

Subject: Studies in the News: (June 15, 2008)



Studies in the News for



California Department of Mental Health

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ADULTS WITH MENTAL ILLNESS

“Unmet Needs of Families of Adults with Mental Illness and Preferences Regarding Family Services.” By Amy L. Drapalski, Maryland Healthcare System, and others. **IN: Psychiatric Services, vol. 59, no. 6 (June 2008) pp. 655-662.**

[“This study used a survey to assess the information and educational needs of family members of adults with mental illness and their preferences regarding how to address those needs. Recruitment was attempted through two sources: local mental health treatment facilities and the Maryland chapter of the National Alliance on Mental Illness (NAMI). Inadequate contact information and low response rate produced only 16 responses from family members of consumers recruited through local mental health facilities. Thus results are reported for a family needs assessment survey mailed to NAMI members (308 of 962 possible responses). Bivariate and multivariate analyses were used

to summarize relationships between characteristics of the family member, characteristics of the ill relative, experience of stigma by the family member, and information needs of the family members.

On average, family members reported a substantial number of unmet needs, often despite prior receipt of information. Family members' experiences of stigma and having an ill relative with a more recently occurring condition (for example, a younger relative or a shorter length of illness) or with a disabling condition (for example, recent hospitalization) were significantly associated with a greater number of unmet needs. Family members preferred that a mental health provider (63%) address their needs on an as-needed basis (58%).

The needs and preferences of family members of adults with mental illness are diverse and varied. Consequently, these families may benefit from ongoing provision of information and support tailored to meet the families' individual needs. Continued efforts should be made to understand and address consumer and family needs, potential barriers to participation in family services, and the relationship between stigma and family need." **NOTE: A copy of this article can be obtained, electronically, from the CA State Library.]**

Related article: Releasing Information to Families of Persons with Severe Mental Illness: A Survey of NAMI Members.

Full text at: <http://ps.psychiatryonline.org/cgi/reprint/51/8/1006>

CHILDREN AND ADOLESCENT MENTAL HEALTH

“Advancing Medical Education Training in Adolescent Health.” By Harriette B. Fox, Incenter Strategies, and others. IN: Pediatrics, vol. 121, no. 5 (May 2008) pp. 1043-1045.

[“Providing comprehensive care to adolescents is a multifaceted undertaking, requiring not only routine medical services but also health education, risk reduction, mental health, behavioral health, and sexual health services. Yet, this vital spectrum of care is unavailable to most adolescents. Not only is there a paucity of adolescent medical specialists, but many pediatricians-the providers increasingly likely to care for adolescents-report that they lack training and confidence in diagnosing and managing adolescents' psychosocial and reproductive problems.” **NOTE: A copy of this article can be obtained from the California State Library.]**

“Assessment Instruments for Measuring Young Children's Social-Emotional Behavioral Development.” By Tonia D. Caselman, University of Oklahoma, Tulsa, and Patricia A. Self, Oklahoma State University. IN: Children & Schools (Special Issue on Assessment Tools and Strategies) vol. 30, no. 2 (April 2008) pp. 103-115.

[“Early identification of social-emotional behavioral problems in infants and preschoolers is critical. Nine parent-report and caregiver/teacher-report instruments measuring preschool social-emotional behavioral problems and strengths are reviewed. Advantages to the use of parent-report and caregiver/teacher-report instruments are that they are easy to administer, are inexpensive, and can be used for repeated administration to monitor treatment effectiveness. Reviewed instruments varied in their assessment domains and psychometric properties. Practitioners and researchers must choose the instrument that fits their purposes and psychometric qualifications. In addition, special attention should be given to an instrument’s cultural sensitivity. Given the relatively low reliabilities and validities of most of the instruments, it is suggested that these measures be used as screening measures rather than as clinical tools and that they be used alongside other assessment methods. Multidimensional assessment is encouraged.” **NOTE: A copy of this article can be obtained from the CA State Library.**]

In Focus: Addressing the “New Morbidity” in Pediatrics through Developmental Screening. By Vida Foubister, the Commonwealth Fund. IN: Quality Matters, Newsletter from Commonwealth Fund. (May/June 2008) pp.1-10.

