

Subject: Studies in the News: (April 30, 2010)



Studies in the News for



California Department of Mental Health

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CHILDREN AND ADOLESCENTS

The Impact of the Social Environment on Children’s Mental Health in a Prosperous City : An Analysis with Data from the City of Munich. By Laura Perna, Institute of Health Economics and Health Care Management, Neuherberg, Germany, and others. IN: BMC Public Health, vol. 10, no. 199 (April 21, 2010) pp. 1-29.

[“Children with a low socioeconomic position are more affected by mental difficulties as compared to children with a higher socioeconomic position. This paper explores whether this socioeconomic pattern persists in the prosperous German city of Munich which features high quality of life and coverage of children mental health specialists that lies well above the national average and is among the highest in Europe....

Results

In Munich, the distribution of mental health difficulties among children follows the same socioeconomic pattern as described previously at the national level, but the overall prevalence is about 30% lower. Comparing different indicators of socioeconomic position, low parental education and household income are the strongest independent variables associated with mental difficulties among children (OR= 2.7; CI= 1.6 - 4.4 and OR= 2.8; CI= 1.4 - 5.6, respectively).

Conclusions

Socioeconomic differences in the prevalence of childhood mental difficulties are very stable. Even in a city such as Munich, which is characterized by high quality of life, high availability of mental health specialists, and low overall prevalence of these mental difficulties, they are about as pronounced as in Germany as a whole. It can be concluded that the effect of several characteristics of socioeconomic position 'overrules' the effect of a health promoting regional environment.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-10-199.pdf>

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**Related Article: “Children’s mental health as a primary care and concern.”
American Psychologist. (September 2005)**

Full text:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2745240/pdf/nihms143149.pdf/?tool=pmcentrez>

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Violence, Suffering, and Mental Health in Afghanistan: A School-Based Survey. By Catherine Panter-Brick, Durham University, UK, and others. IN: Lancet, vol. 374 (September 5, 2009) pp. 807-816.

[“We did a survey of young people (11–16 years old) in the country to assess mental health, traumatic experiences, and social functioning.

Methods—In 2006, we interviewed 1011 children, 1011 caregivers, and 358 teachers, who were randomly sampled in 25 government-operated schools within three purposively chosen areas (Kabul, Bamyan, and Mazar-e-Sharif municipalities). We assessed probable psychiatric disorder and social functioning in students with the Strength and Difficulties Questionnaire multi-informant (child, parent, and teacher) ratings. We also used the Depression Self-Rating Scale and an Impact of Events Scale. We assessed caregiver mental health with both international and culturally-specific screening instruments (Self-Reported Questionnaire and Afghan Symptom Checklist). We implemented a checklist of traumatic events to examine the exposure to, and nature of, traumatic experiences. We analyzed risk factors for mental health and reports of traumatic experiences.

Findings—Trauma exposure and caregiver mental health were predictive across all child outcomes. Probable psychiatric ratings were associated with female gender (odds ratio [OR] 2.47, 95% CI 1.65–3.68), five or more traumatic events (2.58, 1.36–4.90), caregiver mental health (1.11, 1.08–1.14), and residence areas (0.29, 0.17–0.51 for Bamyan and 0.37, 0.23–0.57 for Mazar-e-Sharif vs. Kabul).

The same variables predicted symptoms of depression. Two thirds of children reported traumatic experiences. Symptoms of post-traumatic stress were associated with five or more traumatic events (3.07, 1.78–5.30), caregiver mental health (1.06, 1.02–1.09), and child age (1.19, 1.04–1.36). Children's most distressing traumatic experiences included accidents, medical treatment, domestic and community violence, and war-related events.

Interpretation—Young Afghans experience violence that is persistent and not confined to acts of war. Our study emphasizes the value of school-based initiatives to address child mental health, and the importance of understanding trauma in the context of everyday forms of suffering, violence, and adversity.”]

