

**Subject:** Studies in the News: (December 16, 2009)

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## Studies in the News for



## California Department of Mental Health

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## CHILDREN AND ADOLESCENTS

**“Children on the Home front: The Experience of Children from Military Families.”**  
By Anita Chandra and others, RAND Corporation, Arlington, Virginia. IN:  
**Pediatrics, Official Journal of the American Academy of Pediatrics. vol. 125, no. 1**  
**(January 2010) pp. 13-22.**

[**“OBJECTIVE:** Although studies have begun to explore the impact of the current wars on child well-being, none have examined how children are doing across social, emotional, and academic domains. In this study, we describe the health and well-being of children from military families from the perspectives of the child and nondeployed parent. We also assessed the experience of deployment for children and how it varies according to deployment length and military service component.

**PARTICIPANTS AND METHODS.** Data from a computer-assisted telephone interview with military children, aged 11 to 17 years, and nondeployed caregivers ( $n = 1507$ ) were used to assess child well-being and difficulties with deployment. Multivariate regression analyses assessed the association between family characteristics, deployment histories, and child outcomes.

**RESULTS:** After controlling for family and service-member characteristics, children in this study had more emotional difficulties compared with national samples. Older youth and girls of all ages reported significantly more school-, family-, and peer-related difficulties with parental deployment ( $P < .01$ ). Length of parental deployment and poorer nondeployed caregiver mental health were significantly associated with a greater number of challenges for children both during deployment and deployed-parent reintegration ( $P < .01$ ). Family characteristics (e.g., living in rented housing) were also associated with difficulties with deployment.

**CONCLUSIONS:** Families that experienced more total months of parental deployment may benefit from targeted support to deal with stressors that emerge over time. Also, families in which caregivers experience poorer mental health may benefit from programs that support the caregiver and child.”]

Full text at:

<http://pediatrics.aappublications.org/cgi/reprint/peds.2009-1180v1>

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**Kid Share: An Analysis of Federal Expenditures on Children through 2008. By Julia B. Isaacs, the Brookings Institute, and others. (The Institute, Washington, D.C.) Fall, 2009. 40 p.**

[“Less than one-tenth of the federal budget was spent on children in 2008, \$295 billion out of a total of \$2,983 billion in outlays. Well over a third of the federal budget (38 percent) was allocated to the elderly and disabled for the non-child portions of Social Security,

Medicare and Medicaid. The children's share of the tax expenditure budget was also less than 10 percent.

This third annual Kids' Share report examines expenditures on children during a time federal budgets are undergoing much change. Our estimate of how much of the federal budget was directed toward children in 2008 is based on detailed budget data released in May 2009 and captures the effects of early responses to the recession. The effects of the American Recovery and Reinvestment Act of 2009 do not appear in the 2008 expenditures but do figure prominently in the expenditure projections included in the final section of the report.

After an initial section explaining the methodology involved in estimating children's expenditures across more than 100 federal programs and tax provisions, the report presents findings in four areas: expenditures in 2008, historic trends across the budget, historic trends within children's expenditures, and projections through 2019.”]

Full text at:

[http://www.brookings.edu/~media/Files/rc/reports/2009/1209\\_kids\\_share\\_isaacs/1209\\_kids\\_share\\_isaacs.pdf](http://www.brookings.edu/~media/Files/rc/reports/2009/1209_kids_share_isaacs/1209_kids_share_isaacs.pdf)

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**“Long-term Benefits of Short-term Quality Improvement Interventions for Depressed Youths in Primary Care.” By Joan Rosenbaum Asarnow and others. IN: American Journal of Psychiatry, vol. 166, no. 9 (September 2009) pp. 1002-1010.**