[“The Centers for Disease Control and Prevention (CDC) estimates that about 17 percent of children under age 18 have a developmental or behavioral disability, such as autism or attention-deficit/hyperactivity disorder. However, less than 50 percent of these children are identified as having these problems before they start school. Numbers such as these highlight the need to expand pediatricians' focus beyond immunization and injury prevention, which have significantly lowered the childhood death rate over the past decade, to the "new morbidity" of social difficulties, behavioral problems, and developmental difficulties. But, while instituting developmental screening might seem simple on its face, there are multiple barriers. Among them is getting pediatricians, family physicians, and other child health care professionals to recognize the need for formal developmental screening.”]

Full text at:

http://www.commonwealthfund.org/usr_doc/2008_05_06_QM.pdf?section=4039

Maternal Mental Health Predicts Risk of Developmental Problems at 3 Years of Age: Follow Up of a Community Based Trial. By Suzanne C. Tough, University of Calgary, and others. IN: BMC Pregnancy and Childbirth, vol. 8, no. 16 (May 6, 2008) pp.1-11.

[“Undetected and untreated developmental problems can have a significant economic and social impact on society. Intervention to ameliorate potential developmental problems requires early identification of children at risk of future learning and behaviour difficulties. The objective of this study was to estimate the prevalence of risk for developmental problems among preschool children born to medically low risk women and identify factors that influence outcomes.

Mothers who had participated in a prenatal trial were followed up three years post partum to answer a telephone questionnaire. Questions were related to child health and development, child care, medical care, mother's lifestyle, well-being, and parenting style. The main outcome measure was risk for developmental problems using the Parents' Evaluation of Developmental Status (PEDS). Of 791 children, 11% were screened by the PEDS to be at high risk for developmental problems at age three. Of these, 43% had previously been referred for assessment. Children most likely to have been referred were those born preterm. Risk factors for delay included: male gender, history of ear infections, a low income environment, and a mother with poor emotional health and a history of abuse. A child with these risk factors was predicted to have a 53% chance of screening at high risk for developmental problems. This predicted probability was reduced to 19% if the child had a mother with good emotional health and no history of abuse.

Over 10% of children were identified as high risk for developmental problems by the screening and more than half of those had not received a specialist referral. Risk factors for problems included prenatal and perinatal maternal and child factors. Assessment of maternal health and effective screening of child development may increase detection of children at high risk who would benefit from early intervention.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2393-8-16.pdf>

“Social-Emotional Screening Status in Early Childhood Predicts Elementary School Outcomes.” By Margaret J. Briggs-Gowan, University of Connecticut, and Alice S. Carter, University of Massachusetts. IN: *Pediatrics*, vol. 121, no. 5 (May 2008) pp. 957-962.

[“The goal (of this paper) was to examine whether children who screen positive for social-emotional/behavioral problems at 12 to 36 months of age are at elevated risk for social-emotional/behavioral problems in early elementary school.

The sample studied (N=1004) comprised an ethnically (33% minority) and socioeconomically (17.8% living in poverty and 11.3% living in borderline poverty) diverse, healthy, birth cohort from a metropolitan region of the northeastern United States. When children were 12 to 36 months of age, parents completed the Brief Infant-Toddler Social and Emotional Assessment and questions concerning their level of worry about their child’s behavior, emotions, and social development. When children were in early elementary school, parents completed the Child Behavior Checklist and teachers completed the Teacher Report Form regarding behavioral problems. In a subsample, parents reported child psychiatric status.

Brief Infant-Toddler Social and Emotional Assessment screen status and parental worry were associated significantly with school-age symptoms and psychiatric disorders. In multivariate analyses that included Brief Infant-Toddler Social and Emotional Assessment status and parental worry, Brief Infant-Toddler Social and Emotional

Assessment scores significantly predicted all school-age problems, whereas worry predicted only parent reports with the Child Behavior Checklist. ...Moreover, the Brief Infant-Toddler Social and Emotional Assessment identified 49.0% of children who exhibited subclinical/clinical symptoms according to teachers and 67.9% of children who later met the criteria for a psychiatric disorder.

Conclusions reached were that screening with a standardized tool in early childhood has the potential to identify the majority of children who exhibit significant emotional/behavioral problems in early elementary school.” **NOTE: A copy of this article can be obtained from the California State Library.]**

Youth Risk Behavior Surveillance—United States, 2007. By Danice K. Eaton, National Center for Chronic Disease Prevention and Prevention, and others. Morbidity and Mortality Weekly Report. (The Center, Atlanta, Georgia) 136 p.

[“Priority health-risk behaviors, which are behaviors that contribute to the leading causes of morbidity and mortality among youth and adults, often are established during childhood and adolescence, extend into adulthood, are interrelated, and are preventable.

