

Subject: Studies in the News: (May 12, 2009)



Studies in the News for



California Department of Mental Health

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CHILDREN AND ADOLESCENTS

“The CUIDAR Early Intervention Parent Training Program for Preschoolers at Risk for Behavioral Disorders.” By Kimberley Lakes, University of California at Irvine, and others. IN: Journal of Early Intervention, vol. 31 no. 2 (March 2009) pp. 167-178.

[“Researchers report mental health disparities that indicate that children and families with the highest need for services often are less likely to use them. Only a few investigators have focused on service delivery models to address underuse of services. This study examines the Children's Hospital of Orange County (CHOC)/University of California, Irvine (UC Irvine) Initiative for the Development of Attention and Readiness (CUIDAR) model of service delivery in reducing disparities in access to and use of services and in decreasing child behavior problems in a community-based study with 169 self-referred, low-income, and predominantly minority families. The findings indicate that among minority families, CUIDAR is both more accessible and more equitably used than local, publicly funded mental health services. Among Latinos, attendance rates are higher when services are provided in Spanish. Parents report significant improvements in overall child difficulty and conduct problems. In addition, parents report high levels of satisfaction with the program.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=37167422&site=ehost-live>

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No Bullying Allowed: Understanding Peer Victimization, the Impacts on Delinquency, and the Effectiveness of Prevention Programs. By Jennifer S. Wong, Pardee RAND Graduate School. (RAND, Santa Monica, California) 2009. 354 p.

[“Over the past decade, school bullying has emerged as a prominent issue of concern for students, parents, educators, and researchers around the world. Research evidence suggests nontrivial and potentially serious negative repercussions of both bullying and victimization. This dissertation uses a large, nationally representative panel dataset and a propensity score matching technique to assess the impact of bully victimization on a range of 10 delinquency outcomes measured over a six-year period. Results show that victimization prior to the age of 12 years is significantly predictive of the development of

several delinquent behaviors, including running away from home, selling drugs, vandalism, theft, other property crimes, and assault. As a whole, prevention programs are significantly effective at reducing the problem of victimization in schools but are only marginally successful at reducing bullying. More work is needed to determine why programs are more successful with victims of bullying than with perpetrators, and prevention efforts should focus on the development of programs that are more likely to bring about successful reductions in both bullying and victimization.”]

Full text at: http://www.rand.org/pubs/rgs_dissertations/2009/RAND_RGSD240.pdf

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“Perceived Racial/Ethnic Discrimination among Fifth-grade Students and its Association with Mental Health.” By T.R. Coker, UCLA, and others. IN: *American Journal of Public Health*, vol. 99, no. 5 (May 2009) pp. 878-884.

[“*Objectives:* We sought to describe the prevalence, characteristics, and mental health problems of children who experience perceived racial/ethnic discrimination. *Methods:* We analyzed cross-sectional data from a study of 5147 fifth-grade students and their parents from public schools in 3 US metropolitan areas. We used multivariate logistic regression (overall and stratified by race/ethnicity) to examine the associations of sociodemographic factors and mental health problems with perceived racial/ethnic discrimination. *Results:* Fifteen percent of children reported perceived racial/ethnic discrimination, with 80% reporting that discrimination occurred at school. A greater percentage of Black (20%), Hispanic (15%), and other (16%) children reported perceived racial/ethnic discrimination compared with White (7%) children. Children who reported perceived racial/ethnic discrimination were more likely to have symptoms of each of the 4 mental health conditions included in the analysis: depression, attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder. An association between perceived racial/ethnic discrimination and depressive symptoms was found for Black, Hispanic, and other children but not for White children. *Conclusions:* Perceived racial/ethnic discrimination is not an uncommon experience among fifth-grade students and may be associated with a variety of mental health disorders.”]

This journal is available for loan or hard copy and may be requested from the California State Library.

