

**Subject:** Studies in the News: (January 30, 2009)

---



## Studies in the News for



## California Department of Mental Health

---

### Introduction to Studies in the News

Studies in the News (SITN): California Department of Mental is a service provided to the Department of Mental Health by the California State Library. This service features articles focusing on mental health issues. Prior lists can be viewed from the California State Library's Web site at [California State Library - Studies in the News](#)

### How to Obtain Materials Listed in SITN:

- When available on the Internet, the URL for the full-text of each item is provided.
- **California State Employees** may contact the Information Resources and Government Publications (916-654-0206; [csinfo@library.ca.gov](mailto:csinfo@library.ca.gov)) with the SITN issue date and title of article.
- All other interested individuals should contact their local library-the items may be available there, or may be borrowed by your local library on your behalf.

**The following are the Subject Headings included in this issue:**

**CHILDREN AND ADOLESCENT MENTAL HEALTH**

[The Family Check-Up in Early Childhood.](#)

**CRIMINAL JUSTICE SYSTEM**

[Association between psychiatric diagnosis and violent re-offending in adults.](#)

[The Health and Health Care of US Prisoners: A Nationwide Survey.](#)

[Psychiatric Disorders and Repeat Incarcerations: A Revolving Prison Door.](#)

[Diversion Interventions for Incarcerated Persons with Mental Illness.](#)

**ELDERLY AND MENTAL ILLNESS**

[Depression and the Elder Person.](#)

[Mental health service use in mental health survey of elderly in Singapore.](#)

[Job Loss, Retirement and the Mental Health of Older Americans.](#)

**HOMELESSNESS**

[Pathways into homelessness.](#)

**MENTAL HEALTH SYSTEMS**

[Changing Trends in State Psychiatric Hospital Use from 2002 to 2005.](#)

[Mental hospital reform in Asia: the case of Yuli Veterans Hospital, Taiwan.](#)

**POLICIES AND PROCEDURES**

[Can We Learn From History? Mental Health in Health Care Reform.](#)

[Future Funding for Mental Health and Substance Abuse.](#)

**PREVENTION**

[Reducing Inequities in Health and Safety through Prevention.](#)

**STIGMA**

[The Persistence of Stigma and Discrimination.](#)

**SUICIDE PREVENTION**

[Suicidal behavior in media may promote others towards suicide.](#)

[Detecting suicidality among adolescent outpatients.](#)

[Immigration and Suicidal Behavior among Mexicans and Mexican Americans.](#)

**[NEW CONVENTIONS](#)**

**CHILDREN AND ADOLESCENT MENTAL HEALTH**

**“The Family Check-Up in Early Childhood: A Case Study of Intervention Process and Change.”** By Anne M. Gill, University of Pittsburgh and others. IN: **Journal of Clinical Child & Adolescent Psychology**, vol. 37, no. 4 (October-December 2008) pp. 893-904.

[“This article describes a case study in the use of the Family Check-Up (FCU), a family-based and ecological preventive intervention for children at risk for problem behavior. The FCU is an assessment-driven intervention that utilizes a health maintenance model; emphasizes motivation for change; and offers an adaptive, tailored approach to intervention. This case study follows one Caucasian family through their initial assessment and subsequent treatment for their toddler daughter’s conduct problems over a 2-year period. Clinically meaningful improvements in child and family functioning

were found despite the presence of child, parent, and neighborhood risk factors. The case is discussed with respect to the findings from a current multisite randomized control trial of the FCU and its application to other populations.” **NOTE: This journal is available to be borrowed from the CA State Library or a hard copy of this article can be ordered from the CA State Library.]**

### **CRIMINAL JUSTICE SYSTEM**

**“The Association Between Psychiatric Diagnosis and Violent Re-offending in Adult Offenders in the Community.” By Martin Grann, University of Stockholm, Sweden, and others. IN: BMC Psychiatry, vol. 8, no. 92 (November 25, 2008) pp.1-7.**

[“High rates of repeat offending are common across nations that are socially and culturally different. Although psychiatric disorders are believed to be risk factors for violent reoffending, the available evidence is sparse and liable to bias.