Reporting Period Covered: January--December 2007.

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults, including behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity....

In the United States, 72% of all deaths among persons aged 10--24 years result from four causes: motor-vehicle crashes, other unintentional injuries, homicide, and suicide. Results from the 2007 national Youth Risk Behavior Survey (YRBS) indicated that many high school students engaged in behaviors that increased their likelihood of death from these four causes....

Since 1991, the prevalence of many health-risk behaviors among high school students nationwide has decreased. However, many high school students continue to engage in behaviors that place them at risk for the leading causes of mortality and morbidity. The prevalence of most risk behaviors does not vary substantially among cities and states.

YRBS data are used to measure progress toward achieving 15 national health objectives for *Healthy People 2010* and three of the 10 leading health indicators, to assess trends in priority health-risk behaviors among high school students, and to evaluate the impact of broad school and community interventions at the national, state, and local levels. More effective school health programs and other policy and programmatic interventions are needed to reduce risk and improve health outcomes among youth.”]

Full text at:

http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm?s_cid=ss5704a1_e

Related article: Expanded School Mental Health: A Collaborative Community-School Example.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=19336170&site=ehost-live>

DEPRESSION

Medication Only Therapy and Combination Therapy Both Cost Effective for Treating Teens with Depression. By the National Institute of Mental Health. Science Update. (The Institute, Bethesda, Maryland) May 12, 2008. 2 p.

[“Treating depressed teenagers with either the antidepressant fluoxetine (Prozac) or a combination of fluoxetine and psychotherapy can be cost effective, according to a recent economic analysis of the NIMH-funded Treatment for Adolescents with Depression Study (TADS). The study was published online ahead of print April 15, 2008, in the *American Journal of Psychiatry*.

Marisa Elena Domino, Ph.D., of the University of North Carolina at Chapel Hill, and colleagues compared costs associated with each of the trial’s three active treatment groups—fluoxetine only, cognitive behavioral therapy (CBT) only, and a combination of fluoxetine and CBT—to costs associated with a placebo (sugar pill) group during the first 12 weeks of the trial. The researchers studied direct costs of medication and CBT sessions, and other costs outside the trial, such as visits to primary care providers, school-based services, and lost wages associated with caregivers transporting the adolescent to and from services.

Overall, cost was highest for participants in the combination group—a median of \$2,832 per participant. Median cost per participant was \$2,287 in the CBT-only group, \$942 in the fluoxetine-only group, and \$841 in the placebo group. Combination therapy was associated with the highest time and travel costs at \$762, but medication costs were lower than those associated with the fluoxetine-only group because those in combination treatment tended to take lower doses of the medication. CBT costs for participants in the CBT-only group and participants receiving it as part of combination treatment did not differ.”]

Full text at: <http://www.nimh.nih.gov/science-news/2008/medication-only-therapy-and-combination-therapy-both-cost-effective-for-treating-teens-with-depression.shtml>

Related article: Cost-Effectiveness of Treatments for Adolescent Depression: Results from TADS. IN: The American Journal of Psychiatry.

Note: A copy of this article can be obtained from the CA State Library.

DISASTERS AND MENTAL ILLNESS

“Prevalence and Predictors of Mental Health Distress Post-Katrina: Findings from the Gulf Coast Child and Family Health Study.” By David Abramson, Columbia University, and others. IN: Disaster Medicine and Public Health Preparedness, vol. 2, no. 2 (2008) pp. 77-86.

[“Catastrophic disasters often are associated with massive structural, economic, and population devastation; less understood are the long-term mental health consequences. This study measures the prevalence and predictors of mental health distress and disability of hurricane survivors over an extended period of recovery in a post disaster setting. A representative sample of 1077 displaced or greatly affected households was drawn in 2006 using a stratified cluster sampling of federally subsidized emergency housing settings in Louisiana and Mississippi, and of Mississippi census tracts designated as having experienced major damage from Hurricane Katrina in 2005. Two rounds of data collection were conducted: a baseline face-to-face interview at 6 to 12 months post Katrina and a telephone follow-up at 20 to 23 months after the disaster. Mental health disability was measured using the Medical Outcome Study Short Form 12, version 2 mental component summary score. Bivariate and multivariate analyses were conducted examining socioeconomic, demographic, situational, and attitudinal factors associated with mental health distress and disability.

