

Subject: Studies in the News: (July 21, 2009)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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ATTITUDES

Attitudes to Mental Illness 2009 Research Report. By Gillian Prior, TNS UK for the Care Services Improvement Partnership, Department of Health. Prepared for Care Services Improvement Partnership. (The Department, London, England) May 2009. 61 p.

[“The latest national statistics on Attitudes to Mental Illness produced by the Department of Health were released on 12 June 2009 according to the arrangements approved by the UK Statistics Authority.

Since March 1993, the Department of Health has placed a set of questions on TNS’s Face-to-Face Consumer Omnibus about public attitudes towards mental illness. From 1993 to 1997 the questions were asked on an annual basis and then every third year up until 2003.

Since 2007 the survey has again been carried out annually. The surveys serve as a benchmark, enabling measurement of whether attitudes are improving or worsening over time. The questionnaire included a number of statements about mental illness.

Respondents were asked to indicate how much they agreed or disagreed with each statement.

Key points from the report:

- People are broadly sympathetic towards people with a mental illness.
- However, some attitudes towards people with mental illness are worse compared to when the Department of Health first commissioned the poll in 1994 whilst others have improved. Several attitudes that had worsened over the period up until 1997 have since improved.
- Attitudes to a number of statements have changed significantly since 2008
 - Opinions on some statements changed towards greater tolerance
 - Opinions moved more in favor of integrating people with mental illness into the community
 - Opinions on the causes of mental illness and the need for special services became less favorable
 - Opinions on people with mental illness having the same rights to a job as everyone else became more favorable.”]

Full text at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_100345

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BULLYING

Cyberbullying Legislation: Why Education is Preferable to Regulation. By Berin Szoka and Adam Thierer, The Progress and Freedom Foundation. Progress on Point. Vol. 16 No. 12 (The Foundation, Washington DC) June 2009. 26 p.

[“If Congress wishes to address cyberbullying through federal legislation, it should focus on education-based approaches instead of criminalization, argue Berin Szoka and Adam

Thierer. Criminalizing what is mostly minor-on-minor behavior will not likely solve the age-old problem of kids mistreating each other, a problem that has traditionally been dealt through counseling and rehabilitation at the local level.

In the paper, the authors applaud policymakers for focusing more on cyberbullying, a serious and rising online safety concern, instead of previous fears about online predation, which have been greatly overblown. But because criminalization could raise thorny free speech and due process concerns related to how the law defines harassing or intimidating speech, they argue that education and intervention strategies are generally preferable. By supporting Internet safety education in schools and communities, state and federal lawmakers could make a significant contribution to effectively reducing truly harmful behavior, especially over the long-haul. Such education and awareness-building would also be completely constitutional, meaning lawmakers could avoid the legal challenges that would follow other regulatory approaches.”]

Full text at: <http://www.pff.org/issues-pubs/pops/2009/pop16.12-cyberbullying-education-better-than-regulation.pdf>

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DEPRESSION

Interaction between the Serotonin Transporter Gene (*5-HTTLPR*), Stressful Life Events, and Risk of Depression: A Meta-analysis. By Neil Risch, U.C. San Francisco and Kaiser Permanente, Northern California, and others. IN: *Journal of the American Medical Association*, vol. 301, no. 23 (June 17, 2009) pp. 2462-2471.

[“Stressful life events are strongly associated with a person's risk for major depression, but a certain gene variation long thought to increase risk in conjunction with stressful life events actually may have no effect, according to researchers funded by the National Institute of Mental Health (NIMH), part of the National Institutes of Health. This study challenges a widely accepted approach to studying risk factors for depression....

Most mental disorders are thought to be caused by a combination of many genetic risk factors interacting with environmental triggers. However, finding the exact combinations continues to present significant challenges to research.

