

Subject: Studies in the News: (October 1, 2009)



Studies in the News for



California Department of Mental Health

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CHILDREN AND ADOLESCENTS

“Childhood Bullying Behavior and Later Psychiatric Hospital and Psychopharmacologic Treatment: Findings from the Finnish 1981 Birth Cohort Study.” By Andre Sourander, Turku University Hospital, Finland, and others. IN: *Archives of General Psychiatry*, vol. 66, no. 9 (September 2009) pp. 1005-1012.

[“Childhood bullying and victimization appear to predict future psychiatric problems in both males and females although females appear more likely to be affected regardless of pre-existing psychiatric problems, according to this report....

In total, 6 percent of 8-year-old boys bullied others frequently, but were not victims themselves, while 6.4 percent of boys were frequently victims but not bullies.

Additionally, 2.8 percent of boys were frequently both bullies and victims. Among girls, 3.6 percent were frequent victims of bullying, 0.6 percent were bullies and 0.2 percent were both bullies and victims.

‘Frequent victim status at age 8 years among females independently predicted psychiatric hospital treatment and use of antipsychotic, antidepressant and anxiolytic drugs’ regardless of psychiatric problems at baseline, the authors write. ‘Among males, frequent bully-victim and bully-only statuses predicted use of antidepressant and anxiolytic drugs. Frequent bully-victim status among males also predicted psychiatric hospital treatment and use of antipsychotics. However, when the analysis was controlled with total psychopathology score at age 8 years, frequent bully, victim or bully-victim status did not predict any psychiatric outcomes among males.’

Bullying behavior should be considered an indicator of the risk of a future psychiatric disorder, which may develop into a serious problem for those involved and for society in general, the authors note.” *Medical News Today* (September 8, 2009)] **NOTE: Please contact the California State Library for an electronic copy of this article.**

“Childhood Emotional Problems and Self-perceptions Predict Weight Gain in a Longitudinal Regression Model.” By Andrew Ternouth, King’s College, London, UK, and others. IN: *BioMed Central Medicine*, Published online on September 10, 2009. 23 p.

[“*Background:* Obesity and weight gain are correlated with psychological ill health. We predicted that childhood emotional problems and self-perceptions predict weight gain into adulthood.

Methods: Data on around 6,500 individuals was taken from the 1970 Birth Cohort Study. This sample was a representative sample of individuals born in the UK in one week in 1970. Body mass index was measured by a trained nurse at the age of 10 years, and self-reported at age 30 years. Childhood emotional problems were indexed using the Rutter B scale and self-report. Self-esteem was measured using the LAWSEQ questionnaire, whilst the CARALOC scale was used to measure locus of control.

Results: Controlling for childhood body mass index, parental body mass index, and social class, childhood emotional problems as measured by the Rutter scale predicted

weight gain in women only (least squares regression $N = 3,359$; coefficient 0.004 ; $P = 0.032$). Using the same methods, childhood self-esteem predicted weight gain in both men and women ($N = 6,526$; coefficient 0.023 ; $P < 0.001$), although the effect was stronger in women. An external locus of control predicted weight gain in both men and women ($N = 6,522$; coefficient 0.022 ; $P < 0.001$).

Conclusions: Emotional problems, low self-esteem and an external locus of control in childhood predict weight gain into adulthood. This has important clinical implications as it highlights a direction for early intervention strategies that may contribute to efforts to combat the current obesity epidemic.”]

Full text at:

http://www.biomedcentral.com/imedia/1569424872926815_article.pdf?random=845753

After the embargo: <http://www.biomedcentral.com/bmcmed/>

Promoting Social-emotional Wellbeing in Early Intervention Services: A Fifty-State View. By Janice L. Cooper and Jessica Vick, National Center for Children in Poverty. (The Center, New York, New York) September 2009. 37 p.

[“In 2007 approximately 322,000 young children received services through the Individuals with Disabilities Act (IDEA) Part C, the Early Intervention Program for Infant and Toddlers with Disabilities. Yet research shows that only a fraction of children eligible for the program received services. Against the backdrop of this gap between need for services and service use, special concerns for young children with or at risk for social-emotional developmental delays stand in relief. Even fewer of these children received services to address their social-emotional developmental needs through Part C. In part, this state of affairs reflects the significant flexibility states have in the eligibility criteria used to identify children who will receive services under Part C. However, this flexibility results in significant differences in the number of children identified in specific states. Eligibility criteria are categorized into three groups: restricted, which includes in the determination neither clinical input nor children at-risk for developmental delay; narrow, which does include a clinical option but not at risk children; and liberal, which can include both the clinical option and at-risk children.