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DEPRESSION

“The Effect of Major Depression on Participation in Preventive Health Care Activities.” By Scott B. Patten, Department of Community Health Sciences, University of Calgary, Calgary, Canada, and others. IN: *BMC Public Health*, vol. 9 (March 25, 2009) 7 p.

[“*Background:* The objective of this study was to determine whether major depressive episodes (MDE) contribute to a lower rate of participation in three prevention activities:

blood pressure checks, mammograms and Pap tests. *Methods:* The data source for this study was the Canadian National Population Health Survey (NPHS), a longitudinal study that started in 1994 and has subsequently re-interviewed its participants every two years. The NPHS included a short form version of the Composite International Diagnostic Interview (CIDI-SF) to assess past year MDE and also collected data on participation in preventive activities. Initially, we examined whether respondents with MDE in a particular year were less likely to participate in screening during that same year. In order to assess whether MDE negatively altered the pattern of participation, those successfully screened at the baseline interview in 1994 were identified and divided into cohorts depending on their MDE status. Proportional hazard models were used to quantify the effect of MDE on subsequent participation in screening.

Results: No effect of MDE on participation in the three preventive activities was identified either in the cross-sectional or longitudinal analysis. Adjustment for a set of relevant covariates did not alter this result. *Conclusion:* Whereas MDE might be expected to reduce the frequency of participation in screening activities, no evidence for this was found in the current analysis. Since people with MDE may contact the health system more frequently, this may offset any tendency of the illness itself to reduce participation in screening.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-2458-9-87.pdf>

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Maternal Depression: Making a Difference through Community Action: A Planning Guide. Prepared by Mental Health America. Prepared for the Center for Mental Health Services. (Mental Health America, Alexandria, Virginia) December 2008. 52 p.

[“The *Guide* aims to: build awareness and acceptance of the need for a family-focused, community-driven approach; strengthen the capacity of communities to mobilize around a significant public health issue; promote the use of state, local and even neighborhood partners; and spur strategic thinking that leads to effective community action and change. The *Guide* offers community organizations and other stakeholder groups an easy-to-use, practical framework to create a well-thought-out plan of action that is customized to their communities. It provides: an in-depth look at the issue of maternal depression; examples of outreach programs and practices; an easy-to-follow roadmap for action; and tools and resources to use in all stages of the planning process. The *Guide* is intended for Mental Health America affiliates in the field and organizations like them who are mobilizing their communities to address critical public health and mental health issues.”]

Full text at: <http://www.nmha.org/go/maternal-depression>

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EMPLOYMENT

“Employment among Persons with Past and Current Mood and Anxiety Disorders in the Israel National Health Survey.” By Daphna Levinson, Ministry of Health,

Jerusalem, Israel, and Yaacov Lerner, Jerusalem Mental Health Center. IN: Psychiatric Services, vol. 60, no. 5 (May 2009) pp. 655-662.

[“*Objective:* The study examined associations between having a past or current mood or anxiety disorder and being employed in the past month and salary level. *Methods:* The Israel National Health Survey used data from the National Population Register to compile a representative sample of noninstitutionalized residents aged 21 and older. Data for this study were from 4,859 persons interviewed in their homes between May 2003 and April 2004. Lifetime, past-year, and past-month *DSM-IV* mood and anxiety disorders were assessed with a revised version of the Composite International Diagnostic Interview. Respondents self-reported employment and salary information. Logistic regression was used to estimate associations. *Results:* The employment rate was lowest—35%—among respondents with a past-month mood or anxiety disorder, compared with rates of 52% among those with a past-year disorder, 60% among those with a lifetime disorder who did not have a disorder in the past year, and 58% among those with no disorder. No significant differences in rates of employment were found between those who had never had a disorder and those who had a lifetime or past-year disorder. Age at onset of the disorder was related to earning above the average salary for the population of Israel: those with onset before age 25 had lower odds of being in the above-average group. *Conclusions:* The results indicate that employment was affected only during the acute phase of a disorder and that early onset had lasting effects in terms of job level and salary.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/5/655>

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FOSTER YOUTH

Helping Former Foster Youth Graduate from College: Campus Support Programs in California and Washington State. By Amy Dworsky and Alfred Perez, Chapin Hall at the University of Chicago. (Chapin Hall, Chicago, Illinois) 2009. 77 p.

