childhood 15 Years Later.” By J. David Hawkins, University of Washington, and others. IN: Archives of Pediatric Adolescent Medicine, vol. 162, no. 12 (December 2008) pp. 1133-1141.

[“**Objective** To examine the long-term effects of a universal intervention in elementary schools in promoting positive functioning in school, work, and community, and preventing mental health problems, risky sexual behavior, substance misuse, and crime at ages 24 and 27 years....

Setting Fifteen public elementary schools serving diverse neighborhoods including high-crime neighborhoods in Seattle, Washington.

Participants Sex-balanced and multiracial/multiethnic sample of 598 participants at ages 24 and 27 years (93% of the original sample in these conditions).

Interventions Teacher training in classroom instruction and management, child social and emotional skill development, and parent workshops.

Main Outcome Measures Self-reports of functioning in school, work, and community and of mental health, sexual behavior, and substance use, and crime, and court records.

Results A significant multivariate intervention effect across all 16 primary outcome indices was found. Specific effects included significantly better educational and economic attainment, mental health, and sexual health by age 27 years (all $P < .05$). Hypothesized effects on substance use and crime were not found at ages 24 or 27 years.

Conclusions A universal intervention for urban elementary schoolchildren, which focused on classroom management and instruction, children's social competence, and parenting practices, positively affected mental health, sexual health, and educational and economic achievement 15 years after the intervention ended.”]

Full text at: <http://archpedi.ama-assn.org/cgi/content/short/162/12/1133>

Trends in the Health of Young Children in California. By David Grant and Samantha Kurosky, UCLA Center for Health Policy Research. (The Center, Los Angeles, California) October 2008. 8 p.

[“When it comes to school readiness, children’s health matters. Healthy children are better prepared to learn, concentrate and develop the skills needed to succeed in school—and throughout life. Although good health supports learning among children of all ages, it is particularly important during early childhood when a crucial period of rapid physical and emotional growth occurs between birth and age five. Therefore, providing children early on with an environment conducive to healthy development and learning lays the foundation for a successful future.

Not all children, however, have this opportunity. Research shows children living in poverty, with poor health status or low quality childcare, are more likely to have developmental and learning delays. Many of California’s three million children ages 0-5 grow up in environments where their health may limit their social, emotional and academic development. This brief examines trends in key health indicators for children ages 0-5 in California between 2001 and 2005, based on data from the California Health Interview Survey (CHIS). Conducted every other year since 2001, CHIS is a statewide survey that provides information on health conditions, health behaviors, access to health care, and use of services among children, adolescents and adults in California. Examining CHIS data from multiple survey years provides valuable information on California’s progress toward better health and school readiness for young children.”]

Full text at: http://www.healthpolicy.ucla.edu/pubs/files/Hlth_Children_PB_102008.pdf

Unclaimed Children Revisited: The Status of Children’s Mental Health Policy in the United States. By Janice L. Cooper and others, Columbia University Mailman School of Public Health (National Center for Children in Poverty, New York, New York) November 2008. 160 p.

[“More than 25 years since Knitzer’s call to address the needs of America’s most troubled children service access and outcomes for children and youth appear uncannily similar. There have been scores of Commissions, and hundreds of scholarly papers and an explosion in the knowledgebase on the root causes of child mental health conditions and on effective interventions for them and for those at risk and their families. But our national ability to get ahead of the curve and avert suffering, reduce the impact of some of these conditions remain wanting despite this new knowledge, enhanced technology, improved fiscal strategies and sophisticated infrastructural related supports. Despite these developments, since 1982 there have been few major studies that have focused comprehensively on access to mental health services and supports thorough a policy lens. Some studies have documented the problem of unmet need, others have assessed the merits of system of care initiatives, and still others have focused on one or two components of the service delivery system or of the age-span.

This report seeks to update *Unclaimed Children* by examining ways that, through supportive polices states: ♦ Provide access to a comprehensive array of prevention strategies, treatment and supports that are age-appropriate for children and youth with mental health conditions, those at-risk, and their families; ♦ Infuse empirically-supported, effective practice in the service delivery system; ♦ Promote and support for family- and youth responsive, and culturally- and linguistically competent services and supports; and ♦ Maximize effectiveness and efficiencies through fiscal, infrastructure-related and management supports.”]

