

Subject: Studies in the News: (May 28, 2009)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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NEW CONVENTIONS

CHILDREN AND ADOLESCENTS

“Domino Effect: Domestic Violence Harms Everyone’s Kids.” By Scott E. Carrell, U.C. Davis, and Mark L. Hoekstra, University of Pittsburgh. IN: *Education Next* (Summer 2009) pp. 59-63.

[“Children exposed to domestic violence not only have more disciplinary problems at school, they perform considerably worse in math and reading than other students. They also have a negative effect on their classroom peers, resulting in decreased test scores and increased disciplinary.”]

Carrell and Hoekstra find that adding one troubled student to a classroom of 20 students decreases student reading and math test scores by more than two-thirds of a percentile point and increases misbehavior among other students in the classroom by 16 percent.

The researchers found that troubled peers have a large and statistically significant negative effect on the math and reading achievement of higher income children, but only a small and statistically insignificant effect on the achievement of low-income children. The pattern is opposite for disciplinary outcomes. The presence of troubled peers increases problem behavior of low-income children, but does not significantly increase the disciplinary problems of higher income children.”]

Full text at: http://www.hoover.org/publications/ednext/domino_effect.html

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Major Depressive Episode and Treatment among Adolescents. By the National Survey on Drug Use and Health. (Substance Abuse and Mental Health Services Administration, Rockville, Maryland) May 11, 2009. 4 p.

[“A new report ...reveals that 8.2 percent (2 million) youths aged 12 to 17 experienced at least one major depressive episode (MDE) in the past year. Only about two-fifths (38.9 percent) of these adolescents received treatment during this period according to the report by the Substance Abuse and Mental Health Services Administration (SAMHSA).”]

The report also found that health insurance coverage seemed to be a major factor in determining whether adolescents experiencing MDEs in the past year received treatment. Among these adolescents, those without health insurance coverage were far less likely to have received treatment (17.2 percent) than those with Medicaid/CHIP (42.9 percent) or private health insurance (40.6 percent).

Based on a nationwide SAMHSA survey, Major Depressive Episode and Treatment among Adolescents also reveals the types of treatments adolescents received for MDEs. The report shows that among treated adolescents:

- 58.8 percent saw or spoke with a counselor

- 36.8 percent saw or spoke with a psychologist
- 27.3 percent saw or spoke with a psychiatrist or psychotherapist
- 26.6 percent saw or spoke with a general practitioner or family doctor

In addition, the report shows that less than half (46.8 percent) of adolescents who received treatment for an MDE in the past year used prescription medication for their condition.”]

Full text at: <http://oas.samhsa.gov/2k9/youthDepression/MDEandTXTforADOL.pdf>

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Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health. By the California Infant-Family and Early Childhood Mental Health (CIF&ECMH) Training Guidelines Workgroup. (University of Southern California, Los Angeles, California) February 12, 2009. 66p.

[“During the last decade, professionals in California and throughout the country have worked to clarify the knowledge, skills and competencies needed to provide effective infant-family and early childhood mental health services. In California, an initial set of recommendations and personnel competencies were identified in 1996 through a leadership training grant funded by the U.S. Department of Health and Human Services, Maternal and Child Health Bureau, under the direction of the University of Southern California, University Center for Excellence in Developmental Disabilities at Children’s Hospital Los Angeles... This manual represents the next generation of thinking and guidance in the development of professional competencies and will provide a basis for infant-family and early childhood mental health in-service and pre-service training programs. These guidelines provide a framework for programs and individuals interested in obtaining specialized training in infant-family and early childhood mental health. The manual presents the refined set of training guidelines and recommended competencies for core providers, infant-family and early childhood mental health specialists and reflective practice facilitators. Training, experience and desired competencies for reflective practice facilitators (see definition below) have been delineated to ensure that core providers and mental health specialists receive the appropriate facilitated reflective experiences needed to develop infant-family and early childhood mental health reflective practice. It is hoped that guidance for obtaining additional knowledge and skills, along with appropriate supervision by qualified personnel, results in a better-trained and more effective work force providing enhanced services for infants, very young children and their families. A draft of the Guidelines was sent to infant and early childhood mental health professionals throughout the country for review.”]

