

**Subject:** Studies in the News: (April 30, 2009)

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## Studies in the News for



## California Department of Mental Health

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### Introduction to Studies in the News

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## SUBJECT HEADINGS IN THIS ISSUE

### ACCESS TO MENTAL HEALTH CARE

[Beyond Parity: Primary Care Physicians' Perspectives On Access To Mental Health Care.](#)

[Perceived Access to General Medical and Psychiatric Care among Veterans with Bipolar Disorder.](#)

### CHILDREN AND ADOLESCENT MENTAL HEALTH

[Mothers' and Fathers' Reluctance to Seek Psychological Help for their Children.](#)

[Screening and Treatment for Major Depressive Disorder in Children and Adolescents.](#)

### COMORBIDITY

[Comorbidity: Addiction and other Mental Illnesses. \(Research Report Series.\)](#)

### DEPRESSION

[Culture, Context, and the Internalizing Distress of Mexican American Youth.](#)

### HOUSING

[A New Kind of Homelessness for Individuals with Serious Mental Illness?: The Need for a "Mental Health Home."](#)

[Supportive Housing in Illinois: A Wise Investment.](#)

### POLICIES AND PROCEDURES

[Florida Seeks to Stop a Costly "Revolving Door."](#)

### RESEARCH

[Common Genetic Determinants of Schizophrenia and Bipolar Disorder in Swedish Families: a Population-based Study.](#)

### STIGMA

[Measuring Perceptions of Stigmatization by Others for Seeking Psychological Help: Reliability and Validity of a New Stigma Scale with College Students.](#)

[The Role of Gender in Mental-Illness Stigma: A National Experiment](#)

[Stigma Matters: The Media's Impact on Public Perceptions of Mental Illness.](#)

### SUICIDE PREVENTION

**[Childhood Gender Nonconformity and Harassment as Predictors of Suicidality among Gay, Lesbian, Bisexual, and Heterosexual Austrians.](#)**

**VIOLENCE AND MENTAL ILLNESS**

**[The Intricate Link between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions.](#)**

**[NEWCONVENTIONS](#)**

**ACCESS TO MENTAL HEALTH CARE**

**Beyond Parity: Primary Care Physicians' Perspectives On Access To Mental Health Care.** By Peter J. Cunningham, Center for Studying Health System Change, Washington, DC. IN: *Health Affairs*, vol. 28, no. 3 (April 2009) pp. w490-w501.

“About two-thirds of primary care physicians (PCPs) reported in 2004-05 that they could not get outpatient mental health services for patients--a rate that was at least twice as high as that for other services. Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage were all cited by PCPs as important barriers to mental health care access. The probability of having mental health access problems for patients varied by physician practice, health system, and policy factors. The results suggest that implementing mental health parity nationally will reduce some but not all of the barriers to mental health care.”

Full text at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.28.3.w490/DC1>

[\[Back to Top\]](#)

**Perceived Access to General Medical and Psychiatric Care among Veterans with Bipolar Disorder.** By John E. Zeber, Veterans Affairs, Health Service Research and Development (MSI&D) Center, San Antonio, Texas, and the Department of Psychiatry, University of Texas, Health Science Center, San Antonio, Texas, and others. IN: *American Journal of Public Health*, vol. 99, no. 4 (April 2009) pp. 720-727.

*Objectives:* We examined associations between patient characteristics and self-reported difficulties in accessing mental health and general medical care services. *Methods:* Patients were recruited from the Continuous Improvement for Veterans in Care-Mood Disorders study. We used multivariable logistic regression analyses to assess whether predisposing (demographic characteristics), enabling (e.g., homelessness), or need (bipolar symptoms, substance abuse) factors were associated with difficulties in obtaining care, difficulties in locating specialty providers, and forgoing care because of cost. *Result:* Patients reported greater difficulty in accessing general medical services than in accessing psychiatric care. Individuals experiencing bipolar symptoms more frequently avoided psychiatric care because of cost (odds ratio [OR] = 2.43) and perceived greater difficulties in accessing medical specialists (OR = 2.06). Homeless individuals were more

likely to report hospitalization barriers, whereas older and minority patients generally encountered fewer problems accessing treatment. *Conclusions:* Need and enabling factors were most influential in predicting self-reported difficulties in accessing care, subsequently interfering with treatment dynamics and jeopardizing clinical outcomes. Efforts in the Department of Veterans Affairs to expand mental health care access should be coupled with efforts to ensure adequate access to general medical services among patients with chronic mental illnesses.”