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2748901/pdf/main.pdf/?tool=pmcentrez>

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Related Article: “Mental Health of Refugee Children: Comparative Study.” *British Medical Journal*. (July 2003)

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC165700/pdf/3270134.pdf/?tool=pmcentrez>

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BULLYING

“Bullying Victimization in Youths and Mental Health Problems: ‘Much Ado about Nothing’? By L. Arseneault and others, Institute of Psychiatry, Kings College London, UK. IN: Psychological Medicine, vol. 40, no. 5 (May 2010) pp. 717-729.

[“Bullying victimization is a topic of concern for youths, parents, school staff and mental health practitioners. Children and adolescents who are victimized by bullies show signs of distress and adjustment problems. However, it is not clear whether bullying is the source of these difficulties. This paper reviews empirical evidence to determine whether bullying victimization is a significant risk factor for psychopathology and should be the target of intervention and prevention strategies. Research indicates that being the victim of bullying (1) is not a random event and can be predicted by individual characteristics and family factors; (2) can be stable across ages; (3) is associated with severe symptoms of mental health problems, including self-harm, violent behavior and psychotic symptoms; (4) has long lasting effects that can persist until late adolescence; and (5) contributes independently to children’s mental health problems. This body of evidence suggests that efforts aimed at reducing bullying victimization in childhood and adolescence should be strongly supported. In addition, research on explanatory mechanisms involved in the development of mental health problems in bullied youths is needed.” **NOTE: If you would like an electronic copy of this article, please contact the CA State Library.**]

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EMPLOYMENT/MENTALLY ILL

Working It Out: Employment for People with a Mental Health Condition. By the Mental Health Network. Briefing No. 200. (The National Health System Confederation, London, United Kingdom) March 2010. 6 p.

[“The link between employment and positive mental health is an issue of great importance for the National Health System (NHS), both in terms of supporting service users to recover from mental health conditions and for improving staff productivity. Between 10 per cent and 16 per cent of people with a mental health condition, excluding depression, are in employment.¹ However, between 86 and 90 per cent of this group want to work.² Meaningful work is integral to recovery.

Employers who take steps to improve the management of mental health at work can help to improve staff productivity and save money. As the NHS enters a challenging period for future funding, reducing the costs of staff sickness absence and driving up productivity are critical. This *Briefing* outlines the key themes from recently launched government policies in this field and sets out actions for the NHS, as both an employer and service provider.”]

Full text at:

http://www.nhsconfed.org/Publications/Documents/Mental_health_briefing_200mar10.pdf

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HOMELESS

“Addressing the Needs of the Street Homeless: A Collaborative Approach.” By Vicky Stergiopoulos, St. Michael’s Hospital, Toronto, Canada, and others. IN: International Journal of Mental Health, vol. 39, no. 1 (Spring 2010) pp. 3-15.

[“This article describes a collaborative interagency multidisciplinary outreach team, designed to house individuals who are absolutely homeless (living outdoors), have not successfully responded to other programs, and who have either a severe and persistent mental illness, personality disorder, developmental challenge, or untreated medical needs. The collaborative care model was adapted for an urban Canadian setting from the U.S. Housing First model to meet the housing and treatment needs of chronically homeless persons and to address the unique characteristics and service needs of those living outdoors. Preliminary outcomes and implications for service delivery to this vulnerable group are discussed.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=49069481&site=ehost-live>

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JUVENILE JUSTICE

Youths Needs and Services: Findings from the Survey of Youth in Residential Placement. Juvenile Justice Bulletin. By Andrea S. Sedlak and Karla S. McPherson, Westat Research Services. Juvenile Justice Bulletin. Office of Juvenile Justice and Delinquency Prevention. (U.S. Department of Justice, Washington, D.C.) April 2010. 12 p.