We conducted a historical cohort study in Sweden of a selected sample of 4828 offenders given community sentences who were assessed by a psychiatrist during 1988–2001, and followed up for an average of 5 years for first violent offence, death, or emigration, using information from national registers. Hazard ratios for violent offending were calculated by Cox regression models.

Nearly a third of the sample (31.3%) offended violently during follow-up (mean duration: 4.8 years). After adjustment for socio-demographic and criminal history variables, substance use disorders and personality disorders were significantly associated with an increased risk of violent offending. No other diagnoses were related to recidivism risk. Adding information on diagnoses of substance use and personality disorders to data recorded on age, sex, and criminal history improved only minimally the prediction of violent offending.

Diagnoses of substance use and personality disorders are associated with the risk of subsequent violent offending in community offenders about as strongly as are its better documented demographic and criminal history risk factors. Despite this, assessment of such disorders in addition to demographic and criminal history factors enhances only minimally the prediction of violent offending in the community.”]

Full text at: <http://www.biomedcentral.com/1471-244X/8/92/abstract>

**The Health and Health Care of US Prisoners: A Nationwide Survey. By Andrew P. Wilper, Cambridge Health Alliance, and others. IN: American Journal of Public Health, vol. 99, no. 4 (April 2009). Pp. 1-6.**

[“We analyzed the prevalence of chronic illnesses, including mental illness, and access to health care among US inmates. We used the 2002 Survey of Inmates in Local Jails and the 2004 Survey of Inmates in State and Federal Correctional Facilities to analyze disease prevalence and clinical measures of access to health care for inmates.

Among inmates in federal prisons, state prisons, and local jails, 38.5%, 42.8%, and 38.7%, respectively, suffered a chronic medical condition. Among inmates with a mental condition ever treated with a psychiatric medication, only 25.5% of federal, 29.6% of state, and 38.5% of local inmates were taking a psychiatric medication at the time of arrest, whereas 69.1%, 68.6%, and 45.5% were restarted on a psychiatric medication after admission.

Many inmates with a serious chronic physical illness fail to receive care while incarcerated. Among inmates with mental illness, most were off their treatments at the time of arrest. Improvements are needed both in correctional health care and in community mental health services that might prevent crime and incarceration.”]

Full text at: [http://pnhp.org/prisoners/Wilper\\_Prison.pdf](http://pnhp.org/prisoners/Wilper_Prison.pdf)

**“Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door.” By Jacques Baillargeon, University of Texas Medical Branch, and others. IN: American Journal of Psychiatry, vol. 166, no. 1 (January 2009) pp. 103-109.**

[“A number of legal, social, and political factors over the past 40 years have led to the current epidemic of psychiatric disorders in the U.S. prison system. Although numerous investigations have reported substantially elevated rates of psychiatric disorders among prison inmates compared with the general population, it is unclear whether mental illness is a risk factor for multiple episodes of incarceration. The authors examined this association in a retrospective cohort study of the nation’s largest state prison system.

The study population included 79,211 inmates who began serving a sentence between September 1, 2006, and August 31, 2007. Data on psychiatric disorders, demographic characteristics, and history of incarceration for the preceding 6-year period were obtained from statewide medical information systems and analyzed. Inmates with major psychiatric disorders (major depressive disorder, bipolar disorders, schizophrenia, and no schizophrenic psychotic disorders) had substantially increased risks of multiple incarcerations over the 6-year study period. The greatest increase in risk was observed among inmates with bipolar disorders, who were 3.3 times more likely to have had four or more previous incarcerations compared with inmates who had no major psychiatric disorder.