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=37041116&site=ehost-live>

[\[Back to Top\]](#)

### **CHILDREN AND ADOLESCENT MENTAL HEALTH**

**Mothers’ and Fathers’ Reluctance to Seek Psychological Help for their Children. By Amiram Raviv, Department of Psychology, Tel Aviv University, and others. IN: Journal of Child and Family Studies, vol. 18, no. 2 (April 2009) pp. 151-162.**

“We investigated the gap between parents’ willingness to seek help for their children and their willingness to refer other parents to help, and the relationship of this gap to gender. Two hundred and eleven parent couples with elementary-school children reported their willingness to seek help from professional and informal sources for a hypothetical problem with their child, and their willingness to refer a friend’s child with an identical problem to similar help. Attitudes toward help seeking and parental behaviors were also measured. Findings revealed that parents were more willing to refer a friend’s child to professional help than they were to seek such help for their own child, although no gap was found regarding informal help. No gender differences were found regarding willingness to seek help or to refer another, although gender was related to variables that predicted help seeking.”

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[\[Back to Top\]](#)

**Screening and Treatment for Major Depressive Disorder in Children and Adolescents. By the U.S. Preventive Services Task Force (USPSTF,) Rockville, Maryland. March 2009. Various pagings.**

“The USPSTF updated its 2002 recommendation on screening for child and adolescent MDD among average-risk primary care populations. The objective was to review the literature to summarize the current state of evidence and identify new evidence addressing previously identified gaps. Evidence examined included the benefits and harms of screening, the accuracy of primary care-feasible screening tests, and the benefits

and risks of treating depression by using psychotherapy and/or medications in patients aged 7 to 18 years.

The USPSTF found adequate evidence that screening tests can accurately identify MDD in adolescents. Adequate evidence also supports beneficial decreases in MDD symptoms associated with treatment of adolescents with SSRIs, psychotherapy, and therapy combining SSRIs with psychotherapy. The USPSTF found inadequate evidence of harms of screening adolescents. There is adequate evidence on the harms of SSRIs (risk of suicidality), but there is no evidence on the harms of psychotherapy or combined treatment of adolescents with psychotherapy and SSRIs (fluoxetine), which is bounded to be low. The USPSTF found moderate certainty that the net benefit is moderate for screening followed by treatment with psychotherapy in adolescents.

The USPSTF found inadequate evidence that screening tests can accurately identify MDD in children. Inadequate evidence exists on the benefits of psychotherapy or combined psychotherapy and SSRIs in children (7-11 years of age). The USPSTF found adequate evidence that fluoxetine reduces MDD symptoms in children. The USPSTF found inadequate evidence on the harms of screening for MDD in children. There is adequate evidence on the harms of SSRIs (risk of suicidality). As a result, the USPSTF concluded that the evidence is insufficient to make a recommendation regarding screening for MDD in children aged 7 to 11 years.”

Full text at: <http://www.ahrq.gov/clinic/uspstf09/depression/chdeprss.htm#rationale>

[\[Back to Top\]](#)

## COMORBIDITY

**Comorbidity: Addiction and other Mental Illnesses. (NIDA Research Report Series.) Edited by Nora D. Volkow, Director, National Institute on Drug Abuse, Bethesda, Maryland. 2009. 12 p.**

“This Research Report provides information on the state of the science of comorbidity. And although a variety of diseases commonly co-occur with drug abuse and addiction (e.g. HIV, hepatitis C, cancer, cardiovascular disease), this report focuses only on the comorbidity of drug use disorders and other mental illnesses.

To help explain this comorbidity, we need to first recognize that drug addiction is a mental illness. It is a complex brain disease characterized by compulsive, at times uncontrollable drug craving, seeking, and use despite devastating consequences—behaviors that stem from drug-induced changes in brain structure and function. These changes occur in some of the same brain areas that are disrupted in various other mental disorders, such as depression, anxiety, or schizophrenia. It is therefore not surprising that population surveys show a high rate of co-occurrence, or comorbidity, between drug addiction and other mental illnesses. Even though we cannot always prove a connection

or causality, we do know that certain mental disorders are established risk factors for subsequent drug abuse– and vice versa.

It is often difficult to disentangle the overlapping symptoms of drug addiction and other mental illnesses, making diagnosis and treatment complex. Correct diagnosis is critical to ensuring appropriate and effective treatment. Ignorance of or failure to treat a comorbid disorder can jeopardize a patient's chance of success. We hope that our enhanced understanding of the common genetic, environmental, and neural bases of these disorders– and the dissemination of this information– will lead to improved treatments for comorbidity and will diminish the social stigma that makes patients reluctant to seek the treatment they need.”

