

Subject: Studies in the News: (August 18, 2009)



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California Department of Mental Health

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CHILDREN AND ADOLESCENTS

America's Invisible Children: Latino Youth and the Failure of Justice. By Neelum Arya, and others. Race and Ethnicity Series. Vol. 3. (Campaign for Youth Justice, Washington, DC) May 2009. 95 p.

[“This policy brief examines the most recent information available about Latino youth in the justice system, with a particular focus on youth tried as adults. The report examines the difference in treatment between Latino and white youth tried in the justice system for similar offenses. The policy recommendations included in this brief are action steps that policymakers can take to reduce racial and ethnic disparities of the justice system.”

National Center for Mental Health Promotion and Youth Violence Prevention.]

Full Text at: <http://library.promoteprevent.org/item.php?id=123096>

Evidence-based Social-emotional Curricula and Intervention Packages for Children 0-5 Years and their Families: Roadmap to Effective Intervention Practices. By Diane Powell and Glen Dunlap. (University of South Florida, Tampa, Florida) June 2009. 21 p.

[“This synthesis presents summary information on curricula and intervention packages designed to help young children ages birth to 5 years improve their social-emotional functioning. It includes evidence-based manualized curricula and programs for use with children, in classrooms or small groups, or with families/parents. It builds and expands on Joseph and Strain (2003), using efficacious adoption criteria ratings to reflect the state of the evidence supporting the effectiveness of each intervention package. It is meant to provide practical guidance to early childhood special education and early intervention personnel, early educators, families, and other professionals seeking interventions to promote healthy social emotional development in young children with and without disabilities or to intervene early with young children who may already be displaying problematic social emotional behaviors.

Social-emotional development in young children has become accepted as critical to school readiness and children's long term success in school and in life. Along with this recognition has come increased attention to ways of promoting healthy social-emotional development, preventing the development of social, emotional and behavior problems, and intervening early when young children are displaying challenging behavior or delays in social emotional development. Systems that serve young children and their families including health care, early childhood care and learning, early childhood special education, early intervention, mental health, and family services present opportunities to offer interventions that address these needs for children and their families. Manualized curricula and intervention packages that have been established through research studies to be effective in producing positive social emotional outcomes for children are resources that can be used by programs and agencies within these systems. This synthesis provides information that programs can use as guidance in selecting curricula or intervention packages that are most appropriate for their setting and best meet the needs of the children and families they serve.”]

Full text at: http://www.challengingbehavior.org/do/resources/documents/roadmap_2.pdf

“Identifying Trajectories of Adolescents’ Depressive Phenomena: An Examination of Early Risk Factors.” By James J. Mazza, University of Washington, and others. IN: *Journal of Youth and Adolescence*, published online April 5, 2009. 15 p.

[“Few studies have examined risk factors of childhood and early adolescent depressive symptomatology trajectories. This study examined self-report depressive symptomatology across a 6-year time period from 2nd to 8th grade to identify latent groups of individuals with similar patterns of depressive phenomena in a sample of 951 children (440 girls, 511 boys). Analyses, using semiparametric group modeling (SGM), identified 5 trajectory groups for girls and boys: low depressed stables, low depressed risers, mildly depressed stables, moderately depressed changers, and moderately depressed risers. Individual risk factors, with the exception of shy/withdrawn behavior, were significantly different across trajectory group membership for boys and girls, as was low-income status for boys. Boys in the low depressed and mildly depressed stable trajectory groups had significantly higher levels of antisocial behavior, attention problems, and lower social competency compared to girls in similar groups. These results suggest that universal prevention programs implemented in early elementary school that target selected risk factors may be helpful in reducing future adolescent mental health problems, specifically depressive symptomatology.”]

Full text at: <http://www.springerlink.com/content/k42xw757vk523647/fulltext.pdf>

Screening for Social Emotional Concerns: Considerations in the Selection of Instruments: Roadmap to Effective Intervention Practices. By Jasolyn Henderson and Phillip Strain. (University of South Florida, Tampa, Florida) January 2009. 18 p.