Prison inmates with major psychiatric disorders are more likely than those without to have had previous incarcerations. The authors recommend expanding interventions to reduce recidivism among mentally ill inmates. They discuss the potential benefits of continuity of care reentry programs to help mentally ill inmates connect with community-

based mental health programs at the time of their release, as well as a greater role for mental health courts and other diversion strategies. “[

Full text at: <http://ajp.psychiatryonline.org/cgi/reprint/166/1/103>

**Rethinking Diversion Interventions for Persons with Co-Occurring Mental Illnesses and Substance Abuse. By William H. Fisher, University of Massachusetts, and Robert E. Drake, Dartmouth Medical School. Policy Brief. (Center for Behavioral Health Services and Criminal Justice Research, New Brunswick, New Jersey) January 2009. 4 p.**

[“Criminal justice involvement of persons with mental illnesses has been a longstanding concern of mental health advocates. Much of this concern has centered on the inadequacy of mental health services available in correctional settings and the likely harm to the mental health and well being of persons with mental illnesses in prisons and jails (Human Rights Watch, 2003). Media coverage of the resulting harm from incarceration brought the issue of incarcerating people with mental illnesses to greater prominence on legislative agendas. It also fueled new efforts to divert persons with mental illnesses from the justice system to appropriate mental health services in the community.

Diversion is a policy and program response to some people with mental illnesses who are charged with criminal offenses. Diversion to treatment, instead of incarceration, is a process intended to protect people with mental illnesses from the potential harms of incarceration, promote engagement with treatment, and reduce the likelihood of future offending behavior. In the interest of public safety, diversion efforts have primarily focused on diverting people with mental illnesses who face low-level (i.e., non-violent misdemeanor) charges and are not habitual offenders. It is believed that these individuals have problems that stem chiefly from their failed connections with mental health services. Other attendant problems, typically related to substance abuse and homelessness, are viewed as outcomes resulting from not being actively involved in mental health treatment.”]

Full text at: <http://consensusproject.org/downloads/policybrief>

## **ELDERLY AND MENTAL ILLNESS**

**“Depression and the Elder Person: The Enigma of Misconceptions, Stigma, and Treatment.” By Mary Benek-Higgins, California State University San Bernardino, and others. IN: Journal of Mental Health Counseling, vol. 30, no. 4 (October 2008) pp. 283-296.**

[“It is estimated that half of the 35 million people in the United States who are over the age of 65 are in need of mental health services, though fewer than 20% are actually being treated (Comer, 2004). Coexisting mental and physical problems make recognition of depression in elder persons more difficult because presenting symptoms of depression are

often masked by physical problems. In addition, most elder people who have depression never seek or obtain treatment because of the commonly held myth that depression is a normal part of the aging process and that elder people cannot benefit from psychotherapy. The purpose of this article is to survey these issues as they relate to mental health counseling.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=34923392&site=ehost-live>

**“Determinants of Mental Health Service Use in the National Mental Health Survey of the Elderly in Singapore.”** By Ma Shwe ZIN Nyunt, National University of Singapore, and others. IN: *Clinical Practice and Epidemiology in Mental Health*, vol. 5, no. 2 (January 19, 2009) pp. 1-21.

[“Despite high prevalence of mental health problems, only a minority of elderly people seek treatment. Although need-for-care factors are primary determinants of mental health service use, personal predisposing or enabling factors including health beliefs are important but are not well studied.

In the National Mental Health Survey of Elderly in Singapore, 2003, 1092 older adults aged 60 and above were interviewed for diagnosis of mental disorders (using Geriatric Mental State) and treatment, and their health beliefs about the curability of mental illness, embarrassment and stigma, easiness discussing mental problems, effectiveness and safety of treatment and trust in professionals.

The prevalence of mental disorders was 13%, but only a third of mentally ill respondents had sought treatment. Increased likelihood of seeking treatment was significantly associated with the presence of a mental disorder, disability from mental illness, and poor or fair self-rated mental health, female gender, and formal education. The likelihood of treatment seeking was lower in those reporting financial limitations for medical care, but also higher household income. Negative beliefs showed no meaningful associations, but the positive belief that 'to a great extent mental illness can be cured' was associated with increased mental health service use. The availability of family caregiver showed a negative association.”]