[“Quality improvement programs for depressed youths in primary care settings have been shown to improve 6-month clinical outcomes, but longer-term outcomes are unknown. In this study the authors examine 6-, 12-, and 18-month outcomes of a primary care quality improvement intervention. Findings show that the quality improvement intervention, relative to enhanced treatment as usual, lowered the likelihood of severe depression at 6 months. A similar trend at 18 months was not statistically significant. Path analyses revealed a significant indirect intervention effect on long-term depression due to the initial intervention improvement at 6 months. The authors conclude that the main effect of the intervention on outcomes was to decrease the likelihood of severe depression at the 6-month outcome assessment. These early intervention-related improvements conferred additional long-term protection through a favorable shift in illness course through 12 and 18 months.” RAND Child Policy Update (October 2009)] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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**“The Relation between Change in Symptoms and Functioning in Children with ADHD Receiving School-Based Mental Health Services.” By Julie Sarno Owens and others, Ohio University. IN: School Mental Health, vol. 1, no. 4 (December 2009) pp.183-195.**

[“This study examined the relation between reliable change in symptoms and reliable change in functioning in children with attention deficit hyperactivity disorder (ADHD; N = 64) who were enrolled in a school based mental health program that included a daily

report card intervention, teacher consultation, and behavioral parenting sessions. Parents and teachers completed the disruptive behavior disorders rating scale and the impairment rating scale at pre- and post-treatment. Group-level analyses indicated that symptom improvers demonstrated significant improvement in multiple domains of functioning, whereas symptom no-changers and deteriorators did not. However, individual-level analyses revealed that up to 40% (depending on the domain and the informant) of children achieved reliable symptom change without reliable improvement in functioning, and up to 16% achieved reliable change in functioning without reliable change in symptoms. The results have implications for measurement of treatment outcome.”]

Full text at:

<http://www.springerlink.com/content/w4065n44860158n3/fulltext.pdf>

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**“The Teenaged Brain: Part I.” By John J. Medina, University of Washington School of Medicine and Seattle Pacific University. IN: Psychiatric Times, vol. 26, no. 8 (July 27, 2009) 3 p. and**

**“The Teenaged Brain: Part II.” By John J. Medina, University of Washington School of Medicine and Seattle Pacific University. IN: Psychiatric Times, vol. 26, no. 9 (September 3, 2009) 2 p.**

[“This statistic is as familiar as it is startling. According to the [National Comorbidity Survey-Replication \(NCS-R\)](#), the peak age of onset for any disease involving mental health is 14 years. True for [bipolar disorder](#). True for [anxiety](#). True for [schizophrenia](#) and [substance abuse and eating disorders](#). The data suggest that most mental health challenges emerge during adolescence. If true, this brings to mind an important developmental question: What is up with adolescence?

The teenaged years are chock-full of byzantine, intricately timed, molecular processes that have to be closely choreographed and deployed in a specific sequence to accomplish their sexual mission. Do these extraordinarily complex developmental processes go awry in some children as they evolve through adolescence? Do these changes create, or at least contribute, to future mental disorders? Is this one way to get at what are sometimes called genetic ‘trapdoors’—DNA-based psychopathologies that do not show up until a certain developmental milestone is reached?

These are important issues. Most of the [mental health challenges that emerge during puberty](#) have real staying power. The symptoms tend to be more severe. Many go undetected in the early formative stages of the illness and comorbid disorders often develop. These complications can create problems in determining the correct diagnosis, and make it difficult for the clinician to select the [treatment strategies](#) with the greatest probability of success.

Researchers face similar daunting challenges in attempting to understand the cellular and molecular basis for such disorders. Fortunately, fairly recent findings have provided a ray of hope—potential illumination for both clinician and scientist. From gene to cell, we are beginning to learn more and more about the neurobiological maturation of the brain transiting through adolescence. The question is: Does any of this knowledge help us understand the NCS-R data?

In this column and the next, we will explore the developmental biology of the so-called teenaged brain, focusing first on cellular studies, then on behavioral ones. In this first installment, we will address specific aspects of the brain's developmental trajectory. We'll look initially at structural changes and then focus on the notion of the canonical 'teenage brain' behaviors.