Advances in scientific understanding and technologies during the past decade have led to powerful tools for studying how genetic and environmental factors can affect a person's risk for disease. Such advances allowed mental health researchers in 2003 to show that a gene involved in serotonin activity increased the risk of major depression in people who had a number of stressful life events over a five-year period. Coming at a time of heightened research interest in these gene-environment interactions and the relative lack of progress in the field for mental disorders, this study received wide acclaim and had a far-reaching influence. Not only have considerable resources been invested in subsequent studies that built on this finding, but also some researchers have proposed marketing the gene test to the public, claiming to be able to predict a person's risk for depression.

However, efforts to replicate the 2003 study's findings—a key step in scientific progress that helps show whether a particular finding was a chance event—have had inconsistent results.

The authors concluded that incorporating environmental exposures in candidate gene studies (those that study a particular gene) may be as likely to yield false positive findings as the candidate gene studies themselves. Therefore, the results of other studies using the same approach as the 2003 study also deserve thorough review and meta-analysis.

‘Even though our re-analysis did not confirm an association between the serotonin gene and depression, the finding that the environmental factor was strongly associated with depression in several studies reminds us that environmental factors are also involved in the complex pathways leading to mental disorders. Future progress will require thoughtful integration of the tools of genetics, epidemiology, and clinical and behavioral sciences.’” NIMH Press Release (June 16, 2009)]

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FOSTER CARE

Mental Health Needs of Foster Children and Children at-risk for Removal. Edited by Joann Grayson. Virginia Child Protection Newsletter. Vol. 85. (James Madison University, Harrisonburg, Virginia) Spring 2009. 7 p.

[“This article will explore the range of mental health needs and ways to address those needs using evidence-based practices. It will discuss ways to work with the children as well as methods for parent and foster parent training. Evidence-based practice means the conscientious, explicit choice to allow the best available research to guide decision-making about the care of clients. Providers must be able to evaluate the quality of available research and then select methods that are proven to be the most effective in ameliorating the child’s difficulties. Clinicians then tailor those proven methods to fit unique social and cultural needs of each particular family....

Providing mental health services to children in foster care involves overcoming numerous challenges. The mental health system is taxed because of a shortage of child and adolescent mental health professionals. The shortage is complicated by systematic budget cuts and low insurance rates of reimbursement (Marshall, 2004)... Historically, the child welfare system has not measured the experiences and functioning of foster children, but has instead concentrated upon safety and upon permanency. Developmental outcomes or optimizing child functioning were not considered as measurable goals (Harden, 2004)....

Based upon the findings, the researchers made several recommendations about what agencies can do to improve outcomes for youth in foster care. First, given the number and severity of the mental health problems for foster youth, it is imperative to examine barriers to mental health treatment and remove them.... Second, it is vital to maintain placement stability....The third set of recommendations concern educational success. Treatment for mental health problems can increase the likelihood of success in the

classroom. School personnel can be educated about each foster child's challenges so they are prepared to individualize the learning environment as needed. Fourthly, at each stage of development, racial and ethnic identity formation is critical in helping children develop a positive sense of self and collective belonging.... Next, for youth 'aging out' of foster care, providing appropriate health and mental health care is a critical component of a successful transition to adulthood.... And, changes in attitude and approach are also necessary, according to Betsy Krebs of the Youth Advocacy Center in New York City. She believes that the current system of care includes a 'culture of low expectations for teens in foster care' and 'a lack of accountability for their success or failure.'"]

Full text at: <http://psychweb.cisat.jmu.edu/graysojh/volume%2085.pdf>

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HEALTH CARE REFORM

Statement of David L. Shern, Mental Health America, before the Energy and Commerce Committee, Health Subcommittee, Hearing on Health Care Reform. (Mental Health America, Alexandria, Virginia) June 23, 2009. 7 p.

["People with mental health and substance use conditions have traditionally not been well served by our current health care system. The President's New Freedom Commission on Mental Health proclaimed in 2002 that mental health care in this country is in shambles. We could not agree more, although there are isolated examples of excellent care. And, scientific advances over the last half century have led to reliable diagnosis and a range of treatments for these conditions with effectiveness rates comparable to or exceeding those of treatments for many other health conditions.