Full text at: <http://www.wested.org/cpei/training-guidelines.pdf>

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CULTURAL COMPETENCY

A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report. By the National Quality Forum. (The Forum, Washington, DC) 2009. 116 p.

[“The National Quality Forum (NQF), an organization dedicated to improving healthcare quality, has endorsed 45 practices to guide health care systems in providing care that is culturally appropriate and patient centered. This report presents those practices along with a comprehensive framework for measuring and reporting cultural competency, covering issues such as communication, community engagement and workforce training, and providing health care systems with practices they can implement to help reduce persistent disparities in healthcare and create higher-quality, more patient-centered care. This framework and these preferred practices were vetted through NQF’s Consensus Development Process, granting them special legal status as voluntary consensus standards.”]

Full text at:

http://www.calendow.org/uploadedFiles/Publications/By_Topic/Culturally_Competent_Health_Systems/General/NQF%20Cultural%20Competency%20Report.pdf

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Creating a Front Porch: Strategies for Improving Access to Mental Health Services. By Linda M Callejas and others, Research and Training Center for Children’s Mental Health, University of South Florida. (The Center, Tampa, Florida) July 2008. 58 p.

[“This report shares results of interviews conducted with personnel from selected organizations and focuses on key practices that were reported to increase accessibility of mental health services for underserved populations. It includes a description of each of the target populations served by the participating study sites, as well as information about the history and context of, and general service delivery information for each organization.”]

Full text at:

<http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/porch/CultCompPorch.pdf>

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FEAR

In the Face of Fear: How Fear and Anxiety Affect our Health and Society, and What we Can do about it. By Ed Halliwell, Mental Health Foundation. (The Foundation, London, England) 2009. 58 p.

[“Fear has always been an aspect of human life. Early man would have feared attack by predators, famine, disease and disputes with other communities. Fear would have played

a key part in human evolution as many biologists and anthropologists have attested. The truth is fear still plays a key part in our lives. Individually we experience both rational and irrational fears that drive our behaviour and fear also drives communities and social policies. You only have to go to an airport or some inner city housing estates to see fear at work. Fear too is present in our economic crisis as both a driver and an outcome.

In the context of mental health our ability to master fear is a key part of resilience and being prey to irrational fears is one of the roots of as well as a result of mental illness. If fear levels in the general population are high more people will experience mental illness and particularly the most common mental illnesses such as anxiety and depression and anxiety disorders. Excessive fear poses an enormous burden on our society directly through anxiety related illness, which can be physical as well as mental, and indirectly through inappropriate behaviours such as excessive supervision of children or failure to invest. It also paralyses long term rational planning to deal with key future threats such as global warming by diverting attention to more immediate but less important fears.

We must learn to live with fear as individuals, communities and a society. It is not surprising that we cannot always do this – it is hard wired into our brains. But we have to factor it in, only then can we address the key challenges of the 21st century. This report aims to help individuals, communities, leaders and commentators to find ways to start doing this.”]

Full text at: <http://www.mentalhealth.org.uk/campaigns/mental-health-action-week-2009/in-the-face-of-fear/>

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FOSTER CARE

Foster Care Statistics: Numbers and Trends. By the Child Welfare Information Gateway. (The Gateway, Washington, DC) February 2009. 12 p.

[“This fact sheet provides the most recent national statistical estimates for children and youth in foster care from fiscal year (FY) 2006 and also provides earlier data from FY 2000 to allow for some estimate of trends over time. Data were obtained from the Adoption and Foster Care Analysis and Reporting System (AFCARS). AFCARS collects information on all children in foster care for whom State child welfare agencies have responsibility for placement, care, or supervision and on children who are adopted with public child welfare agency involvement.”]

Full text at: <http://www.childwelfare.gov/pubs/factsheets/foster.cfm>

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Fostering a New Future for California’s Children: Ensuring Every Child a Safe, Secure, and Permanent Home: Final Report and Action Plan. By the California Blue Ribbon Commission on Children in Foster Care. (Judicial Counsel of California, San Francisco, California) May 2009. 108 p.