[“Access to high quality early childhood services is fundamental to the long-term success of our nation’s children and their families (NAEYC, 2000). For children, high quality early childhood services can increase the likelihood of academic success by improving cognitive, social, behavioral, language, and motor skills (e.g. NAEYC, 2000; NASP, 2002). For families, high quality early childhood services can provide the information and resources to help their children be successful in school. An overwhelming body of research indicates that the early years are very influential on later development (NAEYC, 2000; National Research Council, 1998, 2000, 2001; Shonkoff & Phillips, 2000). For some young children, the presence of challenging behavior is a major obstacle to their success in early childhood settings and even predictive of social and academic problems throughout school (Carter, Briggs-Gowan, & Davis, 2004). Although exhibiting some challenging behavior during early childhood is typical and varies greatly across environments, some children exhibit challenging behaviors that are more chronic and result in significant difficulties for the child, family, and learning environment. In these cases, it is important to have specialized early intervention services available to them and their families as soon as possible to help prevent long-term difficulties (Gorey, 2001). The initial step towards detection and amelioration of such problems and the prevention of more severe issues is to conduct screenings across developmental areas to help identify

those children and families that would benefit from early and targeted intervention strategies. Universal screening enables service providers and families to quickly identify difficulties and implement strategies that are likely to lessen the probability of long-term negative outcomes including severe persistent challenging behaviors. The practice of universal screening is in line with the prevention approach that is the foundation of the Pyramid Model framework of the Technical Assistance Center on Social Emotional Interventions (TACSEI) (www.challengingbehavior.org) and the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) (www.vanderbilt.edu/csefel) as well as that embraced by many schools (Levitt et al, 2007). In addition to implementing targeted strategies for those children identified as at-risk by screening, special attention should be given to the quality of the environment and relationships that the all children have with those around them (TACSEI, 2008; CSEFEL, 2008). All of these aspects are important to promoting social and emotional competence in young children. The purpose of this document is to provide a brief overview of the use of screening and to help administrators and teachers choose appropriate instruments for implementing a screening program.”]

Full text at: http://www.challengingbehavior.org/do/resources/documents/roadmap_1.pdf

Working Together to Help Youth Thrive in Schools and Communities. By Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (The Administration, Washington, DC) May 2009. 4 p.

[“An estimated 4.5 to 6.3 million children and youth in the United States face mental health challenges. About two thirds do not receive needed mental health services due to the high costs and limited availability of services in many communities. Families are challenged with obtaining services, and youth are left at risk for difficulties in school and/or the community.

The Comprehensive Community Mental Health Services for Children and Their Families Program, funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, addresses these challenges through the development of community-based systems of care that promote positive mental health outcomes for youth and their families. Families and youth work in partnership with public and private organizations to develop individualized service plans that are family driven, youth guided, and culturally and linguistically competent.³ Service plans also establish effective services and supports that are available in least restrictive settings and build on youth and family strengths. Systems of care help children, youth, and families thrive at home, in school, and in the community throughout life.

Gains made by youth in systems of care frequently translate to improvements in school performance. This short report describes school and clinical outcomes for youth aged 14–18 who received services in systems of care. Data from the national evaluation of the system of care program demonstrate how youth improve academically, behaviorally, and emotionally from entry into systems of care to 12 months after they begin receiving services.”]

Full text at: <http://www.samhsa.gov/children/docs/shortReport.pdf>

Youth Violence: National and State Statistics. By the Centers for Disease Control and Prevention. (The Centers, Atlanta, Georgia) July 15, 2009. 1 p.

[“*Monitoring trends in youth violence helps states develop prevention programs and policies that address risk and protective factors.* Violent injury and death disproportionately affect adolescents and young adults in the United States. It is the second leading cause of death for young people between the ages of 10 and 24.

In 2005, there were 5,686 homicides among young people age 10 to 24 —an average of 16 each day.

In 2006, over 720,000 violence-related injuries in young people age 10 to 24 were treated in U.S. emergency rooms.

CDC monitors and tracks trends in youth violence across the United States. Data help program planners make informed decisions about where to best allocate limited resources.