In order to address the mismatch between service needs and availability for children with social-emotional developmental needs effective collaboration between Part C and other federal programs and initiatives is needed. States’ policy choices yield mixed results regarding their potential to support better integration of strategies designed to address social-emotional developmental delays into early intervention services. A number of strategies are being used by states to foster better integration. One of the study’s most promising findings is that most states (70%) recommend the use of validated screening tools to detect social-emotional developmental delays. The Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) were the most frequently mentioned recommended tools. In addition, nearly 90% of states are involved in efforts to promote early identification by primary care physicians. Nearly all states (96%) have statewide data to measure child performance regarding improved social-emotional skills. Some states have also developed a solid platform for measuring and monitoring progress.

The study reveals several policy challenges which impede states' abilities to support young children who have, or are at risk of developing, social-emotional developmental delays. In particular, fewer than two-fifths of states require that a professional with expertise in social-emotional development sit on the multi-disciplinary evaluation team required to determine eligibility for early intervention services. Among services available through Part C, only half of states support infant-toddler relationship-based training (a core component of a range of research-informed services) and only one-third of states include respite care. States were most likely to pay for group or individual parenting training (73%). While research indicates that group training for parents is not effective for this age group, the survey did not ask respondents to distinguish between group and individual parent training.

No questions related to the quality of the parenting interventions were asked. Finally, while not required by legislation, only 17 states had written agreements in place to guide referral and services for young children. This is significant given both recent federal mandates that require coordination between Part C and child welfare, and data that show poor access to mental health services for young children in child welfare.”]

Full text at: http://www.nccp.org/publications/pdf/text_885.pdf

Treatment of Children with Mental Illness: Frequently Asked Questions about the Treatment of Mental Illness in Children. By the National Institute of Mental Health. (The Institute, Bethesda, Maryland) 2009. 6 p.

[“Research shows that half of all lifetime cases of mental illness begin by age 14. Scientists are discovering that changes in the body leading to mental illness may start much earlier, before any symptoms appear.

Through greater understanding of when and how fast specific areas of children's brains develop, we are learning more about the early stages of a wide range of mental illnesses that appear later in life. Helping young children and their parents manage difficulties early in life may prevent the development of disorders. Once mental illness develops, it becomes a regular part of your child's behavior and more difficult to treat. Even though we know how to treat (though not yet cure) many disorders, many children with mental illnesses are not getting treatment.

This fact sheet addresses common questions about diagnosis and treatment options for children with mental illnesses. Disorders affecting children may include anxiety disorders, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, bipolar disorder, depression, eating disorders, and schizophrenia.”]

Full text at: <http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-disorders/nimh-treatment-children-mental-illness-faq.pdf>

Vulnerable Youth and Transition to Adulthood [8 part series.] By Jennifer Ehrle Macomber and others, Urban Institute. (The Institute, Washington, DC) July and August 2009. Various pagings.

[“This series examines youth vulnerability and risk-taking behaviors on several outcomes for young adults, using the National Longitudinal Survey of Youth, 1997 cohort. Notable results suggest youth follow one of four patterns in connecting to the labor market and school in the transition to adulthood: consistently-connected, later-connected, initially-connected, or never-connected. Second generation Latinos make a fairly smooth transition to young adulthood, but are less likely to engage in post-secondary schooling than whites. Youth from low-income families, distressed neighborhoods, and youth with poor mental health engage in relatively high levels of some adolescent risk behaviors and have relatively lower earnings and levels of connectedness in early adulthood.

Full text at:

- [Multiple Pathways Connecting to School and Work](#)
- [Second-Generation Latinos Connecting to School and Work](#)
- [Youth from Distressed Neighborhoods](#)
- [Youth from Low-Income Families](#)
- [Young Men and Young Women](#)
- [Youth with Depression/Anxiety](#)
- [Low-Income African American Youth](#)
- [Youth from Low-Income Working Families](#)

What Works? A Study of Effective Early Childhood Mental Health Consultation Programs. By Frances Duran and others, Georgetown University Center for Child and Human Development. (The Center, Washington, DC) August 2009.