[“The courts and child welfare agencies share ‘parental’ responsibility for the more than 75,000 children in foster care in California, more than any other state in the nation. Nearly half – 45 percent – of these children are in care for two years or more, 17 percent of them for more than three years. These children too often find themselves in a foster-care limbo, shifted from placement to placement, separated from siblings, friends, and schools. We know that the longer children remain in care, the less likelihood they have of reunifying with their parents. We also know that African-American and American Indian children are disproportionately represented in the system....

Our commission’s recommendations fall under four broad categories:

- 1) Reasonable efforts to prevent removal and achieve permanency;
- 2) Court reform;
- 3) Collaboration among courts and partnering agencies; and
- 4) Resources and funding.

Included within these four categorical recommendations are 79 specific recommendations – 26 of which are under the direct purview of the Judicial Council. The remaining recommendations require collaboration with child welfare and other agency partners. Each one of our recommendations is important and indispensable to the sweeping reform of the foster care and dependency court systems that we envision. For our initial action plan, we took a pragmatic approach, identifying practical first steps that we believe are fiscally responsible and realistically achievable.”]

Executive Summary at: <http://www.courtinfo.ca.gov/jc/tflists/documents/brc-execsummary.pdf>

Full text at: <http://www.courtinfo.ca.gov/jc/tflists/documents/brc-finalreport.pdf>

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HOUSING

“Housing Policy for Persons with Severe Mental Illness.” By Sandra Newman, Johns Hopkins University, and Howard Goldman, University of Maryland. IN: The Policy Study Journal, vol. 37, no. 2 (2009) pp. 299-324.

[“Homelessness among persons with severe mental illness is a visible manifestation of deeply flawed public policies. This article critically assesses research to date on housing and related policies for the homeless mentally ill and recommends that future research target three strategic areas: (i) housing subsidies; (ii) landlord reluctance to rent to persons with mental illness, thereby solving one of their major problems in accessing housing; and (iii) appropriate housing and service mix for this heterogeneous population; that is, answering the longstanding threshold policy question of what housing and service mixes work best and for whom.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=38417668&site=ehost-live>

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OLDER ADULTS

The State of Mental Health and Aging in America. By the National Association of Chronic Disease Directors, Centers for Disease Control and Prevention. Issue Briefs. No. 1 and No. 2. (The Centers, Atlanta, Georgia) 2008/2009. 12 p.

[“The first issue brief reviews existing data and lays the foundation for understanding key issues related to mental health in adults over 50. The second brief focuses on the topic of depression, an important and emerging public health issue with several evidence-based programs that communities can use to improve the mental health and quality of life of older Americans.”]

Full text of **Issue Brief No. 1**: What do the Data Tell us? 2008

http://www.cdc.gov/aging/pdf/mental_health.pdf

Full text of **Issue Brief No. 2**: Addressing Depression in Older Adults: Selected Evidenced-based Programs. 2009.

http://www.cdc.gov/aging/pdf/mental_health_brief_2.pdf

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POLICIES

Report on Comprehensive Study of Mental Health Delivery Systems in Iowa. By Nancy E. Brown and others, Mental Health Study Group. Funded by the League of Women Voters Education Fund. (The League, Ames, Iowa) February 2009. 37 p.

[“The nation’s mental healthcare system is ‘fragmented and in disarray,’ according to a 2006 report by President Bush’s New Freedom Commission on Mental Health. Iowa, in particular, is among the most convoluted mental health systems in the country and receives a failing grade from the National Alliance on Mental Illness (NAMI.) In response, the League of Women Voters of Iowa undertook this comprehensive study of Iowa’s mental health care delivery system. ‘The League of Women Voters holds the position that a basic level of health care, including mental health care, should be available to all,’ says Audrey Hauter, president of the Iowa League of Women Voters. ‘Here in Iowa, we are concerned about reports that mental health care services are unequal among our 99 counties, that the system as a whole is fragmented, and that mental disorders in children as well as adults often go unrecognized and untreated.’ Iowa was one of eight states that received a grade of ‘F’ in NAMI’s 2006 report. Others include Idaho, Illinois, Kansas, Kentucky, Montana, and North and South Dakota. The national average was ‘D’ with neighboring Wisconsin earning a ‘B,’ Minnesota and Missouri, ‘C,’ and Nebraska a ‘D.’ One reason Iowa received the failing grade was its policy of ‘legal settlement’ which requires that individuals be county residents and free of the need for mental health services for at least a year before their new county is