[“In undertaking a thorough assessment of juvenile offenders in custody, it is not sufficient to examine their conditions of confinement or even the histories and characteristics of the offenders. It is also necessary to consider their needs and the services that address them. The Office of Juvenile Justice and Delinquency Prevention’s (OJJDP’s) Survey of Youth in Residential Placement (SYRP) is the first comprehensive national survey to gather information about youth in custody by surveying the detained offenders. This bulletin draws on SYRP’s findings to take a closer look at the needs of youth in residential placement and the services they receive. In the process, it reports on the psychological and sub-stance abuse problems experienced by youth in custody and the mental health and substance abuse counseling they receive to address them, as well as other medical needs and services.

The bulletin also describes the educational background of youth in residential placement and the schooling they receive while in confinement. The findings reported in this bulletin describe how youth's needs have been addressed and indicate areas in which services could be improved. SYRP found substantive needs in each of the areas it examined— mental health, substance abuse, health care, and education. It is OJJDP's hope that the information provided in these pages will contribute to strengthening policies and enhancing practices to better serve the needs of youth in residential placement.”]

Full text at:

<http://www.ncjrs.gov/pdffiles1/ojjdp/227728.pdf>

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POLICIES AND PROCEDURES

“CCBD’s Position Summary on the Use of Physical Restraint Procedures in School Settings.” By the Council for Children with Behavioral Disorders. IN: Behavioral Disorders, vol. 34, no. 4 (August 2009) pp. 223-234.

[“This document provides *policy* recommendations of the Council for Children with Behavioral Disorders regarding the use of physical restraint *procedures* in schools. It includes (a) an introduction, (b) a declaration of principles, and (c) recommendations regarding the use of physical restraint in school settings. Explanation or elaboration of specific recommendations is provided in italics. A similar and parallel document provides *policy* recommendations related to the use of seclusion *procedures* in school settings, which is often associated with the use of restraint *procedures*.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47336996&site=ehost-live>

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Implementing Evidence-Based Practice in Community Mental Health Agencies: A Multiple Stakeholder Analysis. By Gregory A. Aarons, University of California, San Diego, and others. IN: American Journal of Public Health, vol. 99, no. 11 (November 2009) pp.2087-2099.

["Objectives. We sought to identify factors believed to facilitate or hinder evidence-based practice (EBP) implementation in public *mental health* service systems as a step in developing theory to be tested in future studies. Methods. Focusing across levels of an entire large public sector *mental health* service system for youths, we engaged participants from 6 stakeholder groups: county officials, agency directors, program managers, clinical staff, administrative staff, and consumers. Results. Participants generated 105 unique statements identifying implementation barriers and facilitators. Participants rated each statement on importance and changeability (i.e., the degree to which each barrier or facilitator is considered changeable). Data analyses distilled

statements into 14 factors or dimensions. Descriptive analyses suggest that perceptions of importance and changeability varied across stakeholder groups. Conclusions. Implementation of EBP is a complex process. Cross-system-level approaches are needed to bring divergent and convergent perspectives to light. Examples include agency and program directors facilitating EBP implementation by supporting staff, actively sharing information with policymakers and administrators about EBP effectiveness and fit with clients' needs and preferences, and helping clinicians to present and deliver EBPs and address consumer concerns."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47508738&site=ehost-live>

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Related article: “We’re not short of people telling us what our problems are. We’re short of people telling us what to do: An appraisal of public policy and mental health.” *BMC Public Health*. (Sept. 2008).

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2561038/pdf/1471-2458-8-314.pdf/?tool=pmcentrez>

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“Monitoring a Correctional Mental Health Care System: The Role of the Mental Health Expert.” By Jeffrey L. Metzner, University of Colorado School of Medicine. *IN: Behavioral Sciences & the Law*, vol.27, no. 5 (September/October 2009) pp. 727-741.

