

Subject: Studies in the News: (March 15, 2010)



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California Department of Mental Health

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CHILDREN AND ADOLESCENTS

Childhood Stress Such as Abuse or Emotional Neglect can Result in Structural Brain Changes. By Chris Fisher, Managing Editor for The Behavioral Medicine Report. In: The Behavioral Medicine Report. (March 1, 2010) pp. 1-3.

[“New research using magnetic resonance imaging (MRI) shows that childhood stress such as abuse or emotional neglect, in particular when combined with genetic factors, can result in structural brain changes, rendering these people more vulnerable to developing depression. The study led by scientists at Trinity College Dublin has just been published in the international scientific journal, Neuropsychopharmacology.”]

Full text at:

http://www.bmedreport.com/archives/10122?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29

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“Dealing with Psychiatric Disabilities in Schools: A Description of Symptoms and Coping Strategies for Dealing with Them.” By John Rowe, Massachusetts College of Pharmacy and Health Sciences. IN: Preventing School Failure, vol. 54, no. 3 (Spring 2010) pp. 190-198

[“Despite the large number of children that the Surgeon General of the United States estimated to be suffering from a *mental* disorder (Office of the Surgeon General, 2000), the majority of childhood disorders are undiagnosed and untreated. The negative effect of childhood disorders on a child's academic, social, and psychological development can be devastating. The child's teacher is often the 1st person to identify that there is a problem and the 1st person to suggest referrals. The teacher is also often able to make adjustments in the classroom that can enable the child to be successful academically, minimize the negative effects of the illness on the child's development, and manage the child's behaviors that can disrupt the classroom. The author describes the most common disorders that teachers have observed in the classroom, including major depressive disorder, attention deficit hyperactivity disorder, post-traumatic stress disorder, and conduct disorder. The author presents the effects of childhood disorders on a child's classroom performance and offers suggestions for coping with those effects. With these suggestions, teachers can contribute to better outcomes for children with childhood disorders.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47696987&site=ehost-live>

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Related article: ‘Uncovering an Epidemic: Screening for Mental Illness in Teens.’ New England Journal of Medicine. Dec. 28, 2006.

<http://content.nejm.org/cgi/content/full/355/26/2717>

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Related article: “Changing Middle Schoolers’ Attitudes about Mental Illness through Education.” Schizophrenia Bulletin. 2004.

<http://schizophreniabulletin.oxfordjournals.org/cgi/reprint/30/3/563>

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CULTURAL COMPETENCY

Introduction: Cross-Cultural Psychiatry. By Ronald Wintraub, M.D., Brown University. IN: Psychiatric Times (January 10, 2010) pp. 1-3

[“During the past 2 decades, there has been enormous growth of interest in and visibility of cultural psychiatry. Much of this is due to the steady increase in migration of the world’s population from low-income to higher-income regions and countries.

In a report by the Population Division of the United Nations in 2007, it was estimated that the total number of immigrants in the world in 2005 numbered 191 million (3% of the world’s population)—an increase from 155 million in 1990. The United States had the largest percentage of the world’s immigrants in 2005, equaling 12.86% of the total US population.

Since 1980, there has been more diversity in race, ethnicity, and religion among people who have immigrated to the United States. The total US population has increased by 29% from 1980 through 2005. During those years, the Asian-Pacific component has grown 219%; the Hispanic component, 174%; the African American component, 37%; and the white component, 9%.

It is these trends in immigration that have compelled the US government to become much more cognizant of the health and social service needs of its increasingly culturally diverse population. As a result, health policy agencies and clinicians need a better understanding of how to clinically assess and treat people of varied backgrounds that come to their facilities for care.”]

Full text at:

<http://www.psychiatrictimes.com/display/article/10168/1508301?verify=0>

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DIVERSE CULTURES

“Social Support and Quality of Life among Latinos with Mental Illness.” By Ana C. Ribas and Chow S. Lamm Illinois Institute of Technology. IN: The Journal of Nervous and Mental Disease, vol. 198, no. 2 (February 2010) pp. 137-143.

[“We examine the degree of social support and quality of life (QOL) among 60 Latinos with mental illness from a Community Mental Health Center of a large metropolitan Midwestern city. Additionally, we assess the relationship of both the quality and quantity of social support, and control for demographic factors as they all relate to QOL. Latinos had an average network of 3 contacts. Despite their small network, participants were satisfied with the quality of support they received. Their QOL was mixed, comparable to reports from non-Latinos with mental illness, and from the general population. Having better quality of social support being male and younger was associated with a higher QOL. Community treatment programs for Latinos with mental illness could benefit from focusing on nurturing existing networks, fostering social skills, and providing additional forms of support for those Latinos in need.” **NOTE: If you would like a hard copy of this article, please contact the California State Library.]**

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HEALTH CARE REFORM

How much is enough? The Distribution of Lifetime Health Care Costs. By Anthony Webb and Natalia Zhivan, Center for Retirement Research at Boston College. (The Center, Boston, Massachusetts) February 2010. 45 p.