Full text at: http://www.nccp.org/publications/pdf/text_853.pdf

DISPARITIES

Eliminating Racial/Ethnic Disparities in Health Care: What are the Options? By the Henry J. Kaiser Foundation. (The Foundation, Menlo Park, California) October 2008. 4 p.

[“Racial and ethnic disparities in health care — whether in insurance coverage, access, or quality of care — are one of many factors producing inequalities in health status in the United States. Eliminating these disparities is politically sensitive and challenging in part because their causes are intertwined with a contentious history of race relations in America. Nonetheless, assuring greater equity and accountability of the health care system is important to a growing constituency base, including health plan purchasers, payers, and providers of care. To the extent that inequities in the health care system result

in lost productivity or use of services at a later stage of illness, there are health and social costs that affect us all.”]

Full text at: <http://www.kff.org/minorityhealth/upload/7830.pdf>

State-Level Health Care Access and Use Among Children in US Immigrant Families. By Stella M. Yu, Maternal and Child Health Care Bureau, and others. IN: American Journal of Public Health, vol. 98, no. 11 (November 2008) pp. 1-8.

[“We examined the association between children’s state of residence and their access to health care among specific types of immigrant families: foreign-born children and parents, US-born children with 1 foreign-born parent, US-born children with both foreign-born parents, and nonimmigrant families. Methods. We analyzed data from 12400 children from the 2003 National Survey of Children’s Health in the 6 states with the highest proportion of immigrants (California, Florida, Illinois, New York, New Jersey, and Texas). Results. Multivariable analyses indicated that among foreign-born children, those living in California, Illinois, and Texas were more likely to lack access to health care compared with those living in New York. Among foreign-born children with 1 or 2 US-born parents, Texas children were most likely to lack health insurance. Within nonimmigrant families, children from California, Florida, and Texas had significantly more access and use problems. Conclusions. Our findings document differential health care access and use among states for specific immigrant family types.”]

Full text at: <http://www.ajph.org/cgi/reprint/AJPH.2007.117911v1>

“You Get What You Get”: Unexpected Findings About Low-Income Parents’ Negative Experiences With Community Resources. By Michael Silverstein, Boston University School of Medicine, and others. IN: Pediatrics, vol. 122, no. 6 (December 6, 2008) pp. e1141-e1148.

[“Community-based resources are considered a critical part of the American health care system. However, studies evaluating the effectiveness of such resources have not been accompanied by rigorous explorations of the perceptions or experiences of those who use them.

We aimed to understand and classify types of negative perceptions that low-income parents have of community resources. This objective originated from a series of unexpected findings that emerged during the analysis of qualitative data that were initially collected for other purposes. We conducted in-depth qualitative interviews with urban low-income parents. Themes emerged through a grounded theory analysis of coded interview transcripts. Interviews took place in 2 different cities as part of 2 studies with distinct objectives.

We completed 41 interviews. Informants often perceived their interactions with people and organizations as a series of trade-offs, and often perceived important choices as decisions between 2 suboptimal options. Seeking help from community resources was seen in that context. The following specific themes emerged: (1) engaging with services sometimes meant subjecting oneself to requirements perceived as unnecessary and, in the extreme, having to adopt the value systems of others; (2) accepting services was sometimes perceived as a loss of control over one's surroundings, which, in turn, was associated with feelings of sadness, helplessness, or stress; (3) individuals staffing community agencies were sometimes seen as judgmental or intrusive, and when many services were accessed concurrently, information sometimes became overbearing or a source of additional stress; and (4) some services or advice received as part of such services were perceived as unhelpful because they were too generic or formulaic.

Our data suggest that definable patterns of negative perceptions of community resources may exist among low-income parents. Quantifying these perceptions may help improve the client-centeredness of such organizations and may ultimately help reduce barriers to engagement.”]

Full text at: <http://pediatrics.aappublications.org/cgi/reprint/122/6/e1141>

POLICIES AND PROCEDURES

"A Cultural Critique of Community Psychiatry in India." By Sumeet Jain and Sushrut Jadhav, University College London. IN: International Journal of Health Services, vol. 38, no.3 (2008) pp. 561-584.