[“Class action litigation has been instrumental in jail and prison reform over the past four decades. This article provides a very brief introduction underlying the legal basis for such litigation. It focuses on the role of the *mental health* expert in monitoring a correctional *mental health* care system as a result of class action litigation including issues related to selection of the expert, development of the remedial plan, and monitoring of the implementation of the remedial plan. The importance of *policies* and *procedures* and a quality improvement process is emphasized. Essential elements of the monitoring process, prior to and during the site assessment, are described. Inmates and correctional staff alike have benefited substantially from such litigation in the form of increased resources and positive changes in institutional culture.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=44435586&site=ehost-live>

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“A Systematic Review of the International Published Literature Relating to Quality of Institutional Care for People with Longer Term Mental Health Problems.” By

Tatiana L. Taylor, UCL Medical School, London, UK, and others. IN: BMC Psychiatry, vol. 9, no. 55 (September 2009) pp. 1-30.

["Background: A proportion of people with mental health problems require longer term care in a psychiatric or social care institution. However, there are no internationally agreed quality standards for institutional care and no method to assess common care standards across countries. We aimed to identify the key components of institutional care for people with longer term mental health problems and the effectiveness of these components.

Methods: We undertook a systematic review of the literature using comprehensive search terms in 11 electronic databases and identified 12,182 titles. We viewed 550 abstracts, reviewed 223 papers and included 110 of these. A "critical interpretative synthesis" of the evidence was used to identify domains of institutional care that are key to service users' recovery.

Results: We identified eight domains of institutional care that were key to service users' recovery: living conditions; interventions for schizophrenia; physical health; restraint and seclusion; staff training and support; therapeutic relationship; autonomy and service user involvement; and clinical governance. Evidence was strongest for specific interventions for the treatment of schizophrenia (family psychoeducation, cognitive behavioral therapy (CBT) and vocational rehabilitation).

Conclusion: Institutions should, ideally, be community based, operate a flexible regime, maintain a low density of residents and maximize residents' privacy. For service users with a diagnosis of schizophrenia, specific interventions (CBT, family interventions involving psychoeducation, and supported employment) should be provided through integrated programmes. Restraint and seclusion should be avoided wherever possible and staff should have adequate training in de-escalation techniques. Regular staff supervision should be provided and this should support service user involvement in decision making and positive therapeutic relationships between staff and service users. There should be clear lines of clinical governance that ensure adherence to evidence based guidelines and attention should be paid to service users' physical health through regular screening.""]

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2753585/pdf/1471-244X-9-55.pdf?tool=pmcentrez>

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VETERANS

Costs Soar for Compensating Veterans with Mental Disorders. By the Associated Press. Mercury News (April 17, 2010) p. 1-2.

["Corey Gibson, 29, sleeps fitfully, with an AR-15 semi-automatic rifle mounted above his bed."That's my sense of security," he says.

Laurie Emmer, a 47-year-old mother of four, shuns crowds and strangers.

And Eric Johnson, 62, who revisits Vietnam nearly every night in his head, patrols the streets of his South Side neighborhood with his dog.

The veterans come from different generations and different wars, yet they share a common and increasingly costly wartime affliction — post-traumatic stress disorder and other forms of psychological damage. Last year, mental illnesses accounted for 35 percent of the \$22 billion spent on disability payments to veterans who served in the Vietnam, Persian Gulf and "global war on terror" eras, according to a Chicago Tribune analysis.

Compensating veterans with psychological scars has helped fuel a 76 percent surge in service-related disability costs since 2003, the Tribune found, burdening an already overwhelmed system and underscoring the reality that the biggest costs of war are not often immediate or visible.

Studies suggest costs will continue to soar. The percentage of military evacuations from Iraq and Afghanistan that were attributed to mental disorders has increased sharply in the past four years, a recent Defense Department study shows. Another survey of about 100,000 Afghanistan and Iraq veterans found that 31 percent had been diagnosed with mental health or psychosocial problems.”]

Full text at:

http://www.mercurynews.com/news/ci_14907617?source=rss

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“Unreasonable Delay at the VA: Why Federal District Courts Should Intervene and Remedy Five-Year Delays in Veterans' Mental-Health Benefits Appeals.” By Jacob B. Natwick, University of Iowa College of Law. IN: Iowa Law Review, vol. 95, no. 2 (January 1, 2020) pp. 723-746.