[“For states and communities interested in data-driven guidance around development and implementation of effective early childhood mental health consultation programs. Through in-depth site visits to six consultation programs demonstrating positive child, family, staff and/or program outcomes, this study explores the following key questions: What are the essential components of effective mental health consultation programs? What are the skills, competencies, and credentials of effective consultants? What are the training, supervision and support needs of consultants? What level of intervention intensity (i.e., frequency and duration) is needed to produce good outcomes? Which outcomes should be targeted and how should they be measured? The study also reports on the extent to which consultation efforts are occurring nationally and provides a series of recommendations generated by experts in the field to guide policymakers/funders, early childhood mental health consultation providers, early care and education program administrators, and researchers/evaluators.”]

Full report. 232 p.:

https://gushare.georgetown.edu/ChildHumanDevelopment/CENTER%20PROJECTS/WebSite/ECMHCStudy_Report.pdf

Executive summary. 18 p.:

<http://gucchd.georgetown.edu/products/FINAL%20formatted%20executive%20summary.pdf>

Fact sheet. 2 p.:

<http://gucchd.georgetown.edu/products/FINAL%20formatted%20flyer.pdf>

Resource compendium. 1 p.: <http://gucchd.georgetown.edu/products/78366.html>

MILITARY

“Association of Time since Deployment, Combat Intensity, and Posttraumatic Stress Symptoms with Neuropsychological Outcomes Following Iraq War Deployment.”

By Brian P. Marx, Veterans Affairs National Center for PTSD, and others. IN:

Archives of General Psychiatry, vol. 66, no. 9 (September 2009) pp. 996-1004.

[“*Context:* Previous research has demonstrated neuropsychological changes following Iraq deployment. It is unknown whether these changes endure without subsequent war-zone exposure or chronic stress symptoms.

Objective: To determine the associations of time since deployment, combat intensity, and posttraumatic stress disorder (PTSD) and depression symptoms with longer-term neuropsychological outcomes in war-deployed soldiers.

Design: Prospective cohort study involving (1) soldiers assessed at baseline (median, 42 days prior to deployment) and following return from Iraq (median, 404 days after return and 885 days since baseline), and (2) soldiers more recently returned from deployment assessed at baseline (median, 378 days prior to deployment) and following return from Iraq (median, 122 days after return and 854 days since baseline assessment).

Setting: Active-duty military installations.

Participants: Two hundred sixty-eight male and female regular active-duty soldiers (164 with 1-year follow-up; 104 recently returned).

Main Outcome Measures: Neuropsychological performances (verbal learning, visual memory, attention, and reaction time).

Results: There was a significant interaction between time and PTSD symptom severity ($B = -0.01$ [unstandardized], $P = .04$). Greater PTSD symptoms were associated with poorer attention in soldiers tested at 1-year follow-up ($B = 0.01$, $P = .03$) but not in recently returned soldiers. At 1-year follow-up, mean adjusted attention error scores increased by 0.10 points for every 10 points on the PTSD scale. Greater combat intensity was associated with more efficient postdeployment reaction-time performances, regardless of time since deployment ($B = 0.48$, $P = .004$), with mean adjusted reaction efficiency scores increasing by 4.8 points for every 10 points on the combat experiences scale. Neither depression nor contextual variables (alcohol use and deployment head injury) were significantly related to neuropsychological outcomes.

Conclusions: In this study of army soldiers deployed to the Iraq war, only PTSD symptoms (among soldiers back from deployment for 1 year) were associated with a neuropsychological deficit (reduced attention). Greater combat intensity was associated with enhanced reaction time, irrespective of time since return.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

“The Historic Origins of Military and Veteran Mental Health Stigma and the Stress Injury Model as a Means to Reduce It.” By William P. Nash, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and others. IN: *Psychiatric Annals*, vol. 38, no. 8 (August 2009) pp. 789-794.

[“The article reviews the historic origins of mental health stigma as experienced by military service members and war veterans. Military members and veterans who develop posttraumatic stress disorder (PTSD) may think they are branded as weak. To reduce this mental health stigma among military members and veterans, an alternative model is prescribed with the concept that such disorders are literal injuries to the brain and mind and not attributed to the individual's personal weakness. Psychological injuries can have the same respect as other wounds of war.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article. It is available on EBSCO.**

“Suicide among U.S. Veterans: A Prospective Study of 500,000 Middle-aged and Elderly Men.” By Matthew Miller, Harvard School of Public Health, and others. IN: *American Journal of Epidemiology*, vol. 170, no. 4 (August 15, 2009) pp. 494-500.