In the second installment, we will discuss how changes in these developmental processes may contribute to the emergence of mental disorders.”]

Full text of Part I:

<http://www.psychiatrictimes.com/display/article/10168/1430615?pageNumber=1>

Full text of Part II:

<http://www.psychiatrictimes.com/display/article/10168/1444214?pageNumber=1>

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## DISPARITIES

**Improving Care for Individuals with Limited English Proficiency: Facilitators and Barriers in Providing Language Services in California Public Hospitals. By Romana Hasnain, Northwestern University, and others. (The California Endowment, Los Angeles, California) October 2009. 30 p.**

[“Evidence shows that effective communication between patients, clinicians, and other health care professionals is a critical component of providing high quality care. Providing individuals with limited English proficiency (LEP) the means to communicate effectively with their health care providers is critical to improving their experience in the health care setting, the quality of care they receive, and their health outcomes. (“LEP” is the acronym for both “limited English proficiency” and “limited English proficient.”)The U.S. Census Bureau’s operational definition of LEP is a patient’s self-assessed ability to speak English less than “very well.”)Yet, health care providers throughout the country have reported challenges, such as inadequate funding of language services, to be major barriers in providing LEP patients with high-quality care.

Our objective was to better understand the impact of the efforts undertaken by California public hospitals to improve language access to all Californians, and ultimately to identify strategies that engage hospitals in facilitating organizational change to address the provision of language services. According to the 2000 Census, 12.4 million people in California speak a primary language other than English at home, with 6.2 million being identified as LEP. These numbers resonate with health care providers and clinicians, as several studies have found that patients who cannot speak English well receive less than optimal health care.”]

Full text at:

[http://www.calendow.org/uploadedFiles/Publications/By\\_Topic/Culturally\\_Compent\\_Health\\_Systems/Language\\_Access/CalifPublichosp-LanguageServicesReport.pdf](http://www.calendow.org/uploadedFiles/Publications/By_Topic/Culturally_Compent_Health_Systems/Language_Access/CalifPublichosp-LanguageServicesReport.pdf)

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## FIRST EPISODE PSYCHOSIS

**“Multifamily Psychoeducation for First-Episode Psychosis: A Cost-Effectiveness Analysis.”** By Nicholas J.K. Breitborde, PhD, University of Arizona and others. **IN: Psychiatric Services, vol. 60, no. 11 (November 2009) pp. 1477-1488.**

**OBJECTIVE:** Family psychoeducation is considered part of optimal treatment for first-episode psychosis, but concerns about the cost of this intervention have limited its availability. Although evidence suggests that family psychoeducation is cost-effective, many cost-effectiveness analyses have suffered from limitations that reduce their utility in guiding decisions to incorporate this intervention within existing clinical services. These include not presenting results in present-day dollars and not examining whether the intervention would remain cost-effective in situations where the clinical benefits achieved were smaller than those reported in past studies. Thus the goal of this study was to investigate the cost of providing a specific psychoeducation program—multifamily group psychoeducation—to individuals with first-episode psychosis and their families.

**METHODS:** Statistical simulation was used to estimate the cost and burden of illness associated with usual treatment versus usual treatment plus multifamily group psychoeducation. In addition, the simulation model was rerun to test whether multifamily psychoeducation would remain cost-effective in situations where the clinical benefits achieved were smaller than those reported in past studies. **RESULTS:** When provided for two years, multifamily group psychoeducation ranged from a cost-effective to a cost-saving intervention, depending on the clinical benefits achieved by staff delivering the intervention. When provided for longer durations (five, ten, or 20 years), multifamily psychoeducation was a cost-saving intervention even in scenarios where the clinical benefits of the intervention were reduced by 90%. **CONCLUSIONS:** The results suggest that multifamily group psychoeducation may not only be a cost-effective intervention for first-episode psychosis but may often be a cost-saving intervention. **Please contact the California State Library or your local library for a hard copy of this article.**

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## HEALTH CARE REFORM

**Senate Health Care Reform Bill: The Patient Protection and Affordable Care Act—Assessing the Impact for People with Mental Illness.** By the Bazelon Center for Mental Health Law. (The Center, Washington, D.C.) December 3, 2009. 17 p.