[“Estimates of the expected present value of lifetime out-of-pocket medical costs from age 65 onward are of limited value to households managing wealth decumulation in retirement. Their risk characteristics may differ from the average. They will also care about the whole probability distribution of health cost outcomes, and will want to update that probability distribution during the course of retirement. Using *Health and Retirement Study* data, we simulate health, mortality, and health cost histories of retired households. We show that the life expectancy and average health costs of our simulated households closely match published life tables and the findings of previous research. Using our simulated data, assuming a 3-percent real interest rate and including Medicare and private insurance premiums, we estimate that a typical household age 65 has a 5-percent risk of the present value of its lifetime health care costs exceeding \$311,000, or \$570,000 including the cost of long-term care. We find that relatively little resolution of uncertainty occurs with age, even for those who remain free of chronic disease.”]

Full text at:

http://crr.bc.edu/images/stories/Working_Papers/wp_2010-1.pdf

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Long Term Care Financing Reform: Lessons from the U.S. and Abroad. By Howard Gleckman, The Urban Institute. (The Commonwealth Fund, New York, New York) February 2010. 39 p.

[“As part of health care reform, Congress is considering the Community Living Assistance Services and Supports (CLASS) Act. The measure would mark the most significant change since 1965 in the way the U.S. finances long-term care, the personal

assistance delivered both at home and in nursing facilities to the frail elderly and other adults with disabilities. As policymakers consider the CLASS Act, they may be able to learn from past experiments in the U.S. as well as from the experiences of other major industrialized countries, most of which have migrated to universal, government-run financing systems. Although those models vary markedly in their specifics, they appear to be both broadly popular and somewhat more costly than expected. By contrast, the CLASS Act is a voluntary system that attempts to meld public insurance with private long-term care coverage and Medicaid. “[

Full text at:

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1368_Gleckman_longterm_care_financing_reform_lessons_US_abroad.pdf

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Medicaid Expansion Offers Solutions, Challenges. By John Inglehart, Health Affairs Editor. IN: Health Affairs, vol. 29, no. 2 (February 2010) pp. 230-232.

[“Medicaid has been described as the “workhorse” of U.S. health insurance: Under the program, approximately fifty-five million people obtain coverage for various health care and related needs. The joint federal and state program has a broad range of responsibilities— covering comprehensive health care for children and many adults in low-income working families, all the way to long-term care and other needs for the elderly and disabled. Now this workhorse may be saddled with important new roles in closing the nation’s health coverage gaps. Reform legislation recently passed by the U.S. House and Senate would expand the program’s rolls by an estimated fifteen million people by 2019—almost half the number of people who would become newly eligible for health insurance. If the proposed changes are finally adopted into law, an estimated seventy- five million people—approximately one-quarter of all nonelderly Americans— would ultimately obtain coverage through Medicaid.”]

Full text at:

<http://content.healthaffairs.org/cgi/reprint/29/2/230>

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Parity Law Expands Mental Health Access. Washington Post (March 2, 2010) pp.1-3.

[“Denise Camp was resigned to the double standard that had long applied to her medical bills, forcing her to skimp on other expenses so she could pay for mental health treatment.

While visits to her internist for physical problems required a \$20 co-pay, her weekly therapy sessions with a social worker cost \$50 and trips to the psychiatrist who prescribed her medication were \$75. A similar disparity applied to medicines: Drugs to treat the crippling depression that ended her engineering career cost her twice what she paid for an antibiotic.

But recently, Camp's insurance coverage changed -- for the better. The 50-year-old Baltimore resident, who now runs a drop-in center for recovering psychiatric patients, is paying the same charge for physical and mental health treatments: a co-pay of \$10 per visit and \$25 for each prescription.”]

Full text at:

<http://www.kaiserhealthnews.org/Stories/2010/March/02/Mental-Health-Parity.aspx>

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JUVENILE OFFENDERS

Representing Juvenile Status Offenders. By Hannah Benton, Center for Child Advocacy, Hartford, and others. (American Bar Association, Chicago, Illinois) 2010. 160 p.

[“There are few training resources for attorneys representing juvenile status offenders or youth who are truant, runaways, or beyond their parent’s control. Yet representing this population of children, who often fall between the cracks of child welfare and juvenile justice, can be challenging. Often, few community or court resources are devoted to these families in crisis, making advocacy for appropriate services and alternatives to detention difficult.