["India has been considered a pioneer among low-income countries in both policy development and service provision of community mental health. The national strategy of integrating mental health with existing primary care services addresses both the scant resources and the challenges of serving a dispersed remote population of a large and diverse country. While there is no disputing that the country's mental health programs were initiated with bold and well-meaning objectives, numerous problems continue to thwart implementation of these programs. Several of the logistical and administrative difficulties have been detailed in public health and psychiatric publications. Significantly, however, a historical and cultural analysis of the major forces that have shaped the discipline is conspicuously absent in the published literature.

This article therefore presents both a brief cultural history of community psychiatry in India and a critique of its policies and implementation. Analysis of policy documents, review of the published literature, and interviews with India's mental health professionals form the major source of data. Preliminary observations from field work by one of the authors (Jain) in a northern Indian village (2004-2006) and its community mental health team complement the observations. We argue that community psychiatry is primarily a top-down endeavor, driven by policymakers at the center that has edited out the community's voice from official programs and policies. As a result, current mental health

policies and clinical services are incongruent with local experiences of suffering. Paradoxically, it is this bureaucratization and cultural divide that provide legitimacy within international mental health." **NOTE: A hard copy of this article can be obtained from the California State Library.]**

“Telepsychiatry” Brings Treatment to Rural Areas. By Robin Richardson, National Conference of State Legislatures. (NCSL, Washington, D.C.) November 24, 2008. 4 p.

[“States increasingly have to develop creative solutions in order to address shortages in the health care workforce, and the mental health field is no exception. Due to the increasing availability of and decreasing costs of technology, the use of telemedicine is becoming a popular option for many states.

About a year ago, New Mexico joined the growing number of states that are using Medicaid and other programs to bring “telepsychiatry” to residents in underserved areas. As a form of telemedicine, telepsychiatry links psychiatrists and other mental health providers to patients via video, computer or phone. Patients may be in their home, a doctor’s office, or a community health center or school.

The effort grew out of a series of town hall meetings that state officials held last year on the subject of health care. “The need for more health-care providers, especially specialists, was a common theme during the public meetings,” said Human Services Department Secretary Pamela Hyde. So the state added telemedicine—including telepsychiatry—to its list of Medicaid-covered services. “Now Medicaid will pay for services via telehealth the same as if they were face-to-face services,” Hyde said.”]

Full text at: <http://www.ncsl.org/programs/health/shn/2008/sn528c.htm>

STIGMA

“A Qualitative Analysis of the Perception of Stigma among Latinos Receiving Antidepressants.” By Alejandro Interian, University of Medicine and Dentistry, New Jersey, and others. IN: *Psychiatric Services*, vol. 58, no. 12 (December 2007) pp. 1591-1594.

[“This study sought to describe the role of stigma in antidepressant adherence among Latinos. *Methods:* The study utilized data generated from six focus groups of Latino outpatients receiving antidepressants (N=30). By using a grounded theory approach, qualitative analysis focused specifically on the role of stigma in antidepressant treatment, as well as salient Latino values. Perceptions of stigma were related to both the diagnosis of depression and use of antidepressant medication. Qualitative analyses showed that antidepressant use was seen as implying more severe illness, weakness or failure to cope with problems, and being under the effects of a drug. Reports of stigma were also related to social consequences. Also, the perceived negative attributes of antidepressant use were

at odds with self-perceived cultural values. *Conclusions:* Stigma was a prominent concern among Latinos receiving antidepressants, and stigma often affected adherence. Furthermore, culture is likely to play an important role in the communication of stigma and its associated complications.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/58/12/1591>

Related article: Development and evaluation of a youth mental health Community-Awareness Campaign: The Compass Strategy.

Full text at;

<http://www.pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1564138&blobtype=pdf>

SUICIDE PREVENTION

The Holiday Suicide Myth: Newspapers (and TV Shows) Return to Old Ways. By the Annenberg Public Policy Center. (The Center, Philadelphia, Pennsylvania) December 8, 2008. 5 p.