responsible for paying. Such restrictions often lead to inordinate, potentially catastrophic delays in getting services when they are needed.”]

Full text at: <http://www.lwvia.org/Portals/39/Mental%20Health%20Study%20-%202009.pdf>

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State Mandated Benefits in Small Group Private Health Insurance: Mandated Coverage in Mental Health as of January 2009. By the Kaiser Family Foundation/statehealthfacts.org. (The Foundation, Menlo Park, California) 2009. Various pagings.

[“New state-by-state information from the Health Policy Institute on mental health coverage mandates in the small group market and the individual market has been added as of January 2009.”]

Full text at: <http://www.statehealthfacts.org/comparereport.jsp?rep=2&cat=7>

To access the data, please scroll down after you click on this link.

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POVERTY

Poverty Reduction: A Necessary Component of the Federal Government’s Mental Health Strategy for Canadians. By Taylor Alexander, Canadian Mental Health Association. (The Association, Ottawa, Ontario) Submitted to House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities. April 2, 2009. 8 p.

[“Poverty is both a cause of and result of mental illness. To interrupt both causal mechanisms, we have recommended the following:

- Increase Employment Insurance’s salary-replacement ratio from the current 55% to 75% of average weekly earnings.
- Return EI to its pre-1996 status by readopting a 360-hour qualifying period for benefit eligibility.
- Extend the duration of Employment Insurance sickness benefits from 15 to 30 weeks.
- Broaden access and funding for EI training programs to assist re-entry into the labour market for persons experiencing work stoppages due to mental illness or mental health stressors.
- Work with provinces and territories to expand: Supported education and training programs, supported employment programs, and training and resources for employers to implement workplace accommodations.
- Restore the Canada Social Transfer to the present value of 1992 – 93 transfers.
- Develop standards of adequacy and humane program delivery in consultation with the provinces and territories.

- Initiate and operate a basic income program for persons with disabilities, including persons diagnosed with mental illness.
- Change the disability tax credit to a refundable credit at the current federal-plus provincial level, as well as changing the eligibility test.
- Enhance the Canadian Child Tax Benefit and the National Child Benefit Supplement. The maximum amount payable to low-income families should be raised from \$3,271 per child to \$5,100 in 2007 dollars.
- Make housing a primary federal concern.”]

Full text at:

http://www.cmha.ca/data/1/rec_docs/2233_CMHA%20Poverty_Reduction%20-%20HUMA.pdf

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SUICIDE PREVENTION

“Accentuation of Suicides but not Homicides with Rising Latitudes of Greenland in the Sunny Months.” By Karin S. Bjorksten, Karolinska Institutet, Sweden. and others. IN: BMC Psychiatry, vol. 9, no. 20 (May 8, 2009) 26 p.

[“The dreaded blues of dark winter months have long been blamed for seasonal depression, but too *much* sunshine may have an even more dire effect. In northern Greenland more than 80 percent of suicides occur in summer, during which the sun barely dips below the horizon. ‘There is so much light that people can’t take it,’ said lead study author Karin Sparring Björkstén of the Karolinska Institutet in Sweden. The researchers studied records of causes of deaths—1,351 due to suicide—between 1968 to 2002 in Greenland, which is largely above the Arctic Circle. When they looked at the data on a month by month basis, it became clear that suicides were far more frequent in summer, particularly in the north, where the extended summer days are most pronounced. Of the 33 suicides that had occurred in the most northerly province, Avannaq (North Greenland), 82 percent had happened during the period of 24-hour sunlight, March 7 to October 8. (Avannaq disappeared from maps in early 2009, when Greenland’s administrative divisions were revised.)