Full text at: <http://www.cpementalhealth.com/content/pdf/1745-0179-5-2.pdf>

**“Job Loss, Retirement and the Mental Health of Older Americans.”** By Bidisha Mandal, Washington State University, and Brian Roe, Ohio State University. IN: *the Journal of Mental Health Policy and Economics*, vol. 11, no. 4 (December 2008) pp. 167-176.

[“Millions of older individuals cope with physical limitations, cognitive changes, and various losses such as bereavement that commonly associated with aging. Given increased vulnerability to various health problems during aging, work displacement

might exacerbate these due to additional distress and possible changes in medical coverage. Older Americans are of increasing interest to researchers and policymakers due to the sheer size of the Baby Boom cohort, which is approaching retirement age, and due to the general decline in job security in the U.S. labor market. This research compares and contrasts the effect of involuntary job loss and retirement on the mental health of older Americans. Furthermore, it examines the impact of re-employment on the depressive symptoms.” **NOTE: This journal is available for borrowing from the California State Library or a hard copy of this article can be obtained from the CA State Library.]**

### HOMELESSNESS

**“Pathways into Homelessness: Recently Homeless Adults’ Problems and Service Use Before and After Becoming Homeless in Amsterdam.” By Igor R van Laere, University of Amsterdam, and others. IN: BMC Public Health, vol. 9, no. 3 (January 7, 2009) pp. 1-9.**

[“Recently homeless adults (last housing lost up to two years ago and legally staying in the Netherlands) were sampled in the streets, day centers and overnight shelters in Amsterdam. In April and May 2004, students conducted interviews and collected data on demographics; self reported pathways into homelessness, social and medical problems, and service use, before and after becoming homeless.

Among 120 recently homeless adults, (male 88%, Dutch 50%, average age 38 years, mean duration of homelessness 23 weeks), the main reported pathways into homelessness were evictions 38%, relationship problems 35%, prison 6% and other reasons 22%. Compared to the relationship group, the eviction group was slightly older (average age 39.6 versus 35.5 years;  $p = 0.08$ ), belonged more often to a migrant group ( $p = 0.025$ ), and reported more living single ( $p < 0,001$ ), more financial debts ( $p = 0.009$ ), more alcohol problems ( $p = 0.048$ ) and more contacts with debt control services ( $p = 0.009$ ).

The relationship group reported more domestic conflicts ( $p < 0.001$ ) and tended to report more drug (cocaine) problems. Before homelessness, in the total group, contacts with any social service were 38% and with any medical service 27%. Despite these contacts they did not keep their house. During homelessness only contacts with social work and benefit agencies increased, contacts with medical services remained low.

The recently homeless fit the overall profile of the homeless population in Amsterdam: single (Dutch) men, around 40 years, with a mix of financial debts, addiction, mental and/or physical health problems. Contacts with services were fragmented and did not prevent homelessness. For homelessness prevention, systematic and outreach social medical care before and during homelessness should be provided.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2458-9-3.pdf>

## MENTAL HEALTH SYSTEMS

**“Changing Trends in State Psychiatric Hospital Use from 2002 to 2005.” By Ronald W. Manderscheid, SRA International, and others. IN: Psychiatric Services, vol. 60, no. 1 (January 2009) pp.29-34.**

[“National surveys have shown dramatic declines in the number of residents in state psychiatric hospitals since the 1950s and in the number of admissions since the 1970s. However, data from 2002 and 2005 indicate a reversal of these long-term trends. The objective of this study was to present the new data and to advocate for research on the factors contributing to these changes.