Youth violence is a serious problem that can have lasting harmful effects on victims and their family, friends, and communities. The goal for youth violence prevention is simple—to stop youth violence from happening in the first place. Prevention strategies should focus on promoting pro-social behavior, strengthening families, and creating communities in which youth are safe from violence.”]

Full text at: <http://www.cdc.gov/Features/dsYouthViolenceData/>

COSTS OF CARE

The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population. By Anita Soni. Medical Expenditure Panel Survey: Statistical Brief. No. 248. (Agency for Healthcare Research and Quality, Rockville, Maryland) July 2009. 5 p.

[“U.S. spending on mental illness is soaring at a faster pace than spending on any other health care category, new government data shows.

The cost of treating mental disorders rose sharply between 1996 and 2006, from \$35 billion (in 2006 dollars) to almost \$58 billion, according to the report from the Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services.

At the same time, the report showed, the number of Americans who sought treatment for depression, bipolar disorder and other mental health woes almost doubled, from 19 million to 36 million.

According to the report, spending on heart disease rose from \$72 billion in 1996 to \$78 billion in 2006; cancer care rose from \$47 billion to \$58 billion; asthma costs climbed from \$36 billion to \$51 billion, and expenditures for trauma-related care rose from \$46 billion to \$68 billion.

In terms of per-patient costs, cancer led the way at \$5,178 in 2006 (up slightly from \$5,067 in 1996), while costs for trauma care and asthma rose sharply -- from \$1,220 to \$1,953 and from \$863 to \$1,059, respectively.

On the other hand, average per-patient spending for heart conditions fell, from \$4,333 to \$3,964. And spending on mental disorders declined from \$1,825 to \$1,591.” U.S. News and World Report (August 5, 2009)]

Full text at:

http://www.meps.ahrq.gov/mepsweb/data_files/publications/st248/stat248.pdf

RECOVERY

“Patterns of Recovery from Severe Mental Illness: A Pilot Study of Outcomes.” By Leonard Miller, University of California, Berkeley, and others. IN: Community Mental Health Journal, Published online ahead of print on June 24, 2009. 11 p.

[“We performed a pilot study examining the patterns of recovery from severe mental illness in a model integrated service delivery system using measures from the Milestones of Recovery Scale (MORS), a valid and reliable measure of recovery outcomes which ranges from 1 to 8 (8 levels). For purposes of presentation, we constructed an aggregate MORS (6 levels) where the levels are described as follows: (1) extreme risk; (2) unengaged, poorly self-coordinating; (3) engaged, poorly self-coordinating; (4) coping and rehabilitating; (5) early recovery, and (6) self reliant. We analyzed MORS data on individuals followed over time from The Village in Long Beach, California (658 observations). Using Markov Chains, we estimated origin-destination transition probabilities, simulating recovery outcomes for 100 months. Our models suggest that after 12 months only 8% of ‘extreme risk’ clients remain such. Over 40% have moved to ‘engaged, poorly self-coordinating.’ After 2 years, almost half of the initial ‘extreme risk’ clients are ‘coping/rehabilitating,’ ‘early recovery’ or ‘self reliant.’ Most gains occur within 2 years.”]

Full text at: <http://www.springerlink.com/content/g2w3172624mng636/fulltext.pdf>

“Psychometric Properties of an Assessment for Mental Health Recovery Programs.” By Dennis G. Fisher, California State University, Long Beach, and others. IN: Community Mental Health Journal, Published online ahead of print on July 7, 2009. 5 p.

[“The concept of recovery can be operationalized from either the point of view of the consumer, or from the perspective of the agency providing services. The Milestones of Recovery Scale (MORS) was created to capture aspects of recovery from the agency perspective. Evidence establishing the psychometric properties of the MORS was obtained in three efforts: Inter-rater reliability using staff at The Village, a multi-service organization serving the homeless mentally ill in Long Beach, California; inter-rater reliability was also obtained from Vinfen Corporation, a large provider of housing services to mentally ill persons in Boston, Massachusetts. A test–retest reliability study was conducted using staff rating of clients at The Village, and evidence for validity was

obtained using the Level of Care Utilization System (LOCUS) as a validity measure. The intra-class correlation coefficient for the inter-rater reliability study was $r = .85$ (CI .81, .89) for The Village and $r = .86$ (CI .80, .90) for Vinfen Corporation; test-retest reliability was $r = .85$ (CI .81, .87); and validity coefficients for the LOCUS were at or above $r = .49$ for all subscales except one. There is sufficient evidence for the reliability and validity of the MORS.”]