[“In a new study, suicide rates among middle-aged and elderly US military veterans were found to be no different than those of age-matched non-veterans. Several studies of suicide rates among US military veterans have produced different answers to the question of how suicide rates among vets compare with those of the non-veteran population. A new analysis of data collected on nearly 500,000 men who were followed for more than 20 years (in the American Cancer Society Cancer Prevention Study II) sheds more light on the topic. The design of the original study limits the conclusions to middle-aged and older veterans of Vietnam or previous conflicts. Researchers took into account a number of socio-demographic, behavioral, and clinical factors, the war cohort, branch of service, and age. The authors of the study found that “risk of suicide among middle-aged and older male veterans was no higher or lower than that among age-matched male non-veterans.” According to the authors, their finding is “consistent with other reports that used standardized mortality ratios to measure suicide risk among veterans relative to the general population.” This finding differs from the results of the only other prospective study comparing veterans with non-veterans, published in 2007, which found the veteran suicide rate to be twice that of non-veterans. According to Miller et al., the major methodological difference between the studies is that in the 2007 study the non-veteran comparison group was far younger than the veteran cohort. Nearly all studies of suicide rates among active duty members of the military have consistently shown that military members have substantially lower rates of suicide than the general population; and yet, this and several other studies indicate that after discharge from the military suicide rates elevate to levels similar to the general population. Observing that suicide risk seems to increase after discharge from the military, the study’s authors raise two questions. “First, are there factors that heighten risk after separation from the military, even at times remote from service? Second, are there factors that depress suicide risk during active duty that, after separation, allow suicide risk to return to the expected age-specific level afterward?” It is these factors, though poorly understood, that should be the focus of suicide

prevention efforts among veterans, not their status as military veterans per se.”] **Please contact the California State Library for a paper or electronic copy of this article.**

POLICY

Cuts to California Mental Health Care Could Leave Patients with Nowhere to Turn: California Healthline Special Audio Report. By David Gorn, California Healthline. September 17, 2009. Running Time 6:18.

["Earlier this summer, legislators cut about \$92 million from California's mental health budget. Moreover, county-level programs are facing additional strain from deferred state payments and declining tax revenue.

Advocates are concerned that the recent funding losses will prevent community groups from continuing to provide crucial services to people with mental health issues.

In this *California Healthline* Special Report by David Gorn, experts discussed how budget shortfalls could affect the state's mental health services.

The Special Report includes comments from:

John Buck, executive director of Turning Point Community Programs;

Patricia Ryan, executive director of the California Mental Health Directors Association;
and

Rusty Selix, executive director of the Mental Health Association in California.

Experts say cutting mental health programs could drive some patients into homeless shelters and hospital emergency departments, thus placing additional strain on state services.

Meanwhile, some programs are starting to focus on lower-cost offerings for mental health care, such as peer counseling (Gorn, *California Healthline*, 9/17)."]

Full text at: <http://www.californiahealthline.org/Special-Reports/2009/Cuts-to-Calif-Mental-Health-Care-Could-Leave-Patients-With-Nowhere-To-Turn-Advocates-Say.aspx>

Despite Obama Regulatory Rollback, States Continue Bush-era Medicaid Policies on Children’s Mental Health. By Rebecca Farley, Alliance for Children and Families. (The Alliance, Washington, DC) September 2, 2009. 12 p.

["Under President George W. Bush, the Centers for Medicare and Medicaid Services (CMS) implemented a series of policies restricting states’ ability to provide rehabilitation, therapeutic foster care, and targeted case management to children in the child welfare system. These policies began through reviews of several states’ Medicaid plans, were more clearly codified in a later set of proposed regulations, and continued to be enforced by CMS in some states even after Congress blocked the implementation of the regulations. Due to a combination of state momentum and incomplete CMS reversals of the blocked policies, the implementation of these Bush-era policies has continued into President Obama’s administration, despite his withdrawal of the regulations upon taking office. Many states are proceeding with the Bush-era policies of “unbundling” therapeutic foster care and targeted case management services. ‘Unbundling’ refers to the separation of Medicaid treatment services from the comprehensive package of therapeutic programs.