More than half of the cohort at both baseline and follow-up reported significant mental health distress. Self-reported poor health and safety concerns were persistently associated with poorer mental health. Nearly 2 years after the disaster, the greatest predictors of poor mental health included situational characteristics such as greater numbers of children in a household and attitudinal characteristics such as fatalistic sentiments and poor self efficacy. Informal social support networks were associated significantly with better mental health status. Housing and economic circumstances were not independently associated with poorer mental health.

Mental health distress and disability are pervasive issues among the US Gulf Coast adults and children who experienced long-term displacement or other serious effects as a result of Hurricanes Katrina and Rita. As time progresses post disaster, social and psychological factors may play greater roles in accelerating or impeding recovery among affected populations. Efforts to expand disaster recovery and preparedness policies to include long-term social re-engagement efforts post disaster should be considered as a means of reducing mental health sequelae.”]

Full text at: <http://www.dmph.org/cgi/reprint/2/2/77>

Related article: Disaster Medicine and Mental Health: Who, How, When for International and National Disasters.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=28439855&site=ehost-live>

DISPARITIES

"Professional Uncertainty and Disempowerment Responding to Ethnic Diversity in Health Care: A Qualitative Study." By Joe Kai, University of Nottingham, UK, and others. IN: PLoS Medicine, vol. 4, no. 11 (November 2007) pp. 1766-1775.

[“While ethnic disparities in health and health care are increasing, evidence on how to enhance quality of care and reduce inequalities remains limited. Despite growth in the scope and application of guidelines on "cultural competence," remarkably little is known about how practicing health professionals experience and perceive their work with patients from diverse ethnic communities. Using cancer care as a clinical context, we aimed to explore this with a range of health professionals to inform interventions to enhance quality of care.

We conducted a qualitative study involving 18 focus groups with a purposeful sample of 106 health professionals of differing disciplines, in primary and secondary care settings, working with patient populations of varying ethnic diversity in the Midlands of the UK. Data were analysed by constant comparison and we undertook processes for validation of analysis. We found that, as they sought to offer appropriate care, health professionals wrestled with considerable uncertainty and apprehension in responding to the needs of patients of ethnicities different from their own....

This study suggests potential mechanisms by which health professionals may inadvertently contribute to ethnic disparities in health care. It identifies critical opportunities to empower health professionals to respond more effectively. Interventions should help professionals acknowledge their uncertainty and its potential to create inertia in their practice. A shift away from a cultural expertise model toward a greater focus on each patient as an individual may help.”]

Full text at: http://medicine.plosjournals.org/archive/1549-1676/4/11/pdf/10.1371_journal.pmed.0040323-L.pdf

Related article: Health Disparities among Latino/a in Urban and Rural Schools.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=27889438&site=ehost-live>

EVIDENCE-BASED PRACTICES

“Toward a Policy Ecology of Implementation of Evidence-Based Practices in Public Mental Health Settings.” By Ramesh Raghavan, Washington University in St. Louis, and others. *IN: Implementation Science*, vol. 3, no. 26 (May 16, 2008) pp. 1-9.

[“Mental health policymaking to support the implementation of evidence-based practices (EBPs) largely has been directed toward clinicians. However, implementation is known to be dependent upon a broader ecology of service delivery. Hence, focusing exclusively on individual clinicians as targets of implementation is unlikely to result in sustainable and widespread implementation of EBPs.

Policymaking that is informed by the implementation literature requires that policymakers deploy strategies across multiple levels of the ecology of implementation. At the organizational level, policies are needed to resource the added marginal costs of EBPs, and to assist organizational learning by re-engineering continuing education units. At the payor and regulatory levels, policies are needed to creatively utilize contractual mechanisms, develop disease management programs and similar comprehensive care management approaches, carefully utilize provider and organizational profiling, and develop outcomes assessment. At the political level, legislation is required to promote mental health parity, reduce discrimination, and support loan forgiveness programs. Regulations are also needed to enhance consumer and family engagement in an EBP agenda. And at the social level, approaches to combat stigma are needed to ensure that individuals with mental health need access services.

The implementation literature suggests that a single policy decision, such as mandating a specific EBP, is unlikely to result in sustainable implementation. Policymaking that addresses in an integrated way the ecology of implementation at the levels of provider organizations, governmental regulatory agencies, and their surrounding political and societal milieu is required to successfully and sustainably implement EBPs over the long term.”]