Full text at: <http://www.springerlink.com/content/87t63gh137158407/fulltext.pdf>

SCHOOLS

“Enhancing Academic Achievement in a Hispanic Immigrant Community: The Role of Reading in Academic Failure and Mental Health.” By Elaine Clanton Harpine, Kent State University, and Thomas Reid, University of South Carolina. IN: School Mental Health, published online May 13, 2009. 12 p.

[“This field project examines Camp Sharigan, a group-centered approach to reducing academic failure. It examines the program’s benefit to children of Mexican descent from an inner-city immigrant neighborhood. The treatment group improved significantly more than the control group in all the three areas tested: spelling, reading, and sight words. Follow-up testing one year later indicated that the Camp Sharigan students continued to perform better in spelling and sight words. The findings indicate that the Camp Sharigan intervention may be more effective than one-to-one tutoring or classroom-style interventions....

School mental health researchers must search for new techniques to combat academic failure. Academic failure is no longer simply an educational problem. Future studies can examine the relationships among reading failure and mental wellness, depression, and at-risk health behaviors. Additional study of the development of childhood depression and continued research on prevention programs to rebuild self-efficacy with at-risk children may lead to the development of effective preventive group interventions with children.”]

Full text at: <http://www.springerlink.com/content/y52831q56153m251/fulltext.pdf>

Mental Health in Schools. By the National Conference of State Legislatures. State Mental Health Lawmakers’ Digest. Vol. 6. No. 2. (NCSL, Washington DC) Spring 2009. 7 p.

[“Many people face bullies during childhood. However, schools are increasingly facing issues that are more serious than stolen milk money and name-calling. April 20, 2009 marks the 10-year anniversary of the shooting at Columbine High School in Colorado that resulted in the death of 14 students and one teacher. Although this tragedy sparked a flurry of debate concerning gun control laws, school security policies, and teens’ exposure to violence in the media, it also sparked interest in issues that can affect students’ mental health—including harassment, teen suicide and trauma. While serious incidents of school violence are rare, the importance of mental health services in schools cannot be underestimated. Many individuals experience depression and anxiety as they make the transition from childhood to adulthood. In an effort to distinguish between “normal” teenage angst and serious mental health disorders, schools are increasingly providing mental health services to students. Studies estimate that one in five children and adolescents has a diagnosable mental health disorder, two-thirds of whom are not receiving

necessary treatment. When untreated, mental health disorders can lead to failure in school, conflicts with family members, substance abuse, violence and suicide. Children and adolescents can experience a multitude of mental health disorders, including mood disorders (e.g., depression, bipolar disorder), anxiety disorders, attention-deficit and disruptive behavior disorders, pervasive developmental disorders (e.g., autism spectrum disorders), learning disorders, eating disorders and substance-related disorders. Children who experience abuse or witness a traumatic event may have additional mental health needs.”]

Full text at: <http://csmh.umaryland.edu/resources/more/SMHLdigest09.pdf>

Telemental Health in Schools. By the Center for School Mental Health, University of Maryland School of Medicine. Issue Brief. (The Center, Baltimore, Maryland) June 2009. 7 p.

[“Studies have shown that at least one in five children and adolescents have a mental health disorder that causes some impairment in functioning (approximately 5 students in a classroom of 25). Remarkably, only about 20% of these youth receive any mental health services (NAMI, 2006). The provision of mental health services in schools has been one effective strategy for addressing these issues.

Providing mental health services in a school setting has been shown to have many benefits. For example, interventions are more effective when students can be accessed immediately (NASBHC, 2008). Providing services in a school setting helps to ease anxiety and seems less threatening, and since the services are provided at school it may be at a lower cost to families than other community mental health centers (2008). These same advantages are applicable to the use of telemental health in schools.