[Campus support programs provide financial, academic, and other types of supports to help former foster youth succeed in college. However, relatively little is known about the impact of these programs on college retention or graduation rates. This study lays the groundwork for an impact evaluation by examining program implementation from two different perspectives. Researchers conducted telephone interviews with the directors of 10 campus support programs in California and Washington State. The interviews covered a variety of domains, including the population served, referral sources and recruitment, the application process, the provision of services and supports, program staff, relationships with stakeholders, and data collection. In addition, participants from 8 of the 10 programs completed a web-based survey that asked about their perceptions of and experiences with the program. The survey included questions about students’ demographic characteristics, referral and recruitment, the application process, reasons for participating in the program, services and supports received, unmet needs, contact with staff, and recommendations for improvement. The report concludes with several

recommendations for moving forward with a methodologically sound impact evaluation of campus support programs for former foster youth.”]

Full text at: http://www.chapinhall.org/article_abstract.aspx?ar=1483&L2=60&L3=125
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HOUSING

“Does One Size Fit All? What we Can and Can’t Learn from a Meta-analysis of Housing Models for Persons with Mental Illness.” By H. Stephen Leff, Human Services Research Institute, Cambridge, Massachusetts, and others. *IN: Psychiatric Services*, vol. 60, no. 4 (April 2009) pp. 473-482.

[“*Objective:* Numerous studies have evaluated the impacts of community housing models on outcomes of persons with severe mental illness. The authors conducted a meta-analysis of 44 unique housing alternatives described in 30 studies, which they categorized as residential care and treatment, residential continuum, permanent supported housing, and nonmodel housing. Outcomes examined included housing stability, symptoms, hospitalization, and satisfaction. *Methods:* Outcome scores were converted to effect size measures appropriate to the data. Effect sizes were combined to estimate random effects for housing models, which were then compared. *Results* All models achieved significantly greater housing stability than nonmodel housing. This effect was greatest for permanent supported housing (effect size=.63, $p<.05$). No differences between housing models were significant. For reduction of psychiatric symptoms, only residential care and treatment differed from nonmodel housing (effect size=.65, $p<.05$). For hospitalization reduction, both residential care and treatment and permanent supported housing differed from nonmodel housing ($p<.05$). Permanent supported housing achieved the highest effect size (.73) for satisfaction and differed from nonmodel housing and residential care and treatment ($p<.001$ and $p<.05$, respectively). *Conclusions:* The meta-analysis provides quantitative evidence that compared with nonmodel housing, housing models contribute to stable housing and other favorable outcomes. The findings also support the theory that different housing models achieve different outcomes for different subgroups. Data were not sufficient to fully answer questions designed to enable program planners and providers to better meet consumers’ needs. It is important to answer these questions with research that uses common measures and adheres to scientific conventions.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/4/473>
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Supportive Housing: The Most Effective and Integrated Housing for People with Mental Disabilities. By the Bazelon Center for Mental Health Law. (The Center, Washington DC) March 2009. 7p.

[“People with mental disabilities can successfully live in the community like everyone else, as envisioned by the Americans with Disabilities Act. Supportive housing makes this possible. Supportive housing gives them their own apartment

or home while making available a wide variety of services to support recovery, engagement in community life and successful tenancy.