This study is based on state-level data submitted annually to the Center for Mental Health Services. The 11 states showing increases in admissions and residents between 2002 and 2005 were surveyed by telephone about the factors leading to the changes. Between 2002 and 2005, the number of admissions nationwide increased 21.1%, and the number of residents increased by 1.0%. State mental health agency staff attributed the increases principally to one factor—the increase in the number of forensic admissions and residents. Staff also identified increases in the number of admissions with schizophrenia (increased 23.2%) and affective disorders (increased 16.3%) as a second factor, plus declines in the availability of housing and community-based care providers.

The reversal of long-term trends may signal threats to the goal of community-based mental health care. Research is urgently needed to examine the factors associated with these increases. Potential factors to be investigated include the increase in the number of forensic admissions and the antecedents of this phenomenon, increases in the number of admissions with schizophrenia, the changing capacity of general hospital inpatient psychiatric services in the community, and changes in the demographic makeup of American society, reflected in an aging population and increased racial-ethnic diversity.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/1/29>

**“Mental hospital reform in Asia: the case of Yuli Veterans Hospital, Taiwan.” By Chih-Yuan Lin, Yuli Veteran’s Hospital, and others. IN: International Journal of Mental Health Systems, vol. 3, no. 1 (January 2, 2009) pp. 1-39.**

[“Yuli Veterans Hospital (YVH) has been the largest mental hospital for the patients with chronic and severe mental illness in Taiwan for the past 50 years. While this hospital used to be a symbol of hopelessness among patients and their families and an unspoken shame among Taiwan psychiatry and mental health circles it now represents an example of how an old, custodial hospital can be transformed into a very different institution. In this case study we will describe the features of this transformation, which, over the past 20 years, has aimed to help extended stay inpatients with severe mental illness to integrate into the local community of Yuli even though it is not their original home....

There are four main components of the Yuli model: holistic medical support, vocational rehabilitation, case management, and the residential program. The four components help patients recover two essential features of their lives: vocational life and ordinary daily routines. As the process of recovery evolves, patients gradually regain inner stability, dignity, self-confidence, and a sense of control. The four components are critical to rebuild the structure and order of life of the patients and are indispensable and interdependent parts of one service package. They operate simultaneously to benefit the patients to the greatest degree possible....

This case study reveals the possibility of transforming a custodial mental hospital into a hospital providing high quality care. Hospital and community are not in opposition. They are part of a continuum of care for the patients. We reinterpret and redefine the boundary and function of hospital and community, and thereby create a new service model, the Yuli Model, to help patients to reintegrate into the community. The Yuli model, which particularly focuses on the needs of people with long-standing illness and prolonged hospital stay, illustrates one approach to linking hospital and community in a creative and constructive manner.”]

Full text at: <http://www.ijmhs.com/content/pdf/1752-4458-3-1.pdf>

### **POLICIES AND PROCEDURES**

**“Can We Learn From History? Mental Health in Health Care Reform, Revisited.”  
By Chris Koyanagi, Judge David L. Bazelon Center for Mental Health Law. IN  
Psychiatric Services, vol. 60, no. 1 (January 2009) pp. 17-20.**

[“Health reform is again on the national agenda. Serious debate about how mental health might fit into national health policy has not occurred since 1993. The focus of the Clinton reformers was on benefits, integration with the general health system, and a new role for the public sector. A number of issues remain relevant today, such as uncoordinated public and private services, cost-shifting and poor quality care for people with serious mental illness. This column considers the barriers to full inclusion of mental health in health care reform and proposed solutions that were identified in 1993 and describes how they can inform policy decisions in 2009.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/1/17>

**“Future Funding for Mental Health and Substance Abuse: Increasing Burdens for the Public Sector.” By Katherine R. Levit, Health Affairs, and others. IN: Health Affairs, vol. 27, no. 6 (October 7, 2008) pp. w513-w522.**

[“Spending on mental health (MH) and substance abuse (SA) treatment is expected to double between 2003 and 2014, to \$239 billion, and is anticipated to continue falling as a

share of all health spending. By 2014, our projections of SA spending show increasing responsibility for state and local governments (45 percent); deteriorating shares financed by private insurance (7 percent); and 42 percent of SA spending going to specialty SA centers. For MH, Medicaid is forecasted to fund an increasingly larger share of treatment costs (27 percent), and prescription medications are expected to capture 30 percent of MH spending by 2014.”]