[“As a result of modern warfare and the mental-health problems with which veterans return from Iraq and Afghanistan, a very serious problem has developed within the Department of Veterans Affairs ("VA"). An increasing number of veterans face Posttraumatic Stress Disorder and major depression and require benefits to assist them in seeking treatment. The Veterans Benefits Administration, however, has been unable to assist adequately veterans seeking benefits for these mental-health problems. On average, veterans who pursue an appeal of their benefits decision must wait five years before a decision is reached. This Note concludes that the five-year delay is unreasonable and the VA cannot remedy the problem. Therefore, federal district courts of general jurisdiction should intervene.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=49022121&site=ehost-live>

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“VA Mental Health Services Utilization in Iraq and Afghanistan Veterans in the First Year of Receiving New Mental Health Diagnoses.” By Karen H. Seal,

University of California, San Francisco, and others. IN: Journal of Traumatic Stress, vol. 23, no. 1 (February 2010) pp. 5-16.

[“Little is known about mental health services utilization among Iraq and Afghanistan veterans receiving care at Department of Veterans Affairs (VA) facilities. Of 49,425 veterans with newly diagnosed posttraumatic stress disorder (PTSD), only 9.5% attended 9 or more VA mental health sessions in 15 weeks or less in the first year of diagnosis. In addition, engagement in 9 or more VA treatment sessions for PTSD within 15 weeks varied by predisposing variables (age and gender), enabling variables (clinic of first mental health diagnosis and distance from VA facility), and need (type and complexity of mental health diagnoses). Thus, only a minority of Iraq and Afghanistan veterans with new PTSD diagnoses received a recommended number and intensity of VA mental health treatment sessions within the first year of diagnosis.”]

Full text at:

<http://www3.interscience.wiley.com/cgi-bin/fulltext/123278210/PDFSTART>

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Related Article: “Getting beyond “Don’t Ask, Don’t Tell”: An evaluation of US Veterans Administration post deployment mental health screening of veterans returning from Iraq and Afghanistan.” American Journal of Public Health. (April 2008).

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2377001/pdf/0980714.pdf/?tool=pmcentrez>

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Related Article: “Veterans Affairs Health System and Mental Health Treatment Retention among Patients with Serious Mental Illness: Evaluating Accessibility and Availability Barriers.” Health Research and Education Trust (June 2007)

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955257/pdf/hesr0042-1042.pdf/?tool=pmcentrez>

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ONLINE COURSES ON MENTAL HEALTH ISSUES

Information and registration:

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CONFERENCES, MEETINGS AND SEMINARS

Caring for Veterans with Post Deployment Health Concerns: Past, Present, and Future.

May 11, 2010-May 12, 2010
Orlando, Florida

For more information at:

<http://www.warrelatedillness.va.gov/provider/conferences/may-2010/conference-announcement-sec.pdf>

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UC Davis 28th Annual Occupational and Environmental Medicine Symposium

May 22, 2010
Sacramento, CA

For more information see:

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Mental Health America's Annual Conference

June 9-12, 2010
Washington, D.C.

For more information at:

<http://www.mentalhealthamerica.net/go/conference2010/schedule/>

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Western Conference on Behavioral Health and Addictive Disorders

June 17-19, 2010
Newport Beach, California

For more information:

<http://www.usjt.com/ca-training-addictive-disorders10/>

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Summer Institute of Neurodevelopmental Disorders.

August 6, 2010

Sacramento, CA

For more information:

http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/MND2011_SaveDate.pdf

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5th Annual UC Davis Conference Psychotic Disorders: Advanced Strategies for the Management of Psychosis: A State-of-the-Art Conference for Experienced Clinicians.

September 16, 2010

Sacramento, CA

For more information see:

http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/APSYC11_9-16-10.pdf

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