A growing body of evidence confirms that supportive housing works for people with mental disabilities, including those with the most severe impairments. Indeed, these individuals may benefit the most from supportive housing. Supportive housing gets much higher marks than less integrated alternatives; research confirms that people with disabilities vastly prefer living in their own apartment or home instead of in group homes or buildings housing primarily people with disabilities. Moreover, supportive housing is less costly than other forms of government-financed housing for people with disabilities. Studies have shown that it leads to more housing stability, improvement in mental health symptoms, reduced hospitalization and increased satisfaction with quality of life, including for participants with significant impairments, when compared to other types of housing for people with mental disabilities. Supportive housing has been endorsed by the federal government, including the U.S. Department of Housing and Urban Development, the Surgeon General, the U.S. Department of Health and Human Services, and the National Council on Disability.”]

Full text at: http://www.bazelon.org/pdf/Supportive_Housing3-09.pdf

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POLICIES

The Five Most Costly Children’s Conditions, 2006: Estimates for the U.S. Civilian Noninstitutionalized Children, Ages 0–17. By Anita Soni, Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. Statistical Brief. No. 242. (The Agency, Rockville, Maryland) April 2009. 5 p.

[“In 2006, a total of \$98.8 billion was spent for care and treatment of children. The top five conditions in terms of health care expenditures are: mental disorders, asthma, trauma-related disorders, acute bronchitis, and infectious diseases.

The highest expenditures were for care and treatment of mental disorders. Total expenditures to treat mental disorders were \$8.9 billion. This was followed by expenditures for treating asthma, \$8.0 billion and trauma-related disorders at \$6.1 billion. In addition, \$3.1 billion was spent on the treatment of acute bronchitis and \$2.9 billion on the treatment of infectious diseases in children (figure 1).

In terms of number of children who were treated for any of these five conditions, asthma was highest. Almost 13 million children were reported to have been treated for asthma in 2006; 12.8 million children for acute bronchitis and almost 7 million children were treated for trauma-related disorders. The number of children treated for mental disorders and infectious diseases totaled 4.6 million and 4.5 million, respectively (figure 2).

In terms of mean expenditures per child with expenses, the mean expenditures were highest for mental disorders (\$1,931). Trauma-related disorders averaged \$910 per child. An average of \$658 per child was spent on treatment of infectious diseases, followed by asthma at \$621 per child. Of these five conditions, acute bronchitis had the lowest per child mean expenditures at \$242.

Medicaid paid for more than one-third of the expenditures for mental disorders (35.2 percent) and asthma (34.1 percent). The largest percentage of expenditures for all of the top five most costly conditions for children was paid by private insurance. Private insurance had the highest payments for trauma-related disorders (59.8 percent) and infectious diseases (59.4 percent). Out-of-pocket payments were highest for mental disorders at 21.3 percent, asthma and acute bronchitis at 20.2 and 19.1, respectively.”]

Full text at:

http://www.meps.ahrq.gov/mepsweb/data_files/publications/st242/stat242.pdf

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“Focus on Transformation: A Public Health Model of Mental Health for the 21st Century.” By A. Kathryn Power, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. IN: *Psychiatric Services*, vol. 60, no. 5 (May 2009) pp. 580-584.

[“In 2003 the President's New Freedom Commission called for the transformation of the public mental health system to one that is person centered, recovery focused, evidence based, and quality driven. In this column the director of the Center for Mental Health Services describes progress made by the center over the past five years as well as challenges and opportunities. She presents a strategic forecast, based on stakeholder input, to guide policy formulation and resource allocation. Central to the forecast is the concept of a public health model of mental health that takes a community approach to prevention, treatment, and promotion of well-being.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/5/580>

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“Medicaid Prescription Drug Policies and Medication Access and Continuity: Findings from Ten States.” By Joyce C. West, American Psychiatric Institute for Research and Education Psychiatric Practice Research Network, Arlington, Virginia, and others. IN: *Psychiatric Services*, vol. 60, no. 5 (May 2009) pp. 601-610.