Full text at: <http://www.implementationscience.com/content/pdf/1748-5908-3-26.pdf>

Related article: Values-Based Practice: A New Partner to Evidence-Based Practice and a First for Psychiatry.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=32059791&site=ehost-live>

FOSTER CARE

"Use and Predictors of Out-of-Home Placements within Systems of Care." By Frances M. Z. Farmer, Pennsylvania State University, and others. *IN: Journal of Emotional & Behavioral Disorders*, vol. 16, no. 1 (Spring 2008) pp. 5-14.

[“This article examines out-of-home placements for youth with mental health problems in community-based systems of care. Longitudinal data come from the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. One third of youth residing at home when they enrolled in the system of care were placed out of home during the 2-year follow-up period. As expected, youth who were placed out of home displayed more problems, fewer strengths, and more risk factors than youth who remained at home. However, results suggested few differences between youth placed in foster care and those placed in more restrictive settings. In addition, there was increased placement instability for Hispanic and older youth. Findings suggest that out-of-home placements remain a common component in systems of care. This suggests the immediate need for additional work on effectiveness of these settings for youth within systems of care.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31689399&site=ehost-live>

Related article: Fostering Healthy Futures: An Innovative Preventive Intervention for Preadolescent Youth in Out-of-Home Care.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31238334&site=ehost-live>

Related article: Fostered children have high rates of mental health problems.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=25027284&site=ehost-live>

Related article: Mental health needs of youth in foster care: Challenges and Strategies

Full text at:

<http://www.casenet.org/library/foster-care/mental-health-%5Bconnection-04%5D.pdf>

STIGMA

Attitudes to Mental Illness 2008 Research Report. By the National Statistics UK Limited. (Department of Health, London, England) May 2008. 57 p.

[“This report presents the findings of a survey of attitudes towards mental illness among adults in England. Questions on this topic have been asked as part of TNS’s face-to-face Omnibus since 1994. The most recent previous surveys in the series were carried out in 2003 and 2007. The aim of these surveys is to monitor public attitudes towards mental

illness, and to track changes over time. 1,703 adults (aged 16+) were interviewed by TNS in England in January 2008.

The questionnaire included a number of statements about mental illness. They covered a wide range of issues from attitudes towards people with mental illness, to opinions on services for people with mental health problems. Respondents were asked to indicate how much they agreed or disagreed with each statement.

Other questions covered personal experience of mental illness, descriptions of people with mental illness, and awareness of publicity for mental health issues.

For analysis purposes the attitude statements were grouped into four themes – Fear and exclusion of people with mental illness; Understanding and tolerance of mental illness; Integrating people with mental illness into the community; and Causes of mental illness and the need for special services.

Full text at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_084478

Related article: Pentagon Moves to Reduce Stigma of Mental Counseling.

Full text at: <http://www.lasvegassun.com/news/2008/may/01/pentagon-moves-to-reduce-stigma-of-mental-counseli/>

SUICIDE PREVENTION

“Brief Report: Preliminary Results of a Suicide Awareness Mass Media Campaign in Cuyahoga County, Ohio. By Richard J. Oliver, Mental Health Services for Homeless Persons, and others. IN: Suicide and Life-Threatening Behavior, vol. 38, no. 2 (April 2008) pp. 245-249.

[“Little information is currently available concerning the effects of suicide awareness and prevention campaigns. This brief report provides preliminary information about the influence of such a media campaign on the number of suicide-related telephone calls to an emergency mental health service in Cuyahoga County, Ohio. Examination of the pattern of calls before, during, and between phases of the campaign suggests that the media campaign significantly increased telephone calls to the emergency service. We provide this information to catalyze similar sharing of data and experiences among those organizations and agencies working to prevent suicide.” **NOTE: A copy of this article is available from the California State Library.**]

"Comprehensive College Student Suicide Assessment: Application of the BASIC ID." By Derrick Palidino, Rollins College, and Casey A. Barrio Minton, University of North Texas. IN: Journal of American College Health, vol. 56, no. 6 (May/June 2008) pp. 643-650.