While accessing mental health services can be challenging, psychiatric services are often the most difficult, particularly for child and adolescent psychiatry. Within the United States there is a great shortage of child and adolescent psychiatrists (Shortage of Child Psychiatrists, 2006). Telemental health offers a strategy for effectively and efficiently utilizing psychiatry services as well as other forms of mental health services. Telehealth technology serves to increase the quality and accessibility of mental health services, particularly to underserved populations and in areas with limited mental health resource capacity such as in rural settings (Monnier, Knapp, & Frueh, 2003; Myers, Sulzbacher, & Melzer, 2004).

Telehealth technology also provides the opportunity to offer services that are not available in most school-based mental health programs, including multi-site educational training for mental health providers and students as well as professional development opportunities for school staff. Further, using telehealth can help children and adolescents gain access to culturally and linguistically competent mental health care that serves the needs of racial and ethnic minorities.”]

Full text at: <http://csmh.umaryland.edu/resources/CSMH/briefs/TelepsychIssueBrief.pdf>

SUICIDE PREVENTION

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. By the Center for Substance Abuse Treatment, Substance Abuse and Mental Health

Services Administration. A Treatment Improvement Protocol. Series 50. (The Center, Rockville, Maryland) 2009. pp. 159 p.

[“Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment, a new manual which offers substance abuse counselors a four-step process for addressing suicidal thoughts and behaviors in substance abuse treatment, is now available through the Substance Abuse and Mental Health Services Administration (SAMHSA).

The manual is #50 in the Treatment Improvement Protocol (TIP) series. TIPs are best-practice guidelines used for the treatment of substance use disorders, issued by SAMHSA’s Center for Substance Abuse Treatment (CSAT). TIP 50 assists substance abuse counselors in working with adult clients who may be suicidal and helps clinical supervisors and administrators support this work.

TIP 50 is organized into three parts:

- Part 1- Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
- Part 2- Addressing Suicidal Thoughts and Behaviors: An Implementation Guide for Administrators
- Part 3- Addressing Suicidal Thoughts and Behaviors: A Review of the Literature

Parts 1 and 2 are available in one publication, and Part 3 is only available online. Part 1 covers topics for substance abuse counselors, and addresses the ‘what,’ ‘why,’ and ‘how’ of working with clients in substance abuse treatment with suicidal thoughts and behaviors. It provides background information about suicide and substance use disorders, risk factors and warning signs for suicide and a four-step process for addressing suicidal thoughts and behaviors in substance abuse treatment, summarized by the acronym GATE (Gather information, Access supervision, Take responsible action, and Extend the action). Part 2 is an implementation guide for program administrators and presents the benefits of addressing suicidality in substance abuse treatment programs. Part 3, the literature review, synthesizes the most current knowledge and scientific findings on the topic and is only available online at <http://kap.samhsa.gov/>.”]

Full text at: <http://download.ncadi.samhsa.gov/prevline/pdfs/SMA09-4381.pdf>

“Admixture Analysis of Age at First Suicide Attempt.” By F. Slama, and others. IN: Journal of Psychiatric Research, vol. 43, no. 10 (July 2009) pp. 895-900.

[“Patients who make suicide attempts requiring hospitalization appear to fall in two different subgroups: those whose first attempt occurred before age 26 and those whose first attempt occurred after age 26. A sample of 368 consecutively admitted patients with a history of suicide attempt (SA) serious enough to require hospitalization was analyzed to determine whether the age of first suicide attempt fit a mixture of Gaussian distributions. The best-fit model was a mixture of two subgroups, one with a first SA occurring up to age 26 accounting for 40 percent of the sample and another with the first

SA after age 26 accounting for 60 percent of the sample. Those in the early-onset subgroup (average age 19.5 years) were more likely to have comorbid anxiety disorders, a personal history of childhood trauma including emotional and sexual abuse, and/or cannabis abuse or dependence than patients in the late-onset subgroup. Patients in the late-onset group (average age 38.5 years) were characterized by more frequent diagnoses of major depressive disorder. According to the authors, this study is the “first to demonstrate bimodality of the distribution of age of first suicide attempt and to provide evidence to support the unproven notion that age of first SA is a marker for different subtypes of suicide attempt.” **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

“Adolescents’ Suicidal Thinking and Reluctance to Consult General Medical Practitioners.” By Coralie J. Wilson, Illawarra Institute for Mental Health, Australia, and others. IN: Journal of Youth and Adolescence. Published online on July 15, 2009. 14 p.