[NOTE: UPDATED INFORMATION AS OF 12-03-09. “On November 18, 2009, Senate Democratic leaders unveiled the Patient Protection and Affordable Care Act (H.R. 3590); a bill to reform America’s health care system. Earlier bills passed by the Senate Health, Education, Labor and Pensions Committee and Senate Finance Committee were merged to create a single bill that fulfills the goals of expanding access to quality, affordable health care, reducing health care costs, improving the quality of care and emphasizing prevention.

On November 18th, the Congressional Budget Office released estimates indicating that H.R. 3590 would extend insurance coverage to 31 million Americans who are currently uninsured and reduce the federal budget deficit by \$130 billion within the first 10 years after implementation. On November 21, the full Senate overcame a threatened filibuster and voted 60-39 to consider the bill — a process expected to last some weeks.

### ***Overview***

The bill includes the following reforms:

- Insurance reforms that end discriminatory practices too often experienced by individuals with mental illnesses, such as elimination of: lifetime or annual dollar limits, exclusions for preexisting conditions and rates based on health status, gender or occupation;
- State Health Insurance Exchanges that would serve as a marketplace to assist uninsured individuals and small employers in purchasing private health plans;
- Standardized benefit packages among the plans offered through the Exchanges that would make it easier to compare and select coverage based on cost and quality information;
- A minimum benefit package that includes mental health and addiction services;
- Tax credits and cost-sharing reductions to assist low-income households with the cost of purchasing insurance;
- Out-of-pocket spending limits, restricting the amount an individual is required to contribute towards the cost of care, which would help ease the burden on people who have frequent needs for health care services, drugs and supplies;
- A requirement that individuals obtain coverage or pay a penalty; and
- Expansion of Medicaid to children and pregnant women with incomes at or below 133 percent of the federal poverty level and limited Medicaid coverage to childless adults with incomes at or below 133 percent of poverty.”]

Full text at:

<http://www.bazelon.org/issues/healthreform/SenateBillSummary12-3-09.pdf>

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**Will Health Care Reform Help People with Mental Illness? An analysis of the three proposals under consideration in Congress in November 2009 and how their provisions would affect adults with psychiatric disabilities. By Chris Koyanagi, Policy Director of the Bazelon Center for Mental Health Law. (The Center, Washington, D.C.) November 2009. 19 p.**

["It's important for people with serious mental illnesses, including those who rely on the public mental health system for services, to know how health care reform proposals could affect them. After health reform, will they have better access to the services and supports they need to recover?

Community integration and recovery for people with psychiatric disabilities, while unique for each individual, require that a set of basic needs be met. A safe, secure place to live, enough income for life's necessities, recreational opportunities, social contact and

a sense of purpose are all part of recovery. High on the list, and affecting most of the other areas, is good health.

Legislation currently moving through Congress addresses both the lack of access to health care and the quality of the care that is provided in both public and private health systems. Pending bills could significantly affect people with psychiatric disabilities and their ability to integrate fully into their communities. However, these bills do not directly address the current failings of the public mental health system.

This paper examines the health reform bills moving through Congress and their impact on opportunities for community integration for people with psychiatric disabilities. The bills are:

The House bill, Affordable Health Care for America Act (H.R. 3962);

The Senate Finance Committee bill, America's Healthy Future Act, S. 1796;  
and

The Senate Labor, Health, Education and Pensions (HELP) Committee bill,  
The Affordable Health Choices Act, S. 1679.”]