Full text at: <http://www.drugabuse.gov/PDF/RRComorbidity.pdf>

[\[Back to Top\]](#)

## DEPRESSION

**Culture, Context, and the Internalizing Distress of Mexican American Youth. By Antonio J. Polo, DePaul University, and Steven R. Lopez, University of Southern California. IN: Journal of Clinical Child and Adolescent Psychology, vol. 38, no. 2 (March-April 2009) pp. 273-285.**

“Latino youth appear to be at higher risk for depression relative to youth from other ethnic groups. This study assessed the relationship between nativity and several forms of internalizing distress among Mexican American middle school students as well as sociocultural factors that may help explain this relationship. Immigrant Mexican American youth (n = 78) reported significantly higher social anxiety and loneliness than U.S.-born Mexican American youth (n = 83). Acculturation stress and English proficiency were identified as significant mediators of these nativity differences. Although internalizing problems and depression symptoms did not vary across nativity groups, both were related to lower affiliative obedience. The findings point to cultural socialization values and contextual influences as important variables in the mental health of youth in immigrant families.”

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[\[Back to Top\]](#)

## HOUSING

**A New Kind of Homelessness for Individuals with Serious Mental Illness?” The Need for a “Mental Health Home.” By Thomas E. Smith, New York State Psychiatric Institute, Columbia University, and Lloyd I. Sederer, New York State**

**Office of Mental Health. IN: Psychiatric Services, vol. 60, no. 4 (April 2009) pp. 528-533.**

“Individuals with serious mental illness often are unable to access consumer- and family-oriented community care, resulting in repeated hospitalizations, incarceration, and homelessness. The "medical home" concept was developed in primary care to provide accessible and accountable services for individuals with chronic medical conditions. Building on the work done in primary care, the authors propose a "mental health home." The model of care incorporates medical home characteristics, such as access to and coordination of services, integration of primary and preventive care, adoption of recovery orientation and evidence-based practices, and family and community outreach. Barriers to and strategies for implementation of mental health homes are discussed.”

Full text at: <http://ps.psychiatryonline.org/cgi/reprint/60/4/528>

[\[Back to Top\]](#)

**Supportive Housing in Illinois: A Wise Investment. By The Heartland Alliance, Mid-America Institute on Poverty. (The Alliance, Chicago, Illinois) April 2009. 41 p.**

“This study reports on 177 supportive housing residents around Illinois, comparing their use of publicly-funded services two years before entering supportive housing to two years after entry. Data were collected from Medicaid-reimbursed services, state mental health hospitals, substance use treatment, state prisons, and various county jails and hospitals. The study found an overall cost savings of over \$850,000 in the two years after entry into supportive housing, a little over \$2,400 per person annually. There was a drastic reduction in state prison, county jail, and state mental health hospital overnight stays. There was a shift from using expensive inpatient services before housing (nursing homes, inpatient care, and state mental health hospitals) to less expensive outpatient services after entry into housing (outpatient medical and psychiatric care, case management.)”

Full text at: <http://www.heartlandalliance.org/whatwedo/advocacy/reports/study-of-supportive-housing-in-illinois-final.pdf>

[\[Back to Top\]](#)

## **POLICIES AND PROCEDURES**

**Florida Seeks to Stop a Costly “Revolving Door.” By Robin Richardson, National Conference of State Legislatures, Denver, Colorado. IN: State Health Notes: Vital Signs for State Policymakers, vol. 30, no. 358 (April 27, 2009) 2 p.**

“Florida lawmakers are considering a bill that would shift persons with mental illness who have been arrested from costly state psychiatric facilities into less expensive community-based systems of treatment. The bill—sponsored by Senator Mike Fasano ([SB 2018](#)) and Representative William Snyder ([HB 7103](#))—seeks to eliminate the costly

revolving door that ensnares both correctional facilities and persons with mental illnesses who have been arrested. Currently, individuals with mental illness—and often, co-occurring substance use disorders—who have been arrested are taken to forensic (i.e., related to the correctional system) mental health facilities, where they are assessed, stabilized for trial, and usually, eventually released back into the community. Lacking medication, case management and often a home, they frequently deteriorate and are re-arrested, upon which the costly cycle begins again... By providing community-based services, an estimated two-thirds of the new program's costs would be covered by Medicaid, saving the state significant money. Health services that are provided to individuals while they are within the state's correctional system do not qualify for Medicaid matches.”

Full text at: <http://www.ncsl.org/programs/health/shn/2009/sn538b.htm>

[\[Back to Top\]](#)

## RESEARCH

**Common Genetic Determinants of Schizophrenia and Bipolar Disorder in Swedish Families: a Population-based Study.** By Paul Lichtenstein, Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden, and others. IN: *The Lancet*, vol. 373, no. 9659 (January 17, 2009) pp. 234-239.