Full text at: <http://content.healthaffairs.org/cgi/reprint/27/6/w513>

## **PREVENTION**

**Reducing Inequities in Health and Safety through Prevention. By the Prevention Institute. (Joint Center for Political and Economic Studies, Washington, D. C.) 2008. 15 p.**

[“Advancing health equity to ensure all Americans have the opportunity to lead healthy lives should be a priority. We have an opportunity to do so in a way that alleviates pressure on the health system and saves money. Prevention Institute and the Health Policy Institute at the Joint Center for Political and Economic Studies developed this memo in January ’09 to provide background and recommendations for achieving equitable health outcomes for all.

Barack Obama has stated: “We’re going to have some very aggressive initiatives...around things like prevention that reduce costs.”We applaud the growing recognition across Congress, within the new Administration, and among the American people that prevention can and must be part of the solution to reform the US health system. Prevention is crucial to improving health and reducing inequities between racial, ethnic, and socioeconomic groups. Strategic investment and implementation of prevention strategies can address the underlying conditions that lead to death, illness, injury, and health inequities in the first place....

This memo offers our suggested strategy for developing a comprehensive, prevention-oriented approach to health equity, building upon related thinking such as that expressed in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* and *Promoting Health: Intervention Strategies from Social and Behavioral Research* by the Institute of Medicine and *Blueprint for America* by Trust for America’s Health, as well as PolicyLink’s work on health and place and the Institute for Alternative Future’s *Disparity Reducing Advances* project.”]

Full text at:

[http://www.preventioninstitute.org./documents/HealthEquityMemo\\_010809.pdf](http://www.preventioninstitute.org./documents/HealthEquityMemo_010809.pdf)

## **STIGMA**

**The Persistence of Stigma and Discrimination. By Kenneth J. Gill, University of Medicine and Dentistry New Jersey. IN: *Psychiatric Rehabilitation Journal*, vol. 31, no. 3 (Winter 2008) pp.183-184.**

[“The author reflects on the existence of stigma and discrimination among people with serious mental illnesses in treatment programs and employment development. He cites that the discrimination experienced by these people remain widespread. He illustrates that some people views individuals with mental illness as incompetent. He believes that innovative advancement approach is playing an important role towards the full recovery of the individuals with mental illness.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=28522030&site=ehost-live>

### **SUICIDE PREVENTION**

**“Copycat Suicidal Attempt by a 7 year old boy after Watching Homicidal Behavior in Media: A Case Report.”** By Ahmad Ghanizadeh, Shiraz University Medical Sciences, Hafez Hospital, Iran. IN: *BMC Cases Journal*, vol. 2, no. 43 (January 2009) pp. 1-7.

[“Suicidal behavior in media may promote others towards suicide. No published study was found about suicidal attempt in children less than 10 years old after watching a homicidal behavior. This is a report of a 7 year old boy referred because he hanged himself after watching homicidal behavior of hanging in a fictional movie. To the author's knowledge, there was no published report of copycat suicidal attempt in a 7 year old child after watching a homicidal behavior in media. This report warns about an imitative effect of movie watching of homicidal behavior on suicidal attempt.”]

Full text at: <http://www.casesjournal.com/content/pdf/1757-1626-2-43.pdf>

**“Detecting Suicidality among Adolescent Outpatients: Evaluation of Trained Clinicians' Suicidality Assessment against a Structured Diagnostic Assessment Made by Trained Raters.”** By Matti Mikael Holi, University of Helsinki, and others. IN: *BMC Psychiatry*, vol. 8, no. 97 (December 31, 2008) pp. 1-6.