Tragically, despite such significant advances in our understanding of how to effectively treat behavioral health conditions, people with serious mental illnesses who are treated in our public systems die on average 25 years earlier than the general population due primarily to other co-occurring health disorders including diabetes, heart disease, cancer, and asthma.² Behavioral health consumers have some of the greatest unmet needs for improved care coordination and prevention services.

Mental health and addiction treatment have historically been subject to blatantly discriminatory limits on coverage through private insurance plans that block access to effective and critically needed therapies. And more insidious but no less devastating has been the more aggressive management of care for these conditions than for other health conditions through utilization management and other treatment limitation techniques. A recent report found that about two-thirds of primary care physicians could not get outpatient mental health services for their patients – a rate that was at least twice as high as that for other services – due in part to health plan barriers and inadequate coverage... We are very pleased to see that the principle of non-discrimination and parity for behavioral health services would be maintained in the new Health Insurance Exchange and health care coverage provisions proposed in the Tri-Committee bill. In light of the long history of discrimination against individuals with behavioral health conditions, we also strongly support the insurance market reforms in the bill that would establish a guaranteed issue requirement and prohibit pre-existing condition exclusions and premium

rating based on health status as well as annual and lifetime limits on benefits. In addition, we appreciate the provision to repeal the discriminatory 190-day lifetime limit on psychiatric hospital inpatient care under Medicare...

In light of the high degree of mental health needs among the uninsured population, we commend the efforts of so many in Congress and the Administration to expand health care coverage to all. And, we strongly support the provision requiring outreach to vulnerable populations to inform them about the Exchange, including individuals with mental health conditions. As we have learned through implementation of the Medicare Part D program, additional efforts will be needed to ensure that those with serious mental health conditions are aware of the program and can successfully enroll. Mental health providers and other organizations that regularly interact with individuals with behavioral health conditions can provide valuable assistance in educating these individuals about the new coverage program and helping them navigate it.”]

Full text at: http://www.mentalhealthamerica.net/files/testimony_shern%5b1%5d.pdf

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LAW AND POLICY

Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice. By Melissa Reuland and others, Council of State Governments Justice Center. (The Center, New York, New York) 2009. 36 p.

[“The current body of research provides a window into how specialized law enforcement responses to people with mental illnesses can contribute to greater safety for all those involved in encounters and provide better long-term results. Though study design issues—such as sampling, methodology, and reporting errors— require cautious interpretation of the results, the findings can begin to inform defensible policy and practice.

Circumstances do not always allow time for policymakers to thoroughly investigate a problem in their community before responding; tragic incidents can require quick decisions. This guide can help ready policymakers for a quick, responsible response and assist them in communicating the research-based benefits of instituting a specialized law enforcement response to people with mental illnesses. It can also justify the investment of resources in determining the scope of the problem in a particular jurisdiction. Once the decision to explore a specialized response is reached, the additional resources described in this guide can help jurisdictions understand the essential elements and particular considerations for any successful initiative. Although there is still much more information needed to guide decision-making, researchers and practitioners who have contributed to the current body of knowledge have put us on track to create collaborative law enforcement strategies that are based on the best thinking and evidence available. With the proper leadership at all levels of government, that work can be continued and carried out in jurisdictions across the United States.”]

Full text at: http://www.ojp.usdoj.gov/BJA/pdf/CSG_le-research.pdf

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Mental Health Courts: A Primer for Policymakers and Practitioners. By the Council of State Governments Justice Center. Prepared for the U.S. Department of Justice. (The Council, New York, New York) 2008. 34 p.