["Whether one knows someone who is thinking of suicide, has attempted suicide, or has completed suicide, nearly all individuals who encounter suicide are affected. The influence and residual affects of suicide are further amplified as the issue reaches across communities such as college or university campuses. College and university staff must improve their response to suicidal ideation with comprehensive assessment and intervention. The authors discuss risk factors and basic screening methods for suicide risk. They present Lazarus' BASIC ID tool (i.e., Behavior, Affective Responses, Sensations, Images, Cognitions, Interpersonal Relationships, and Drugs or Biological Influences) as a method for conducting a comprehensive *suicide* assessment. The authors demonstrate assessment procedures through a case vignette."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=32013566&site=ehost-live>

“Cultural Considerations in Adolescent Suicide Prevention and Psychosocial Treatment.” By David B. Goldston, Duke University School of Medicine, and others. IN: American Psychologist, vol. 63, no. 1 (January 2008) pp. 14-31.

["Ethnic groups differ in rates of suicidal behaviors among youths, the context within which suicidal behavior occurs (e.g., different precipitants, vulnerability and protective factors, and reactions to suicidal behaviors), and patterns of help-seeking. In this article, the authors discuss the cultural context of suicidal behavior among African American, American Indian and Alaska Native, Asian American and Pacific Islander, and Latino adolescents, and the implications of these contexts for suicide prevention and treatment. Several cross-cutting issues are discussed, including acculturative stress and protective factors within cultures; the roles of religion and spirituality and the family in culturally sensitive interventions; different manifestations and interpretations of distress in different cultures; and the impact of stigma and cultural distrust on help-seeking. The needs for culturally sensitive and community-based interventions are discussed, along with future opportunities for research in intervention development and evaluation." **NOTE: A copy of this article can be obtained, electronically, from the CA State Library.]**

“Preventing Suicide: A Resource for the Family.” By Barrero, Sergio A. Perez, Medical University of Granma, Cuba. IN: Annals of General Psychiatry, vol. 7, no. 1 (January 2008) pp. 1-6.

["The family can play an important role in the prevention of suicide if it is capable of aiding the mental health care services in the early detection and management of family members at risk. In order to attain this goal, the whole family should be informed in how to prevent suicide."]

Full text at: <http://www.annals-general-psychiatry.com/content/pdf/1744-859X-7-1.pdf>

Related article: Familial Pathways to Early-Onset Suicide Attempt: Risk for Suicidal Behavior in Offspring of Mood-Disordered Suicide Attempters.

Full text at: <http://archpsyc.ama-assn.org/cgi/content/full/59/9/801>

Related article: Giving Up or Finding a Solution: The Experience of Attempted Suicide in Later Life.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=22832018&site=ehost-live>

Related article: Model for Analyzing Suicide Prevention. IN: Crisis.

Note: A copy of this article can be obtained, electronically, from the CA State Library.

TRAUMA

“Five Essential Elements of Immediate and Mid—Term Mass Trauma Intervention: Empirical Evidence.” By Stefan E. Hobfoll, Kent State University, and others. IN: Psychiatry: Interpersonal & Biological Processes, vol. 70, no. 4 (Winter 2007) pp. 283-315.

[“Given the devastation caused by disasters and mass violence, it is critical that intervention policy be based on the most updated research findings. However, to date, no evidence-based consensus has been reached supporting a clear set of recommendations for intervention during the immediate and the mid-term post mass trauma phases. Because it is unlikely that there will be evidence in the near or mid-term future from clinical trials that cover the diversity of disaster and mass violence circumstances, we assembled a worldwide panel of experts on the study and treatment of those exposed to disaster and mass violence to extrapolate from related fields of research, and to gain consensus on intervention principles. We identified five empirically supported intervention principles that should be used to guide and inform intervention and prevention efforts at the early to mid-term stages. These are promoting: 1) a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=28439851&site=ehost-live>

Related article: Trauma, Depression, Coping, and Mental Health Service Among Impoverished Women.

Full text at: http://www.rand.org/pubs/reprints/2008/RAND_RP1329.pdf

VETERAN’S AND MENTAL ILLNESS

“Gender Differences in Health-Related Quality of Life for Veterans with Serious Mental Illness.” By Carrie Farmer Teh, University of Pittsburg, and others. IN: *Psychiatric Services*, vol. 59, no. 6 (June 2008) pp. 663-669.

[“This study assessed gender differences in health-related quality of life (HRQOL) in a national sample of veterans with serious mental illness. *Methods:* Data were analyzed from the Large Health Survey of Veterans, which was mailed to a national random sample of veterans in 1999. The linear and logistic multiple regression analyses included 18,017 veterans with schizophrenia, schizoaffective disorder, or bipolar disorder who completed the survey. HRQOL was measured by using the various subscales of the 36-Item Short Form of the Medical Outcomes Study (MOS SF-36) (mental component summary, physical component summary, and activities of daily living) and by questions assessing self-perceptions of health status.