“Schizophrenia and bipolar disorder (also known as manic-depressive illness) are the two most common psychotic disorders. For over a century, the two diseases have been treated as distinct by clinical practitioners and researchers as regards definitions and risk factors. However, such strict classification has met increasing skepticism over the years, partly owing to the results of modern genetic science, which has shown that certain genes seem to affect both disorders.

To study whether schizophrenia and bipolar disorder have the same genetic causes, Swedish scientists analyzed the records of two million families, including 35,985 patients with schizophrenia, 40,487 patients with bipolar disorder, and the blood relatives of both.

Their results show that members of families in which someone has either schizophrenia or bipolar disorder run an increased risk of developing the same condition. The results also show that this is chiefly the result of genetic factors, and only slightly due to shared environmental factors. The scientists also found that patients with schizophrenia are also more prone to bipolar disorder, and that relatives of patients with one of the diseases are more likely to have relatives with the other.” *Medical News Today* (January 18, 2009)

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[\[Back to Top\]](#)

## STIGMA

**Measuring Perceptions of Stigmatization by others for Seeking Psychological Help: Reliability and Validity of a New Stigma Scale with College Students. By David L. Vogel and others, Iowa State University. IN: Journal of Counseling Psychology, vol. 56, no. 2 (April 2009) pp. 301-308.**

“Fear of being stigmatized is the most cited reason why individuals avoid psychotherapy. Conceptually, this fear should be strongest when individuals consider the reactions of those they interact with. Across 5 samples, the authors developed the Perceptions of Stigmatization by Others for Seeking Help (PSOSH) scale. In Sample 1 ( $N = 985$ ), the 5 items of the PSOSH were selected ( $r = .91$ ). In Sample 2 ( $N = 842$ ), the unidimensional factor structure of the scale was examined across a diverse sample. In Sample 3 ( $N = 506$ ), concurrent validity was supported through moderate associations with 3 different stigma measures (i.e., public stigma toward counseling,  $r = .31$ ; public stigma toward mental illness,  $r = .20$ ; and self-stigma,  $r = .37$ ). In Sample 4 ( $N = 144$ ), test–retest reliability across a 3-week period was calculated ( $r = .82$ ). Finally, in Sample 5 ( $N = 130$ ), reliability ( $r = .78$ ) and validity were explored with a sample experiencing symptoms of psychological distress. Relationships between variables (i.e., public stigma toward counseling,  $r = .31$ , and self-stigma,  $r = .40$ ) were similar to those in previous samples.”

Full Text at: <http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=cou-56-2-301&site=ehost-live>

[\[Back to Top\]](#)

**The Role of Gender in Mental-Illness Stigma: A National Experiment. By James H. Wirth, Purdue University, and Galen V. Bodenhausen, Northwestern University. IN: Psychological Science, vol. 20, no. 2 (February 2009) pp. 169-173.**

“The stigma of mental illness imposes substantial costs on both the individuals who experience mental illness and society at large. Understanding the psychological underpinnings of this stigma is therefore a matter of practical and theoretical significance. In a national, Web-based survey experiment, we investigated the role played by gender in moderating mental-illness stigma. Respondents read a case summary in which the gender of the person was orthogonally manipulated along with the type of disorder; the cases reflected either a male-typical disorder or a female-typical disorder. Results indicated that when cases were gender-typical, respondents felt more negative affect, less sympathy, and less inclination to help, compared to when cases were gender atypical. This pattern can be explained by the fact that gender-typical cases were significantly less likely to be seen as genuine mental disturbances.”

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[\[Back to Top\]](#)

**Stigma Matters: The Media's Impact on Public Perceptions of Mental Illness. By Kismet Baun, Canadian Mental Health Association. IN: Ottawa Life (February 2009) pp. 31-33.**

“Battling the societal stigma that enshrouds neurological disorders is difficult, and the ability to overcome centuries-old biases is often thwarted by the stereotypical representations of mentally ill individuals. Negative media images promote negative attitudes, and ensuing media coverage feeds off an already inaccurate perception. For real change to occur, the media must play a role in changing such negative perceptions. Accurate and positive messages and stories about mental illness and people living with mental illnesses must become more commonplace. Furthermore, it is vital to highlight stories of successful recovery. Society needs to continue to strive to reduce and eliminate the stigma and discrimination that so many with mental illness experience in their day-to-day lives.