[“An overview of mental health courts is provided. Sections of this report include: the need for mental health courts; what a mental health court is; the types of individuals who participate in mental health courts; what a mental health court looks like; what the goals of mental health courts are; how mental health courts are different from drug courts; mental health courts for juveniles; what the research says about mental health courts; what issues should be considered when planning or designing a mental health court; and what resources communities can get to help them develop mental health courts.”]

Full text at: <http://consensusproject.org/mhcp/mhc-primer.pdf>

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State Mental Health Agency (SMHA), Mental Health Services Expenditures, FY2006. By National Association of State Mental Health Program Directors Research Institute. (The Institute, Alexandria, Virginia) 2009. 1 p.

[“The latest information from the National Association of State Mental Health Program Directors Research Institute, Inc (NRI) on mental health services expenditures and mental health services expenditures per capita has been added for all states and the nation for fiscal year (FY) 2006.”]

Full text at: <http://www.statehealthfacts.org/comparemactable.jsp?ind=277&cat=5>

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Still Waiting...The Unfulfilled Promise of Olmstead. By the Bazelon Center for Mental Health Law. (The Center, Washington DC) June 24, 2009. 25 p.

[“The Bazelon Center for Mental Health Law issues this call to action to inform advocates, policymakers and the public about the vital role the Supreme Court’s landmark decision plays in enabling people with mental illnesses to benefit from community life. The *Olmstead* decision is now 10 years old. On its fifth anniversary, the Bazelon Center issued the following statement:

‘While many Americans with disabilities have made progress since the *Olmstead* ruling, people with mental illnesses have been largely left behind in efforts to implement the decision. Most states are enacting *Olmstead* reforms at a snail’s pace, defying the spirit of the ruling and preventing Americans with mental illnesses from participating in their communities.

...Budget pressures have closed psychiatric hospitals across the country, but few appropriate community services have been adequately funded to help people with mental illnesses live successfully in the community. Instead, states have ‘transinstitutionalized’

people with mental illnesses to settings as outmoded, isolating and inappropriate as the facilities they were meant to replace.

...Where real progress has occurred, it is largely because states have been sued. Five years after *Olmstead* and 14 years after enactment of the Americans with Disabilities Act, litigation should be unnecessary. Yet it remains the single most effective way to combat the persistent segregation of people with mental illnesses. It's past time for *Olmstead* implementation to move out of the courtroom and into America's communities.'

Five more years have gone by. Too many people with mental illnesses remain segregated in board-and-care homes, nursing facilities and other institutional placements, at high cost to strapped state mental health systems, even though supportive community living is cost-effective—and the right thing to do.”]

Full text at: http://www.bazelon.org/pdf/Olmstead_Call-to-Action.pdf

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OLDER ADULTS

Social Support, Networks, and Happiness. By Meghan Cagley and Marlene Lee, Population Reference Bureau. **Today's Research on Aging: Program and Policy Implications. No. 17.** (The Bureau, Washington DC) June 2009. 6 p.

[“As Americans live longer, researchers have begun to investigate how people can move into old age not just healthier, but also happier. Increasingly, researchers are exploring relationships between physical and mental health and social connections among the elderly. The Behavioral and Social Research Program at the National Institute on Aging (NIA) supports research on the relationships between aging and social connections. This newsletter reviews recent NIA-sponsored and other research that explores these relationships, especially research on the ways social networks affect health and happiness and influence longevity.”]

Full text at: <http://www.prb.org/pdf09/TodaysResearchAging17.pdf>

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PREVENTION

“Staying Sane May be Easier than you Think: How not to get Sick.” By John Cloud. **IN: Time Magazine (June 22, 2009) pp. 21-37.**

[“We tend to view the brain like an alien that happens to reside in the skull. We see it as unpredictable, ungovernable in ways that other organs aren't. Proper diet, exercise, no smoking — these will help prevent heart and lung disease. But diseases of the mind? They strike at will, right? You just can't keep yourself from going crazy. And yet — what if you can? The most exciting research in mental health today involves not how to treat mental illness but how to prevent it in the first place. Hundreds of studies that have appeared in just the past decade collectively suggest that the brain isn't so different from, say, the arm: it doesn't simply break on its own. In fact, many mental illnesses — even

those like schizophrenia that have demonstrable genetic origins — can be stopped or at least contained before they start.