Full text at:

<http://www.bazelon.org/issues/healthreform/WillReformHelp.pdf>

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## MEDICAID AND MEDICARE

**“Part D and Dually Eligible Patients with Mental Illness: Medication Access Problems and Use of Intensive Services.” By Haiden A. Huskamp, Ph.D. Harvard Medical School and others. IN: Psychiatric Services, vol. 60, no. 9 (September 2009) pp. 1169-1181.**

[“This study examined the occurrence of medication access problems and use of intensive mental health services after the transition in January 2006 from Medicaid drug coverage to Medicare Part D for persons dually eligible for Medicaid and Medicare benefits.... Many dually eligible patients had difficulty accessing psychiatric medications after implementation of Part D. These patients were significantly more likely to visit psychiatric emergency departments than patients who did not experience difficulties. These findings raise concerns about possible negative effects on quality of care. Additional study is needed to understand the full effects of Part D on outcomes and functioning as well as treatment costs for this population.”] **Please contact the California State Library or your local library for a hard copy of this article.**

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**“Recent Changes in Medicaid Policy and their Possible Effects on Mental Health Services.” By Jeffrey A. Buck, Ph.D., Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. IN: Psychiatric Services, vol. 60, no. 11, (November 2009) pp. 1504-1509.**

[“As Medicaid has emerged as the primary funder of public mental health services, its character has affected the organization and delivery of such services. Recent changes to the program, however, promise to further affect the direction of changes in states' mental

health service systems. One group of changes will further limit the flexibility of Medicaid mental health funding, while increasing provider accountability and the authority of state Medicaid agencies. Others will increase incentives for deinstitutionalization and community-based care and promote person-centered treatment principles. These changes will likely affect state mental health systems, mental health providers, and the nature of service delivery.”] **Please contact the California State Library or your local library for a hard copy of this article.** [\[Back to Top\]](#)

## MINORITIES

**“Enhancing Academic Achievement in a Hispanic Immigrant Community: The Role in Academic Failure and Mental Health.”** By Elaine Clanton Harpine, Kent State University, and Thomas Reid, University of South Carolina. IN: *School Mental Health*, vol. 1, no. 4 (December 2009) pp. 159-170.

[“This field project examines Camp Sharigan, a group-centered approach to reducing academic failure. This study examines the program’s benefit to children of Mexican descent from an inner-city immigrant neighborhood. The treatment group improved significantly more than the control group in all the three areas tested: spelling, reading, and sight words. Follow-up testing one year later indicated that the Camp Sharigan students continued to perform better in spelling and sight words. The findings indicate that the Camp Sharigan intervention may be more effective than one-to-one tutoring or classroom-style interventions.”]

Full text at:

<http://www.springerlink.com/content/y52831q56153m251/fulltext.pdf>

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**“Improving the Mental Health, Healthy Lifestyle Choices, and Physical Health of Hispanic Adolescents: A Randomized Controlled Pilot Study.”** By Bernadette M. Melnyk and others, Arizona State University. IN: *Journal of School Health*, vol. 79, no.12 (December 2009) pp. 575-584.

[“Obesity and *mental health* disorders are 2 major public *health* problems in American adolescents, with prevalence even higher in Hispanic teens. Despite the rapidly increasing incidence and adverse *health* outcomes associated with overweight and *mental health* problems, very few intervention studies have been conducted with adolescents to improve both their healthy lifestyles and *mental health* outcomes. Even fewer studies have been conducted with Hispanic youth. The purpose of this study was to evaluate the preliminary efficacy of the COPE (Creating Opportunities for Personal Empowerment) Healthy Lifestyles TEEN (Thinking, Emotions, Exercise, and Nutrition) program, a manualized educational and cognitive behavioral skills-building program, on Hispanic adolescents' healthy lifestyle choices as well as *mental* and physical *health* outcomes. METHODS: A cluster randomized controlled pilot study was conducted with 19 Hispanic adolescents enrolled in 2 *health* classes in a southwestern high school. One class received COPE and the other received an attention control program. RESULTS:

Adolescents in the COPE program increased their healthy lifestyle choices and reported a decrease in depressive and anxiety symptoms from baseline to post intervention follow-up. A subset of 7 overweight adolescents in the COPE program had a decrease in triglycerides and an increase in high-density lipoproteins. In addition, these overweight adolescents reported increases in healthy lifestyle beliefs and nutrition knowledge along with a decrease in depressive symptoms. **CONCLUSION:** The COPE TEEN program is a promising school-based strategy for improving both physical and *mental health* outcomes in adolescents.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45109605&site=ehost-live>

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## **POLICY DEVELOPMENT**

**“Mental Health Policy Development in the States: The Piecemeal Nature of Transformational Change.”** By Rachel L. Garfield, Ph.D., M.H.S., University of Pittsburgh. IN: *Psychiatric Services*, vol. 60, no. 10 (October 2009) pp. 1329-1335).

[“Transformation-systemic, sweeping changes to promote recovery and consumerism-is a pervasive theme in discussions of U.S. mental health policy. State systems are a fundamental component of national transformation plans. However, it is not clear how the vision of transformation will be balanced against the idiosyncratic political forces that traditionally characterize state policy making. This article examines the development of state mental health policy to assess whether and how it reflects the broader context of transformation versus political forces....

States’ mental health policies are largely guided by the problems and resources of the states: sometimes these forces dovetail with nationwide transformation goals and processes, and sometimes they are idiosyncratic to a particular state. Thus, although states can play an integral role in forwarding transformation, their own mental health policy agendas are not eclipsed by this nationwide movement.”] **Please contact the California State Library or your local library for a hard copy of this article.**

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## **PRIVATE HEALTH INSURANCE**

**“Does Private Insurance Adequately Protect Families of Children with Mental Health Disorders?”** By Susan H. Busch, PhD and Colleen L. Barry, PhD, Yale School of Medicine. IN: *Pediatrics*, vol. 124, Supplement no. 4 (December 2009) pp. S399-S406.

[“**OBJECTIVE:** Although private insurance typically covers many health care costs, the challenges faced by families who care for a sick child are substantial. These challenges may be more severe for children with special health care needs (CSHCN) with mental

illnesses than for other CSHCN. Our objective was to determine if families of privately insured children who need mental health care face different burdens than other families in caring for their children.

**PATIENTS AND METHODS:** We used the 2005–2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) to study privately insured children aged 6 to 17 years. We compared CSHCN with mental health care needs ( $N = 4918$ ) to 3 groups: children with no special health care needs ( $n = 2346$ ); CSHCN with no mental health care needs ( $n = 16250$ ); and CSHCN with no mental health care need but a need for other specialty services ( $n = 7902$ ). The latter group was a subset of CSHCN with no mental health care need. We used weighted logistic regression and study outcomes across 4 domains: financial burden; health plan experiences; labor-market and time effects; and parent experience with services.

**RESULTS:** We found that families of children with mental health care needs face significantly greater financial barriers, have more negative health plan experiences, and are more likely to reduce their labor market participation to care for their child than other families.

**CONCLUSIONS:** Families of privately insured CSHCN who need mental health care face a higher burden than other families in caring for their children. Policies are needed to help these families obtain affordable, high-quality care for their children.”]

Full text available at:

[http://pediatrics.aappublications.org/cgi/reprint/124/Supplement\\_4/S399](http://pediatrics.aappublications.org/cgi/reprint/124/Supplement_4/S399)

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## SUICIDE PREVENTION

**“A Call for Research: The Need to Better Understand the Impact of Support Groups for Suicide Survivors.”** By Julie Cerel, University of Kentucky, and others. **IN: Suicide & Life Threatening Behavior, vol. 39, no. 3 (June 2009) pp. 269-281.**

[“Support groups for suicide survivors (those individuals bereaved following a suicide) are widely used, but little research evidence is available to determine their efficacy. This paper outlines the pressing public health need to conduct research and determine effective ways to identify and meet the needs of suicide survivors, particularly through survivor support groups. After describing the various approaches to survivor support groups, we explain the need for further research, despite the inherent challenges. Finally, we pose several questions for researchers to consider as they work with survivors to develop a research agenda that sheds more light on the experiences of survivors and the help provided by survivor support groups.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=44122892&site=ehost-live>