The sample was 7.3% female, 75.7% white, and 83.8% unemployed. Mean±SD age was 54.3±12.2 years. After the analysis adjusted for sociodemographic characteristics, health status, and other variables, compared with male veterans, female veterans with serious mental illness had lower scores on the SF-36 physical component summary (indicating worse symptoms), were more likely to report that they were limited “a lot” in activities of daily living, and had more pain. However, female respondents were more likely to have a positive outlook on their health.

Among veterans who received a diagnosis of serious mental illness from providers of the Department of Veterans Affairs, women reported substantially poorer HRQOL than men across several domains but women reported better self-perceived health. Attention to the particular needs of female veterans with serious mental illness is imperative as the numbers of female veterans continue to increase.” **NOTE: A copy of this article can be obtained, electronically, from the CA State Library.]**

VIRGINIA TECH

The Ripple Effect of Virginia Tech: Assessing the Nationwide Impact on Campus Safety and Security Policy and Practice. By Chris Rasmussen and Gina Johnson, Midwestern Higher Education Compact. (The Compact, Minneapolis, Minnesota) May 2008. 32 p.

[“This report is the result of a nationwide survey conducted in March 2008 of student life officers and campus safety directors to assess the impact of the tragic events at Virginia Tech on campus safety and security policy and practice. The events of April 16, 2007, were followed by a flurry of activity on campuses across the nation as colleges and universities conducted internal reviews of emergency procedures, notification systems, and policies related to student behavior. Many campuses have implemented new or enhanced processes and technologies to improve communications and the mobilization of emergency resources and first responders.

The shootings also spurred renewed discussion and debate about gun safety and weapons regulation, mental health counseling, and the often difficult balance between student privacy and the need to share certain information with parents, medical professionals, and law enforcement agencies. Subsequent shootings at Delaware State University, Louisiana Technical College and Northern Illinois University have raised further questions about how such crimes can be prevented and whether colleges and universities are sufficiently prepared to respond to incidents of violence and other emergency situations. This report provides a snapshot of how colleges and universities are addressing these issues and the changes that have resulted from safety and security audits conducted at institutions across the country.”]

Full text at: http://www.mhec.org/policyresearch/052308mhecsafetyrpt_lr.pdf

Related article: Is There a Duty? Limiting College and University Liability for Student Suicide.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=28439855&site=ehost-live>

NEW Webcasts: Suicide Prevention Resource Center Discussion Series

[“The SPRC Discussion Series seeks to foster meaningful dialogue on suicide and suicide prevention among practitioners, researchers, and others working in the field. Each invitational teleconference is 90 minutes in length and moderated by an SPRC staff member.

An archive of recordings from this series can be accessed using the Windows Media Player or the RealOne Player. Supplementary materials available for each session include a description of the topic, speaker biographies, a list of discussion participants, and any handouts or PowerPoint presentations provided by the speaker.

If there are particular topics you would like to see addressed in the Discussion Series, or if you are interested in participating in a future session, please contact SPRC info@sprc.org.”]

Full text at: http://www.sprc.org/traininginstitute/disc_series/index.asp

New June-August 2008 Conferences

6/27/2008 - 6/28/2008

Survivor of Suicide Loss Support Group Facilitator Training Program

American Foundation for Suicide Prevention

San Diego

San Diego, CA

http://www.sprc.org/featured_resources/trainingandevents/calendar/index.asp?day=1&month=6#516