This isn't wishful thinking but hard science. Earlier this year, the National Academies — an organization of experts who investigate science for the Federal Government — released a 500-page report, nearly two years in the making, on how to prevent mental, emotional and behavioral disorders. The report concludes that pre-empting such disorders requires two kinds of interventions: first, because genes play so important a role in mental illness, we need to ensure that close relatives (particularly children) of those with mental disorders have access to rigorous screening programs. Second, we must offer treatment to people who have already shown symptoms of illness (say, a tendency to brood and see the world without optimism) but don't meet the diagnostic criteria for a full-scale mental illness (in this case, depression).

Neither approach is without controversy. Early-detection programs will identify as candidates for mental illness some people who are merely persnickety or shy or eccentric. Some prevention programs even prescribe psychiatric medications, including antipsychotics and antidepressants, to people who aren't technically psychotic or depressed. 'This is a big concern,' says Joseph Rogers, founder of the Philadelphia-based National Mental Health Consumers' Self-Help Clearinghouse. 'Because, gee, if you miss, you can really do more harm with some of these drugs than good.'”]

Full text at:

http://www.time.com/time/specials/packages/article/0,28804,1903873_1903871_1903857,00.html

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Suicide Prevention Toolkit for Rural Primary Care: A Primer for Primary Care Providers. By Tamara Dehay and others. (Western Interstate Commission on Higher Education (WICHE,) Boulder, Colorado) 2009. Various pagings.

[“Primary care providers can implement some of the most effective strategies for suicide prevention. These include training staff to identify and respond to warning signs of suicide, training providers to recognize and effectively treat depression, and taking measures to limit access to lethal means. Ideally, a primary clinic would plan a comprehensive suicide prevention approach that includes all the strategies in the box below. We will discuss the strategies in five sections: staff training, screening and management of depression, screening for suicide risk, patient education and restricting means for lethal self-harm. Assessing and managing patients at risk for suicide are discussed in Modules 4 and 5 of this Primer.”]

Full text at: <http://www.sprc.org/pctoolkit/index.asp>

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STIGMA

“Children’s Beliefs about Causes of Childhood Depression and ADHD: A Study of Stigmatization.” By Daniel Coleman, Portland State University, and others. IN: *Psychiatric Services*, vol. 60, no. 7 (July 2009) pp. 950-957.

[“*Objective:* Children's causal attributions about childhood mental health problems were examined in a national sample for prevalence; relative stigmatization; variation by age, race and ethnicity, and gender; and self-report of a diagnosis of depression or attention-deficit hyperactivity disorder (ADHD). *Methods:* A national sample of 1,091 children were randomly assigned to read vignettes about a peer with depression, ADHD, or asthma and respond to an online survey. Causal attributions and social distance were assessed, and correlations were examined. Logistic regression models for each causal item tested main effects and interaction terms for conditions, demographic characteristics, and self-reported diagnosis. *Results:* The beliefs that parenting, substance abuse, and low effort caused the condition were all strongly intercorrelated and were moderately correlated with social distance. The depression condition was the strongest predictor of endorsement of the most stigmatizing causal beliefs. Stigmatizing causal beliefs were evident for ADHD, but with more modest effects. Children who reported a diagnosis were more likely to endorse parenting and substance abuse as causes (attenuated for ADHD). Modest to moderate effects were found for variation in causal beliefs across ethnic groups. *CONCLUSIONS:* This study demonstrated a consistent presence of stigmatization in children's beliefs about the causes of childhood mental health problems. Low effort, parenting, and substance abuse together tapped a moralistic and blaming view of mental health problems. The results reinforce the need to address stigmatization of mental disorders and the relative stigmatization of different causal beliefs. The findings of variation by ethnicity and diagnosis can inform and target anti-stigmatization efforts.”]