In this process, the treatment services are either billed separately or entirely eliminated from the program. The Alliance estimates that left unaddressed, these policies could reduce needed care for tens of thousands of children across the nation. This policy brief draws on interviews with state association directors and nonprofit Medicaid providers to examine their experiences with CMS, therapeutic foster care, and targeted case management in the post- Bush era. Reports indicate that the continuation of the Bush policies on unbundling has had many negative consequences for children, nonprofit Medicaid providers, and states, including:

- Funding cuts to therapeutic and rehabilitative services;
- Closures of TFC and residential programs providing children’s mental health services; and
- Poorer health outcomes for children and damaging effects on community safety, in some cases leading to increased violence in schools or other harmful effects on communities.”]

Full text at: http://www.alliance1.org/Public_Policy/Health/Bush_era.pdf

Individuals with Special Needs and Health Reform: Adequacy of Health Insurance Coverage. By Karen Pollitz, Georgetown University Health Policy Institute, and others. Focus on Health Reform. (Kaiser Family Foundation, Menlo Park, California) September 2009. 22 p.

[“As the Congress and the Obama Administration continue work on health reform to expand health insurance coverage through a combination of private health insurance and public programs, a key question will be “Coverage for what?” Under legislation pending in Congress, people would be required to obtain health insurance coverage, mostly from private companies. Today private health insurance is generally designed to cover acute care services. The content of coverage varies enormously, however. Studies show that millions of non-elderly Americans are underinsured – that is, their health insurance coverage nonetheless leaves them to pay large amounts out-of-pocket for covered and/or non-covered services. Under-insurance might result from policies that exclude or limit coverage for certain medical care items and services, or it might result from the imposition of high cost sharing for covered services, or both. Under reform, minimum coverage standards would be developed for private health insurance that define what benefits must be covered and what level of cost sharing (deductibles, co-pays, etc.) can apply. Subsidies would be available on a sliding scale to reduce both premiums and cost-sharing for covered services for people who buy private health insurance.

In addition, health reform proposals would broaden eligibility for Medicaid. Today Medicaid covers a broad low-income population, including children and their parents, individuals with diverse physical and mental disabilities and seniors. A critical role of Medicaid is to finance services for people with very high medical costs who often have both acute care and long-term service needs, making it a vital safety net program for those unable to obtain health insurance in the private market or for whom such insurance is inadequate. How health care reform ultimately defines the content of what health insurance must cover will affect everyone, but it will matter most to people at times when their health care needs are greatest. This issue brief examines the health care needs of

three individuals with extensive acute medical care and long-term service needs – a seven year old born prematurely, a 50 year old male with a spinal cord injury and a 45 year old woman with cerebral palsy. It compares their estimated medical expenses to a benchmark private health insurance plan – the Blue Cross Blue Shield Standard Option (BCBSSO) plan offered through the Federal Employees Health Benefits Program (FEHBP.) The BCBSSO plan is the most popular FEHBP option and is often cited an example of generous job-based coverage. This analysis also considers what coverage these individuals have received under Medicaid to meet their medical and long-term care needs.”]

Full text at: <http://www.kff.org/healthreform/upload/7967.pdf>

A Primary Prevention Framework for Substance Abuse and Mental Health. By the San Mateo County Health System: Behavioral Health and Recovery Services. (The Prevention Institute, Oakland, California) March 2009. 20 p.

[“San Mateo County Health System Behavioral Health & Recovery Services (BHRS) is dedicated to promoting wellness, resilience, and recovery so that all San Mateo County residents can live fully as contributing and successful individuals and members of their families and communities. As part of this commitment, BHRS is dedicated not only to treating and serving those in need, but also to reducing the number of people who may need services in the first place. For decades, funding and services have been primarily focused on the treatment end of the continuum. Although part of the original community mental health movement, prevention has been largely absent within the mental health system for several decades. Within the alcohol and other drug services system, prevention has focused primarily on programs aimed at individual behavior change and early intervention. More recent developments—the *RoadMap for Alcohol, Tobacco and Other Drug Prevention: A Guide to Community Action*, the implementation of the alcohol and other drug services strategic plan, and funding through the Mental Health Services Act—have provided an opportunity to examine the underlying factors leading to addiction and mental health-related problems, and to consider evidence-based and promising prevention strategies to reduce the number of people in need of more intensive and long term BHRS services. The purpose of this document is to describe this new prevention approach and provide a broad framework for promoting behavioral health and community well-being.