CALENDAR JUNE 18-THROUGH AUGUST 2008

<p>June 18-20</p>	<p>Implementing a Comprehensive Continuum of Services: Beyond Tradition—Creating Synergy.</p>	<p>The theme of the ADP 2008 conference is “Implementing a Comprehensive Continuum of Services: Beyond Tradition—Creating Synergy.” The conference strives to bring together diverse staff and policy makers throughout California’s alcohol and other drug fields and other stakeholders in order to:</p> <ul style="list-style-type: none"> • Build Unity Across The Field. • Share The Best In The Field. • Support Change Efforts. • View the Landscape. • Promote Gender and Cultural Responsiveness. <p>Location: Hyatt Regency Burlingame Hotel Time: Contact: Ron Bevers Phone: Reservations: 650-347-1234 or 800-233-1234 Email: rbevers@adp.ca.gov Website: www.cce.csus.edu</p>
<p>June 26-28</p>	<p>2008 National Conference on Problem Gambling</p>	<p>The National Council on Problem Gambling and the California Council on Problem Gambling are bringing you to beautiful Southern California for the 22nd Annual Conference On Problem Gambling. The conference will provide training and the latest research on the prevention and treatment of problem gambling, co-occurring disorders and public awareness.</p> <p>Location: Hyatt Regency Hotel 200 S. Pine Avenue Long Beach, CA 90802</p> <p>Time: Contact: The National Council on Problem Gambling 216 G Street NE, Ste 200 Washington, DC 20002</p> <p>Phone: 202-547-9204 Fax: 202-547-9206 Email: ncpg@ncpgambling.org</p>
<p>July 2008</p>		
<p>July 16-17</p>	<p>Voices: A Program of Self Discovery and Empowerment for Girls</p>	<p>Voices: A Program of Self Discovery and Empowerment for Girls This training will be conducted by Stephanie Covington, Ph.D. for 2 full days exploring the keys issues of self esteem, relationships, sexuality, and spirituality in the lives of adolescent girls, as well as the therapeutic techniques for dealing with these issues.</p> <p>Location: Covina Women's Club 128 South San Jose Avenue Covina, CA 91723</p> <p>Time: 9:00 a.m. - 4:00 p.m.</p>

		<p>Contact: Brianna Phone: 916-338-9460 Email: Website: http://www.caarr.org</p>
July 18	Governor's Prevention Advisory Council (GPAC)	<p>The purpose of the Council is to coordinate the State's strategic efforts to reduce the inappropriate use of alcohol, tobacco and other drugs (ATOD). The Council will discuss various ATOD prevention efforts, including its strategic planning process, its workgroups' activities, and an update on the implementation of the federal grant program (California Screening, Brief Intervention, Referral and Treatment Grant Program), which the Council oversees.</p> <p>Location: Dept.of Alcohol and Drug Programs 1700 K Street, First Floor Conference Room Sacramento, CA 95811</p> <p>Time: 9:30 a.m. – 12:30 p.m.</p> <p>Contact: Cheryl Ito Program Services Division, ADP</p> <p>Phone: (916) 322-7567 Email: Website:</p>
August 2008		
August 5-7	37th Annual Summer Clinical Institute in Addiction Studies	<p>The University of California, San Diego, Center for Criminality & Addiction Research, Training & Application is proud to offer a 3-day conference of lectures, workshops, and discussion sessions featuring UCSD faculty and other experts in the fields of substance abuse, forensic psychiatry, co-occurring disorders, posttraumatic stress disorder, and intercultural relations.</p> <p>Location: UCSD Price Center</p> <p>Time: 8:00 – 4:30 p.m.</p> <p>Contact: Jennifer Waldon</p> <p>Phone: 858-456-6784</p> <p>Email: sci@ucsd.edu</p> <p>Website: www.ucsdsci.com</p>
August 8	Responsive Services for Latinas	<p>This one day conference offers the opportunity to dialog and develop an understanding of culturally and gender responsive services for Latinas. It will offer knowledge, skills and inspiration to treatment providers working with the Latina population. Presenters will share current research, resources, and programs and practices from the AOD, mental health and family services. Topics include: Trends in the Latina Population; Best Practices and Models for working with Latinas; Addressing risk factors in working with the Latina population; Engaging Latinas in case management services; Culturally responsive services for Latinas; Addressing the needs of Latina youth; and, Migration, Acculturation and assimilation of the Latina.</p> <p>Location: Center for Healthy Communities</p> <p>Time: 8:30 a.m. - 4:00 p.m.</p> <p>Contact: Marta Ortegon Davis</p> <p>Phone: 714-505-3525</p>

		Email: mortegon@cffutures.org Website:
August 19 - 22	SAPT Block Grant Conference	Location: Washington D.C. area Time: Multi-day event Contact: Alice Huffaker Phone: (916) 322-3014 Email: ahuffaker@adp.ca.gov Website:
August 24 - 27	21st Annual National Prevention Network Prevention Research Conference	The National Prevention Network (NPN) invites you to our 21st Annual Prevention Research Conference, August 24-27, 2008 in Indianapolis, Indiana. The theme for this year's conference is "Prevention Research: Driving Successful Outcomes." Location: Indianapolis, Indiana Time: 8:00 a.m. - 5:00 p.m. Contact: Sue Carlson Phone: (405) 826-4011