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“Relationships between Stigma, Depression, and Treatment in White and African American Primary Care Patients.” By Rena Menke, Wayne State University, and Heather Flynn, University of Michigan. IN: *The Journal of Nervous and Mental Disease*, vol. 197, no. 6 (June 2009) pp. 407-411.

[“Although many depressed patients are treated in primary care, depression in these settings has been underdetected and undertreated, which may be influenced by mental health beliefs such as stigma. This study examined the relationships among depression, mental health stigma, and treatment in African American and white primary care patients. Data were collected at 3 primary care settings from 1103 patients who completed surveys measuring depression, stigma, and treatment use. Overall, African American women reported greater stigma than white women. White patients were found to be more likely to use depression treatment than African American patients. Multivariate analyses showed that greater depression severity fully mediated the relationship between stigma

and treatment use, and that patients with the highest depression scores had significantly higher stigma scores as well. These results suggest that greater severity of depressive symptoms may override stigma and other beliefs about mental health in determining treatment use, but may be important to address for patients with more moderate levels of symptomatology.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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WORKFORCE DEVELOPMENT

“A National Action Plan for Workforce Development in Behavioral Health.” By Michael A. Hoge, Yale University School of Medicine, and others. IN: *Psychiatric Services*, vol. 60, no. 7 (July 2009) pp. 883-887.

[“Across all sectors of the behavioral health field there has been growing concern about a workforce crisis. Difficulties encompass the recruitment and retention of staff and the delivery of accessible and effective training in both initial, preservice training and continuing education settings. Concern about the crisis led to a multiphased, cross-sector collaboration known as the Annapolis Coalition on the Behavioral Health Workforce. With support from the Substance Abuse and Mental Health Services Administration, this public-private partnership crafted *An Action Plan for Behavioral Health Workforce Development*. Created with input from a dozen expert panels, the action plan outlines seven core strategic goals that are relevant to all sectors of the behavioral health field: expand the role of consumers and their families in the workforce, expand the role of communities in promoting behavioral health and wellness, use systematic recruitment and retention strategies, improve training and education, foster leadership development, enhance infrastructure to support workforce development, and implement a national research and evaluation agenda. Detailed implementation tables identify the action steps for diverse groups and organizations to take in order to achieve these goals. The action plan serves as a call to action and is being used to guide workforce initiatives across the nation.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

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NEW CONFERENCES, MEETINGS and WEBINARS

Mental Health Services Oversight and Accountability Commission Meeting

July 23, 2009
Sacramento, California

For more information:

http://www.dmh.ca.gov/MHSOAC/docs/Meetings/2009/July/Agenda_July_2009.pdf

Webinar - Current Federal and State Legislation in Suicide Prevention: Presented by SPAN USA, a division of AFSP, and SPRC

July 27, 2009
3:30-4:30 Eastern Standard Time

To sign up:
http://www.surveymonkey.com/s.aspx?sm=dO4_2fEKreQ2eKb1_2buzeiEOw_3d_3d
For more information: contact Elly Stout at estout@edc.org

Webinar - Screening for Mental Health: *“Guide to Getting Through Tough Economic Times”*

July 30, 2009
1 – 2 pm Eastern Standard Time

For more information and registration email: NDSD@MentalHealthScreening.org

2009 Indian Health Service National Behavioral Health Conference: *“Honoring Our Traditions, While Embracing Change”*

August 4–7, 2009
St. Paul, Minnesota

For more information and registration: info@bhconference.com or call Barbara Gongyin at 509-789-2675

World Congress of the World Federation for Mental Health: *“Working Together for Mental Health”*, reflects the call to action to “Make Mental Health a Global Priority”

September 2-9, 2009
Athens, Greece

For further information and registration: <http://www.wmhc2009.com/static/index.html>
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