This approach requires a new way of doing business by expanding prevention efforts to focus on organizational practices and policy change, reaching out to new partners, and taking a comprehensive approach to understanding and addressing the underlying determinants of behavioral health— those elements that influence rates of particular mental health conditions and addiction. Prevention, along with early intervention and treatment, are critical components of the BHRS continuum of care and support. As treatment has focused on the integration of services for individuals with co-occurring mental health and alcohol and other drug disorders for the past three years, this framework creates a similar path for BHRS prevention.”]

Full text at:

http://www.preventioninstitute.org/documents/SMBHRS_MainDoc_050909_000.pdf

SUICIDE PREVENTION

“Spirituality, Religion and Suicidal Behavior in a Nationally Representative Sample.” By D.T. Rasic, Dalhousie University, Canada, and others. IN: Journal of Affective Disorders, vol. 114, no. 1-3 (April 2009) pp. 32-40.

[“A large national survey in Canada found that people who participated in religious services or considered themselves at least somewhat spiritual had decreased risk for both suicidal ideation and attempts. Those who participated in religious services or considered themselves at least somewhat spiritual had decreased risk for both suicidal ideation and attempts, according to a large national survey in Canada. A survey of a nationally representative sample (n = 36,984) of individuals aged 15 and older from the 10 Canadian provinces was conducted by telephone or in person to study the relationship between self-assessed spirituality, attendance at religious services, and suicidal behaviors (ideation and attempts) in the general population and in individuals with certain mental disorders (major depression, mania, panic disorder, social phobia, agoraphobia without panic, alcohol dependence, and drug dependence). Levels of social support were also assessed. Interaction effects were examined for any mental disorder, major depression, any anxiety disorder, and any substance dependence. “Identifying oneself as being at least somewhat spiritual was significantly associated with decreased odds of a past year suicide attempt (odds ratio [OR] = 0.57, 95% CI: 0.39–0.81) in the general population but not suicidal ideation,” the study’s authors reported. This association was not significant after adjustment for the effects of social supports, however. “Attending religious services at least once per year was significantly associated with decreased odds of past year suicidal ideation (OR = 0.61, 95% CI: 0.50–0.73) and decreased odds of a past year suicide attempt (OR = 0.53, 95% CI: 0.37–0.77),” wrote the authors. The association with suicidal ideation was slightly reduced after correcting for social supports (OR = 0.68, 95% CI: 0.45–1.03), but remained significant for suicide attempts (OR = 0.38, 95% CI: 0.17–0.89). There were no significant differences in the relationships between spirituality, religion and suicidal behaviors for those in the general population compared to community-dwelling individuals with a mental disorder in the previous 12 months. Community religious and spiritual organizations play significant roles in suicide risk reduction that includes, but also goes beyond their ability to provide social supports to individuals, and therefore should be key players in suicide prevention campaigns.”]

NOTE: Please contact the California State Library for a paper or electronic copy of this article.

Suicidal Thoughts and Behaviors among Adults. By Substance Abuse and Mental Health Services Administration. The NSDUH (National Survey on Drug Use and Health) Report. (The Administration, Rockville, Maryland) September 17, 2009. 4 p.

[“Nearly 8.3 million adults (age 18 and older) in the U.S. (3.7 percent) had serious thoughts of committing suicide in the past year according to the first national scientific survey of its size on this public health problem. The study by the Substance Abuse and Mental Health Services Administration (SAMHSA) also shows that 2.3 million adult

Americans made a suicide plan in the past year and that 1.1 million adults - 0.5 percent of all adult Americans – had actually attempted suicide in the past year.

The study provides important insights into the nature and scope of suicidal thoughts and behaviors. For example, the risk of suicidal thoughts, planning and attempts varies significantly among age groups. Young adults aged 18 to 25 were far more likely to have seriously considered suicide in the past year than those aged 26 to 49 (6.7 percent versus 3.9 percent), and nearly three times more likely than those aged 50 or older (2.3 percent). These disparities in risk levels among younger and older adults also were found in suicide planning and suicide attempts.

Substance use disorders also were associated with an increase in the risk of seriously considering, planning or attempting suicide. People experiencing substance abuse disorders within the past year were more than three times as likely to have seriously considered committing suicide as those who had not experienced a substance abuse disorder (11.0 percent versus 3.0 percent). Those with past year substance abuse disorders were also 4 times more likely to have planned a suicide than those without substance abuse disorders (3.4 percent versus 0.8 percent), and nearly seven times more likely to have attempted suicide (2.0 percent versus 0.3 percent).