[“Appropriate help-seeking is widely recognized as a protective factor, and vital for early treatment and prevention of mental health problems during adolescence. General medical practitioners (GPs), that is, family doctors, provide a vital role in the identification of adolescents with mental health problems and the provision of treatment as well as access to other specialists in mental health care services. The current study examined the association between suicidal ideation and intentions to seek help from a GP for suicidal thoughts, emotional problems and physical health problems, using a sample of 590 Australian high school students that was 56.7% female and aged 13–18 years ($M = 15.56$ years, $SD = .66$ years). Higher levels of suicidal ideation and general psychological distress were related to lower intentions to seek help from a GP for suicidal and physical problems. The results suggest that even at subclinical levels, increases in suicidal ideation or psychological distress may lead to help avoidance. School personnel and other gatekeepers need to be aware of this trend in order to be more assertive in encouraging and supporting appropriate help-seeking for mental health problems. School health promotion programs should consider including information to explicitly address the help negation process.”]

Full text at: <http://www.springerlink.com/content/g98h838x828532nq/fulltext.pdf>

“Association of Temporal Factors and Suicides in the United States, 2000–2004.” By Augustine J. Kposowa and Stephanie D’Auria, University of California, Riverside. IN: Social Psychiatry and Psychiatric Epidemiology (published online June 18, 2009) 13 p.

[“Nearly one-quarter of suicides in the U.S. occur on Wednesdays, about twice as many as almost every other day of the week, a new study has found. The study contradicts earlier findings that suicides are more common on Mondays and left experts puzzling over what may be behind Wednesday’s grim distinction. Kposowa and D’Auria also found that more suicides occurred in summer and spring than in fall or winter, contrasting with traditional thinking that winter months bring more risk of suicide.

Other parts of the study were consistent with previous research, showing that men are more likely to take their lives than women, and people who are divorced, white, educated or living in nonmetropolitan areas have a higher risk of suicide.

Kposowa pointed to workplace stress as a potential explanation and believes changes in Americans' work and family life may be behind the shift in suicide's concentration from Mondays to Wednesdays.

Increased economic competition worldwide has threatened job security for many workers, heightening stress, frustration and even feelings of betrayal, said Kposowa, a sociology professor. 'Individuals work harder and harder, but seem to be losing ground; they have little or nothing to show for their labor — especially among those who depend on others for wages,' he wrote in an e-mail. 'It is highly likely that the middle of the week (represented by Wednesday) is when these stressors and feelings of hopelessness are at their highest.'" Houston Chronicle (July 11, 2009)]

Full text at: <http://www.springerlink.com/content/d236q44ut3582v91/fulltext.pdf>

CONFERENCES, MEETINGS AND PODCASTS

The Third Annual Latino Mental Health Conference: *Meeting the Mental Health Needs of the Latino Families and Communities.*

October 30-31, 2009
New York, New York

For information and registration:

<https://tools.med.nyu.edu/CMECourses/index.cfm?fuseaction=courses.DisplayCourse&TheCourseID=5962>

The National Resource Center for Hispanic Mental Health's 1st Biennial National Latino Mental Health Conference

November 9-10, 2009
Miami, Florida

For more information and registration: <http://www.nrchmh.org/events.html>

2009 Cultural Competence & Mental Health Summit XVI - *Embracing Social Justice and Equity to Build Healthier Communities*

November 17-18, 2009
San Francisco, California

For more information and registration:

<http://elearning.networkofcare.org/CiMH/registerForEvent.asp?EventId=231389&ClientId=167>