[“Medications are among the first-line, evidence-based treatments for most mental illnesses. Although prescription drugs are an increasingly costly component of state Medicaid budgets, current state prescription drug utilization management strategies are associated with significant adverse clinical consequences for this population. Medication disruptions or switches that are not clinically indicated have been shown in this and other studies to be associated with significant adverse effects for psychiatric patients. It is therefore of concern that reported rates of these problems varied widely across the states we studied, even after we adjusted for patient case mix. These patterns of associations suggest that state prescription drug policies may have a major impact on outcomes for beneficiaries with mental illness and highlight the need for more effective prescription drug management strategies and policies to promote medication continuity and more cost-effective treatment. Clinical and fiscal accountability and transparency are critical in pharmacy benefit management, especially with the limited evidence base for current utilization management strategies. Further data development and sharing are vital in

establishing an evidence base to inform these formulary management approaches. Medicaid prescription drug utilization management policies based primarily on cost rather than on clinical considerations may ultimately result in significant human, economic, and social costs.”]

Full text at: <http://ps.psychiatryonline.org/cgi/reprint/60/5/601>

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Mental Health Care: Better, Not Best. [Issue Theme] Health Affairs, Vol. 28, No. 3 (May/June 2009) pp. 635-929.

[“Mental illness and its treatment are largely invisible. We use multiple publicly available data sources to evaluate changes in the well-being of Americans with mental illnesses over the past decade. We find that access to care, including specialty psychiatric and inpatient care, and financial protection have improved. However, not all people with mental health problems have shared in these improvements. Access to care among those with mental health impairments appears to have declined, and we estimate that because of continued increases in incarceration, at least 7 percent of the population with serious and persistent mental illnesses are incarcerated in jail or prison each year.”]

For this issue’s Table of Contents: <http://content.healthaffairs.org/current.shtml>

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“State Mental Health Policy: Mending Missouri's Safety Net: Transforming Systems of Care by Integrating Primary and Behavioral Health Care.” By Dorn Schuffman, Missouri Behavioral Health/Primary Care Integration Initiative, and others. IN: Psychiatric Services, vol. 60, no. 5 (May 2009) pp. 585-588.

[“Missouri has begun a three-year pilot program across the state to integrate the primary care services provided by federally qualified health centers (FQHCs) and the behavioral health services provided by community mental health centers (CMHCs.) This column describes the integration initiative, in which start-up funds were provided in 2008 to seven FQHC-CMHC partnerships (a total of \$700,000 to each pair over 3.5 years). It reviews lessons learned during the first year of the project in bringing these two very different public systems of care together to mend the public health safety net.”]

Full text at: <http://psychservices.psychiatryonline.org/cgi/reprint/60/5/585>

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STIGMA

“A Study of Stigmatized Attitudes towards People with Mental Health Problems among Health Professionals.” By H. Rao, Mile End Hospital, London, and others.

IN: Journal of Psychiatric & Mental Health Nursing, vol. 16, no. 3 (April 2009) pp. 279-284.

[“The project aimed to assess stigmatized attitudes among health professionals directed towards patients with mental health problems. The Attitude to Mental Illness Questionnaire was used to assess participants' attitudes towards fictitious patients from a secure forensic hospital and patients with schizophrenia and substance use disorders. Participants were health professionals from acute and mental health settings. In total, 108 completed questionnaires were received. Participants had highly stigmatized attitudes towards patients from a forensic hospital and those with active substance use disorders. Attitudes were less stigmatized to people with substance use disorders who were recovering in remission. This suggested that health professionals have stigmatized attitudes towards an illness such as schizophrenia and this is worse towards patients from a secure hospital. The manner in which patients with substance use disorder are presented can have a significant effect on stigmatized attitudes by health professionals.”]

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SUBSTANCE ABUSE

The NSDUH (National Survey on Drug Use and Health) Report: Children Living with Substance-dependent or Substance-abusing Parents: 2002 to 2007. By the Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (The Office, Rockville, Maryland) April 16, 2009. 4 p.