The study also revealed that adult females had marginally higher levels of suicidal thoughts and behaviors than males in the past year.

‘This study offers a far greater understanding of just how pervasive the risk of suicide is in our nation and how many of us are potentially affected by it,’ said SAMHSA Acting Administrator, Eric Broderick, D.D.S., M.P.H. ‘While there are places that people in crisis can turn to for help like the National Suicide Prevention Lifeline 1-800-273-TALK, the magnitude of the public health crisis revealed by this study should motivate us as a nation to do everything possible to reach out and help the millions who are at risk — preferably well before they are in immediate danger.’

The study notes that only 62.3 percent of adults who had attempted suicide in the past year received medical attention for their suicide attempts. It also notes that 46.0 percent of those attempting suicide stayed in a hospital overnight or longer for treatment of their suicide attempts.” SAMHSA News Release (September 17, 2009.)]

Full text at: <http://oas.samhsa.gov/2k9/165/SuicideHTML.pdf>

“Suicide and Alcohol: Do Outlets Play a Role?” By Fred W. Johnson, Paul J. Gruenewald, and Lillian G. Remer, Prevention Research Center, Berkeley, California. IN: Alcoholism: Clinical and Experimental Research, vol. 33, no. 12 (December 2009) 10 p.

[“Suicide rates in rural communities are linked to the number of pubs and bars in the area, according to new research.

And shutting bars may be one way to bring suicide rates down, according to the researchers.

Research suggests that both attempted and completed suicides are more likely in rural areas with larger numbers of alcohol outlets per head.

Alcohol and suicide were already strongly linked, with more than 20 per cent of suicides in the US linked to alcohol dependence. However, this is believed to be the first research linking bar density to suicide rates.

The study looked at 581 zip (postal) code areas in California between 1995 and 2000. They looked at regional demographics such as age and ethnic makeup, the number of alcohol outlets in the area, and the number of completed suicides and hospitalizations for suicide attempts.

The results showed that suicide rates, as well as being higher in low income areas and areas with a large proportion of older, lower-income white people, went up in communities with more bars per person.

Fred W Johnson, one of the authors of the study, said: 'This study suggests... that one way to reduce suicides and other problems related to alcohol outlets is to reduce the number of outlets, particularly bars.'

However, he warned that the figures should be treated with caution. 'When using aggregate data in a study like ours, one must take great care interpreting the results. Although one cannot make the strong statement that more bars cause more suicides, our findings are at least consistent with what we would expect if patronizing bars or other alcohol outlets were in fact causally related to suicide.'" Telegraph.co.uk (September 21, 2009)] **NOTE: Please contact the California State Library for an electronic copy of this article.**

CONFERENCES, MEETINGS AND WEBCASTS

Reducing Mental Health Stigma: Real Warriors, Real Battles, Real Strength. By Brigadier General Loree K. Sutton, M.D, Department of Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. September 14, 2009. Continuing Education & Training Webinar: *Available online for 30 days.*

The goal of this webinar is to increase awareness and educate professionals about current mental health challenges faced by U.S. Military service members and their families, identify sources of mental health stigma as well as program and activities undertaken by U.S. Military to reduce stigma attached to mental health and mental health care.

For more information: <http://www.taps.org/training.aspx?id=3184>

National Conference of State Legislatures: *Mental Health in Schools: Two Part Webinar Series*

Part I: Mental Health in Higher Education Webinar

June 5, 2009

[ARCHIVED RECORDING AVAILABLE!](#)

Part II: Mental Health in K-12 Schools Webinar

June 12, 2009

[ARCHIVED RECORDING AVAILABLE!](#)

For more information: <http://www.ncsl.org/default.aspx?tabid=17491>

Division for Early Childhood: *25th Annual International Conference on Young Children with Special Needs and their Families.*

Albuquerque, New Mexico
October 15-18, 2009

For more information and registration: http://www.dec-spced.org/Conference?utm_source=TACSEI+%26+CSEFEL+Updates&utm_campaign=9226f0b606-TACSEI+and+CSEFEL+Updates_9.2009&utm_medium=email

BIAD's (Brain Injury Association of Delaware) 2009 Brain Injury Conference:
ABCs of Brain Injury.

Newark, Delaware
October 21, 2009

For more information:

http://www.biausa.org/Delaware/docs/2009_conference_full_brochure.pdf

For registration: <https://www.signup82north.com/beventLive.aspx>