Intentional or not, naïve assumptions, stereotyping and discrimination can have damaging effects on an individual's course of recovery from mental illness. However, people can and do recover from mental illness if provided with the supports and services necessary to facilitate and nurture a sense of hope, wellness and a belief that tomorrow will be better than today.”

Full text at: [http://www.ontario.cmha.ca/admin\\_ver2/maps/olm\\_stigma\\_matters\\_200902.pdf](http://www.ontario.cmha.ca/admin_ver2/maps/olm_stigma_matters_200902.pdf)  
[\[Back to Top\]](#)

## **SUICIDE PREVENTION**

**Childhood Gender Nonconformity and Harassment as Predictors of Suicidality among Gay, Lesbian, Bisexual, and Heterosexual Austrians. By Martin Ploderl and Reinhold Fartacek. IN: Archives of Sexual Behavior, vol. 38, no. 3 (June 2009) pp. 400-410.**

“The role of childhood gender role nonconformity (CGNC) and childhood harassment (CH) in explaining suicidality (suicide ideation, aborted suicide attempts, and suicide attempts) was examined in a sample of 142 lesbian, gay, and bisexual (LGB) adults and 148 heterosexual adults in Austria. Current and previous suicidality, CGNC, and CH were significantly greater in LGB participants compared to heterosexual participants. After controlling for CGNC, the effect of sexual orientation on CH diminished. CGNC correlated significantly with current suicidality in the LGB but not in the heterosexual group, and only non-significant correlations were found for CGNC with previous suicidality. Controlling for CH and CGNC diminished the effect of sexual orientation on current suicidality. Bayesian multivariate analysis indicated that current suicidality, but not previous suicidality, depended directly on CGNC. CH and CGNC are likely implicated in the elevated levels of current suicidality among adult LGB participants. As for previous suicidality, the negative impact of CGNC on suicidality might be overshadowed by stress issues affecting sexual minorities around coming out. The association of CGNC with current suicidality suggests an enduring effect of CGNC on the mental health and suicide risk of LGB individuals.”

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## VIOLENCE AND MENTAL ILLNESS

**The Intricate Link between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. By Eric B. Elbogen and Sally C. Johnson, Department of Psychiatry, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, and others. IN: Archives of General Psychiatry, vol. 66, no.2 (February 2009) pp.152-161.**

“*Context:* The relationship between mental illness and violence has a significant effect on mental health policy, clinical practice, and public opinion about the dangerousness of people with psychiatric disorders. *Objective:* To use a longitudinal data set representative of the US population to clarify whether or how severe mental illnesses such as schizophrenia, bipolar disorder, and major depression lead to violent behavior. *Design:* Data on mental disorder and violence were collected as part of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a 2-wave face-to-face survey conducted by the National Institute on Alcohol Abuse and Alcoholism. *Participants:* A total of 34 653 subjects completed NESARC waves 1 (2001-2003) and 2 (2004-2005) interviews. Wave 1 data on severe mental illness and risk factors were analyzed to predict wave 2 data on violent behavior. *Main Outcome Measures:* Reported violent acts committed between waves 1 and 2. Results: Bivariate analyses showed that the incidence of violence was higher for people with severe mental illness, but only significantly so for those with co-occurring substance abuse and/or dependence. Multivariate analyses revealed that severe mental illness alone did not predict future violence; it was associated instead with historical (past violence, juvenile detention, physical abuse, parental arrest record), clinical (substance abuse, perceived threats), dispositional (age, sex, income), and contextual (recent divorce, unemployment, victimization) factors. Most of these factors were endorsed more often by subjects with severe mental illness. *Conclusions:* Because severe mental illness did not independently predict future violent behavior, these findings challenge perceptions that mental illness is a leading cause of violence in the general population. Still, people with mental illness did report violence more often, largely because they showed other factors associated with violence. Consequently, understanding the link between violent acts and mental disorder requires consideration of its association with other variables such as substance abuse, environmental stressors, and history of violence.”

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**NEW CONVENTIONS**

**American Psychiatric Association Annual Meeting.** “Shaping our Future: Science and Service.”

San Francisco, Ca – May 16-21, 2009

For more information and registration:

<http://www.psych.org/MainMenu/EducationCareerDevelopment/Meetings.aspx>

**Association for Psychological Science: 21<sup>st</sup> Annual Convention.** “Crossing Boundaries: Becoming a Cumulative Science.”

San Francisco, Ca – May 22-25, 2009

For more information and registration:

[http://www.psychologicalscience.org/convention/program\\_2009/](http://www.psychologicalscience.org/convention/program_2009/)

[\[Back to Top\]](#)