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**“Public Awareness Campaigns about Depression and Suicide: A Review. By Helene Dumesnil, M.S. Institut National de la Sante et de la Recherche Medicale, and Pierre Verger, M.D., M.S., Observatoire Regional de la Sante. IN: Psychiatric Services, vol. 60, no. 9 (September 2009) pp. 1203-1213.**

[“*OBJECTIVE*: Numerous institutions, including the World Health Organization, recommend education campaigns targeted at the general public to improve awareness of suicidal crises and, more broadly, of depression; to improve access to care; and to combat the stigma associated with these illnesses and discrimination against people who have them. The purpose of this literature review was to gather information on campaigns about depression or suicide awareness and summarize data on the impact and effectiveness of these campaigns. *METHODS*: A search was conducted of MEDLINE, the Cochrane Library, PsycINFO, HDA (Health Development Agency) Evidence Base, DARE (Database of Abstracts of Reviews of Effects), and the ISI Web of Science to identify articles written in English and published between 1987 and 2007 that described depression or suicide awareness programs that targeted the public. *RESULTS*: Among the 200 publications for which references were found, 43 publications that described 15 programs in eight countries met inclusion criteria. Comparing the programs was difficult because of the diversity of their objectives and the methods used to deliver the programs and to evaluate them. Results suggest that these programs contributed to a modest improvement in public knowledge of and attitudes toward depression or suicide, but most program evaluations did not assess the durability of the attitude changes. No study has clearly demonstrated that such campaigns help to increase care seeking or to decrease suicidal behavior. *CONCLUSIONS*: Developing guidelines for assessment of public education campaigns to improve knowledge about suicide and depression is essential for the sharing of knowledge among scientists and stakeholders.”] **Please contact the California State Library or your local library for a hard copy of this article.**

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**Suicide Prevention Curriculum makes Federal Registry. Press Release. Office of Superintendent of Public Instruction, (State of Washington, November 20, 2009). 2 p.**

[“The numbers are grim. According to the most recent Washington State Healthy Youth Survey, almost 25 percent of eighth graders reported feeling depressed. Fourteen percent said they had seriously considered killing themselves. But now there is help and hope.

A curriculum developed by the Youth Suicide Prevention Program of Washington State, with funding from the Office of Superintendent of Public Instruction, gives middle-school students skills to help a friend in need.”]

Full text at:

<http://k12.wa.us/Communications/PressReleases2009/SuicidePrevention.aspx>

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## CONFERENCES, MEETINGS AND WEBINARS

### **Social Work Research Conference 2010**

January 14-17, 2010  
San Francisco, California

“The SSWR Annual Conference offers a scientific program that reflects a broad range of research interests, from workshops on the latest quantitative and qualitative research methodologies to symposia **featuring studies in child welfare, aging, mental health, welfare reform, substance abuse, and HIV/AIDS.**”

For more information and registration: <http://www.sswr.org/conferences.php>

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### **The Chadwick Center for Children and Families: 24<sup>th</sup> Annual San Diego International Conference on Child and Family Maltreatment**

January 25-29, 2009  
San Diego, California

For more information and registration: <http://www.chadwickcenter.org/conference.htm>

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### **Winter-Research Institute-Community-Based Participatory Research to Sustaining Healthy Families and Multicultural Communities. Presented by the Center for the Study and Prevention of Suicide.**

February 6-10, 2010  
San Jose, California

For more information and registration: <http://www.rochesterpreventsuicide.org/>

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### **Breaking the Silence: Empowering School Counselors & and Lesbian Gay Bi-Sexual Transgender Queer/Questioning & Intersex (LGBTQI) Youth.**

February 5-7, 2010  
San Diego, California

For more information and registration:  
<http://www.cescal.org/documents/SavetheDateLGBTQI-2.pdf>

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