[“Accurate assessment of suicidality is of major importance. We aimed to evaluate trained clinicians' ability to assess suicidality against a structured assessment made by trained raters

Treating clinicians classified 218 adolescent psychiatric outpatients suffering from a depressive mood disorder into three classes: 1-no suicidal ideation, 2-suicidal ideation, no suicidal acts, 3-suicidal or self-harming acts. This classification was compared with a classification with identical content derived from the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS-PL) made by trained raters. The convergence was assessed by kappa- and weighted kappa tests.

The clinicians' classification to class 1 (no suicidal ideation) was 85%, class 2 (suicidal ideation) 50%, and class 3 (suicidal acts) 10% concurrent with the K-SADS evaluation ( $\chi^2 = 37.1$ ,  $df = 4$ ,  $p = 0.000$ ). Weighted kappa for the agreement of the measures was 0.335 (CI = 0.198–0.471,  $p < 0.0001$ ). The clinicians' under-detected suicidal and self-harm acts, but over-detected suicidal ideation.

There was only a modest agreement between the trained clinicians' suicidality evaluation and the K-SADS evaluation, especially concerning suicidal or self-harming acts. We suggest a wider use of structured scales in clinical and research settings to improve reliable detection of adolescents with suicidality.”]

Full text at: <http://www.biomedcentral.com/1471-244X/8/97/abstract>

**“Immigration and Suicidal Behavior Among Mexicans and Mexican Americans.”**  
**By Guilherme Borges, Universidad Autonoma Metropolitana, and others. IN:**  
**American Journal of Public Health, vol. 99, no. 4 (April 2009) pp. 1-6.**

[“We examined migration to the United States as a risk factor for suicidal behavior among people of Mexican origin.

We pooled data from 2 nationally representative surveys in the United States (2001–2003;  $n=1284$ ) and Mexico (2001–2002;  $n=5782$ ). We used discrete time survival models to account for time-varying and time-invariant characteristics, including psychiatric disorders.

Risk for suicidal ideation was higher among Mexicans with a family member in the United States, Mexican-born immigrants who arrived in the United States at 12 years or younger, and US-born Mexican Americans than among Mexicans with neither a history of migration to the United States nor a family member currently living there. Risk for suicide attempts was also higher among Mexicans with a family member in the United States and US-born Mexican Americans. Selection bias caused by differential migration or differential return migration of persons at higher risk of suicidal ideation or attempt did not account for these findings.

Public health efforts should focus on the impact of Mexico–US migration on family members of migrants and on US-born Mexican Americans.” **NOTE: A copy of this article may be requested from the California State Library.]**

Full text at: <http://www.ajph.org/cgi/reprint/AJPH.2008.135160v1>

### **NEW CONVENTIONS**

**American Association of Suicidology: April-12-18 2009 in San Francisco.**

**Annual Conference Goals and Objectives**

“The goal of the 42nd Annual Conference of the American Association of Suicidology is to provide a forum for those who share an interest in suicidology, including physicians, researchers, psychologists, nurses, social workers, clinicians, educators, public policy makers, clergy, crisis center staff and volunteers, as well as those who have lost a loved one to suicide to meet and share information about suicide, suicidal persons, and the repercussions of suicide.”

Full text at: <http://www.suicidology.org/web/guest/education-and-training/annual-conference>

**8<sup>th</sup> Annual Developmental Disabilities: An Update for Health Professionals.  
March 5<sup>th</sup>-March 9<sup>th</sup> 2009, San Francisco, California**

[“This conference provides a practical and useful update for primary care and subspecialty physicians, nurses, and other health care professionals caring for children, youth, and adults with complex health care needs and developmental disabilities, including autism spectrum disorders. This year's conference features select topics addressing issues of dual diagnosis (developmental disabilities and emotional/behavioral disabilities). The course provides a variety of diagnostic and treatment perspectives, research findings, and clinical guidelines, plus an overview of relevant information for pediatricians, family physicians, internists, nurse practitioners, psychologists, psychiatrists, social workers, and other health professionals who are involved in the care of individuals with these special needs.”]

Full text at:  
<https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MOC09001>