[“Almost 12 percent of children under the age of 18 years of age live with at least one parent who was dependent on or abused alcohol or an illicit drug during the past year, according to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA). The report is based on national data from 2002 to 2007.

...Among the findings:

Almost 7.3 million children lived with a parent who was dependent on or abused alcohol

About 2.1 million children lived with a parent who was dependent on or abused illicit drugs

5.4 million children lived with a father who met the criteria for past year substance dependence or abuse, and 3.4 million lived with a mother who met this criteria.

Findings for Children Living with Substance-Dependent or Substance-Abusing Parents: 2002 to 2007 are drawn from the National Survey on Drug Use and Health, an annual nationwide survey of persons aged 12 and older. This report focused on questions asked of 87,656 parents aged 18 and older about their substance dependence and abuse.”]

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

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SUICIDE PREVENTION

Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP.) By Peter W. Chiarelli, Vice Chief of Staff, U.S. Department of the Army. (The Department, Washington, DC) April 16, 2009. 32 p.

[“In calendar year 2008, the Army's confirmed suicide rate reached an all-time high of 20.2 per 100,000, a measure of tragedy and loss to our Army and Nation that we will simply not allow to continue. The intent of this campaign plan is to take a strategic approach to mitigating suicides and high-risk behavior across the Army. The Army will employ every available resource and every member of the Army team, towards promoting overall soldier and family health. This campaign plan will emphasize the physical, mental, and spiritual aspects of health to achieve an immediate and lasting impact. This comprehensive approach is the optimal means of reversing the increasing occurrence of suicide among our soldiers. Simply put, this campaign plan will operationalize my intent to do everything in our power to reduce the occurrence of suicides in our Army.”]

Full text at:

<http://www.armyg1.army.mil/hr/suicide/docs/Complete%20Signed%20Campaign%20Plan%20and%20Annexes.pdf>

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“A Comparative Review of U.S. Military and Civilian Suicide Behavior: Implications for OEF/OIF Suicide Prevention Efforts.” By Jeffrey Martin, Uniformed Services University of the Health Sciences. IN: *Journal of Mental Health Counseling*, vol. 31, no. 2 (April 2009) pp. 101-118.

[“Suicide is a significant public health concern within the United States military. Suicide may occur before, during, and after military deployment or service for a multitude of reasons that may or may not be directly related to deployment. Therefore, it is crucial that mental health counselors are trained to identify risk at an early stage so they can offer evidence-based practices to manage and reduce it. Enhanced understanding of the similarities and differences in suicide risk and protective factors for civilian and military individuals is crucial for counselors who work directly with Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) active-duty personnel, veterans, and family members. This review aims to educate counselors about the role of demographic, life event, psychopathology, and behavioral and psychological variables in exacerbating or alleviating the desire to die. The information presented is based on an electronic search of medical and psychological databases for terms related to suicide by military service members. Recommendations related to identification, prevention, and management of suicide risk in OEF/OIF service members and beneficiaries are presented.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=38313507&site=ehost-live>

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NEW CONVENTIONS

Mental Health America's Centennial Conference. Celebrating the Legacy: Forging the Future.

Washington DC – June 10-13, 2009

For more information and registration:

<http://www.mentalhealthamerica.net/go/conference>

Building on Family Strengths Conference. Research and Training Center on Family Support and Children's Mental Health, & Regional Research Institute for Human Services, School of Social Work, Portland State University. Putting Youth and Families First.

Portland, Oregon – June 23-25, 2009

For more information and registration: <http://www.rtc.pdx.edu/conference/2009/pdf-09/brochure2009.pdf>

NAMI California Annual Conference 2009: "Destination: Recovery!"

Torrance, California – August 21 & 22, 2009

For more information and registration:

http://www.namicalifornia.org/webbdata/HOMEPAGE-DTD-2009-00/NAMI%20California%20Conference%202009/registration%20form%202009_eng.pdf

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