[“One of the more persistent myths about the end-of-year holidays is that suicides rise during this period. According to a recently completed analysis of news reporting during last year’s holiday period, there was renewed repetition of this myth in newspaper reporting. Despite the sizeable drop that occurred during the preceding holiday period in 2006, newspapers displayed a surge in both the number and proportion of stories that supported the myth.

The analysis, released today by the Annenberg Public Policy Center (APPC) shows that about half of the articles written during last year’s holiday season that made a direct connection to the season perpetuated the myth. That represents a statistically significant increase from the previous holiday period when less than 10 percent supported the myth.”]

Full text at:

http://www.annenbergpublicpolicycenter.org/Downloads/Releases/Release_HolidaySuicide/suiciderelease%202008%20with%20tables.pdf

“School-Based Screening to Identify at-Risk Students Not Already Known to School Professionals: The Columbia Suicide Screen.” By Michelle A. Scott, Columbia University, and others. IN: American Journal of Public Health, vol.99, no. 2 (February 2009) pp. 1-6.

[“Objectives. We sought to determine the degree of overlap between students identified

through school-based suicide screening and those thought to be at risk by school administrative and clinical professionals. Methods. Students from 7 high schools in the New York metropolitan area completed the Columbia Suicide Screen; 489 of the 1729 students screened had positive results. The clinical status of 641 students (73% of those who had screened positive and 23% of those who had screened negative) was assessed with modules from the Diagnostic Interview Schedule for Children. School professionals nominated by their principal and unaware of students' screening and diagnostic status were asked to indicate whether they were concerned about the emotional well-being of each participating student. Results. Approximately 34% of students with significant mental health problems were identified only through screening, 13.0% were identified only by school professionals, 34.9% were identified both through screening and by school professionals, and 18.3% were identified neither through screening nor by school professionals. The corresponding percentages among students without mental health problems were 9.1%, 24.0%, 5.5%, and 61.3%. Conclusions. School-based screening can identify suicidal and emotionally troubled students not recognized by school professionals." NOTE: A copy of this article can be obtained from the CA State Library upon request.]

Full text at: <http://www.ajph.org/cgi/reprint/AJPH.2007.127928v1>

Substance Abuse and Suicide Prevention: Evidence and Implications. A White Paper. By the Substance Abuse and Mental Health Services Administration (SAMHSA). (SAMHSA, Rockville, Maryland) 46 p.

[“Almost a decade ago, then-Surgeon General David Satcher, MD, issued a Call to Action to Prevent Suicide (1999) as the first step toward adoption of a National Strategy on Suicide Prevention and the acknowledgement of suicide as an issue of public health concern and for national action. Recognizing that each year, over 30,000 individuals of all ages, races and ethnicities lose their lives by suicide in the U.S., Dr. Satcher observed that the “difference between knowing and doing can be fatal.” Pointing out that “...even the most well considered plan accomplishes nothing if it is not implemented,” he urged action to

advance the Report's 15 key recommendations focused on awareness, intervention and methodology. The Call to Action called for the implementation of strategies to reduce the stigma associated not only with suicidal behavior and mental illnesses, but also with substance abuse disorders. It urged that resources be enhanced for suicide prevention programs and for mental and substance abuse disorder assessment and treatment. Moreover, it recommended that health care provider capacity be enhanced to better recognize and either refer or treat depression, substance abuse and other major mental illnesses associated with suicide risk.

Since publication of the Call to Action, considerable necessary progress has been made, thanks to a confluence of concerted action by policymakers, administrators, researchers,

clinicians, and families touched by suicide. The body of scientific knowledge about suicide prevention and intervention has grown markedly. Increasing numbers of evidence-based programs have been taking their place in the realm of best practices. The Garrett Lee Smith Memorial Act has resulted in the implementation of grant programs focused on youth suicide prevention in communities and on college campuses around the country. The Suicide Prevention Lifeline network of over 125 call centers is reaching out to reduce suicides one call at a time, including from populations at elevated risk, such as our nation's returning veterans. The Suicide Prevention Resource Center is facilitating dissemination of awareness messages and primary care education, giving the public and practitioners better suicide prevention tools than ever before.”]

Full text at: <http://www.samhsa.gov/matrix2/508SuicidePreventionPaperFinal.pdf>

NEW PODCASTS

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