Across Greenland, a province of Denmark, 80 percent of the suicide victims were men. Ninety-five percent of the victims took their lives in violent ways—shooting themselves, hanging themselves, or jumping, for example. There was no evidence that the summer increases were related to depressive disorders or increased alcohol consumption. Björkstén and her colleagues believe the increase in summer suicides is related to lack of sleep.

‘People live their lives differently during the Arctic summer. Farmers plough their fields in the middle of the night, and children are out playing after midnight. They lose their daily rhythm,’ Björkstén said.

Other countries may not have the extreme seasonal sunlight variations, but anyone can learn from the new research, she said.

‘Today’s 24-hour society is not good for us. Public health would improve if people cared more about their sleep,’ said Björkstén.”] National Geographic News (May 19, 2009.)

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-9-20.pdf>

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WOMEN

Action Steps for Improving Women’s Mental Health. By the Office of Mental Health, U.S. Department of Health and Human Services. (The Office, Washington, DC) May 2009. 64 p.

[“A report that brings together the most recent research, resources, products, and tools on mental health issues in women and explores the role gender plays in diagnosing, treating, and coping with mental illness. It also points to resilience and social support systems as key factors in overcoming mental illness.

The report outlines specific action steps for policy-makers, health care providers, researchers, and others to take in an effort to address the burden of mental illness on women's lives and increase their capacity for recovery.”]

Full text at: <http://download.ncadi.samhsa.gov/ken/pdf/OWH09-PROFESSIONAL/ActionSteps.pdf>

Related publication:

Women’s Mental Health: What it means to you. By the Office of Women’s Health, U.S. Department of Health and Human Services. (The Office, Washington, DC) May 2009. 22 p.

[“A consumer booklet that addresses the stigma associated with mental health, with information on the signs and symptoms of mental illness. It also provides suggestions for support and solutions for preventing and coping with mental illness.”]

Full text at: <http://download.ncadi.samhsa.gov/ken/pdf/OWH09-CONSUMER/womenmentalhealth.pdf>

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YOUNG ADULTS

Center for the Study of Collegiate Mental Health (CSCMH): 2009 Pilot Study. By Ben Locke and others, Pennsylvania State University. (The University, University Park, Pennsylvania) 2009. 24 p.

[“This report outlines a preliminary effort to describe the range of information on college student mental health that could be accessed via a comprehensive long-term strategy. As a result of nearly five years of unprecedented collaboration, a pilot test of the CSCMH infrastructure produced data on over 28,000 students receiving mental health services at 66 institutions during the fall semester of 2008. Though substantial, this accomplishment represents a fraction of the theoretical capacity of a mental health informatics

infrastructure. Because it is not possible to discuss the entire range of findings in this summary, we have instead chosen to offer an overview of salient findings observable in the data. Whereas many of the findings described here will be submitted to peer-reviewed journals, we trust that these preliminary, informal findings will serve to educate, inspire, and enhance efforts to understand and improve college student mental health.”]

Executive Summary: <http://www.sa.psu.edu/caps/pdf/2009-CSCMH-Pilot-Report.pdf>

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NEW CONVENTIONS

Third Annual National Conference on Health Communication, Marketing and Media, 2009. National Center for Health Marketing, the Office of Enterprise Communication, Centers for Disease Control and Prevention.

Atlanta, Georgia - August 11-13, 2009

For more information and registration:

<http://www.cdc.gov/healthmarketing/NCHCMM2009/>

National Federal of Families for Children’s Mental Health. 20th Anniversary Conference.

Washington DC - December 3-6, 2009

For more information and registration:

<http://www.ffcmh.org/conference2009/indexconference.html>

The Mental Research Institute’s 50th Anniversary: Forum for Change: Inviting the Next Generation of Innovation

San Francisco, CA - August 13-15, 2009

For more information and registration: http://www.mri.org/50th_Conference.html