This book is your guide to advocating for juvenile status offenders. They are an underserved group, yet thousands enter the court system every year. They face sometimes insurmountable obstacles: abuse, neglect, high family conflict and domestic violence; desperately poor and violent neighborhoods; serious mental health needs, learning disabilities, emotional or behavioral problems; gangs; bad peer group choices; and poor educational and employment options. They are in need of strong advocacy to help them avoid deeper juvenile justice system involvement and detention. They and their families need help mending dysfunctional relationships and accessing community assistance.”]

Full text at:

http://www.abanet.org/child/rjso_final.pdf

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Related article: Juvenile Status Offenders Fact Sheet. American Bar Association.

http://www.act4jj.org/media/factsheets/factsheet_17.pdf

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SENIORS

Medicare Doctor Shortage Endangers Seniors Access to Care. By Matt Patterson, Policy Analyst. National Policy Analysis. (National Center for Public Policy Research, Washington, D.C.) February 2010.

[“2009-2010 has seen a great national debate over the role of government in health care. But few Americans realize just what an expansive role the government already plays in our health care system: In 2008, government spending on health care constituted 36 percent

of federal outlays, up eight percent from the previous year. And public financing of health care, aggregating federal, state and local programs, makes up 46 percent of U.S. health spending.

Medicare alone represents 19 percent of those health care dollars. It is therefore wise, as the nation's legislators consider an expanded federal role in health insurance, to examine the viability of existing programs such as Medicare to determine whether the government is capable of meeting its existing health care obligations.”]

Full text at:

<http://www.nationalcenter.org/NPA602.html>

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SUBSTANCE ABUSE

“Association between Cannabis Use and Psychosis-Related Outcomes Using Sibling Pair Analysis in a Cohort of Young Adults.” By John McGrath, Queensland Center for Mental Health Research, Australia, and others. IN: Archives of General Psychiatry, vol. 67, no. 5 (March 2010) pp. E1-E8

[“Prospective cohort studies have identified an association between cannabis use and later psychosis-related outcomes, but concerns remain about unmeasured confounding variables. The use of sibling pair analysis reduces the influence of unmeasured residual confounding.

Objective To explore the association between cannabis use and psychosis-related outcomes.

Design A sibling pair analysis nested within a prospective birth cohort.

Setting Births at a Brisbane, Australia, hospital.

Participants Three thousand eight hundred one young adults born between 1981 and 1984 as part of the Mater-University Study of Pregnancy.

Main Outcome Measures Cannabis use and 3 psychosis-related outcomes (nonaffective psychosis, hallucinations, and Peters et al Delusions Inventory score) were assessed at the 21-year follow-up. Associations between duration since first cannabis use and psychosis-related outcomes were examined using logistic regression adjusted for sex, age, parental mental illness, and hallucinations at the 14-year follow-up. Within 228 sibling pairs, the association between within-pair differences in duration since first cannabis use and Peters et al Delusions Inventory score was examined with general linear modeling. The potential impact of attrition was examined.

Results Duration since first cannabis use was associated with all 3 psychosis-related outcomes. For those with duration since first cannabis use of 6 or more years, there was a significantly increased risk of (1) nonaffective psychosis (adjusted odds ratio, 2.2; 95% confidence interval, 1.1-4.5), (2) being in the highest quartile of Peters et al Delusions Inventory score (adjusted odds ratio, 4.2; 95% confidence interval, 4.2-5.8), and (3) hallucinations (adjusted odds ratio, 2.8; 95% confidence interval, 1.9-4.1). Within sibling pairs, duration since first cannabis use and higher scores on the Peters et al Delusions Inventory remained significantly associated.

Conclusions Early cannabis use is associated with psychosis-related outcomes in young adults. The use of sibling pairs reduces the likelihood that unmeasured confounding explains these findings. This study provides further support for the hypothesis that early cannabis use is a risk-modifying factor for psychosis-related outcomes in young adults.”]

Full text at:

<http://archpsyc.ama-assn.org/cgi/content/full/2010.6?home>

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“Mental Disorders as Risk Factors for Later Substance Disorders.” By D. Meyer Glantz, National Institutes of Health, and others. IN: Psychological Medicine, vol. 39, no. 8 (August 2009) pp. 1365-1377.

[“Although mental disorders have been shown to predict subsequent substance disorders, it is unknown if substance disorders could be cost-effectively prevented by large-scale interventions aimed at prior mental disorders. While experimental intervention is the only way to resolve this uncertainty, a logically prior question is whether the associations of mental disorders with subsequent substance disorders are strong enough to justify mounting such an intervention. We investigate this question here using simulations to estimate the number of substance disorders that might be prevented under several hypothetical intervention scenarios focused on mental disorders.

Methods

Data come from the National Comorbidity Survey-Replication, a nationally representative US household survey that retrospectively assessed lifetime history and age-of-onset of DSM-IV mental and substance disorders. Survival analysis using retrospective age-of-onset reports was used to estimate associations of mental disorders with subsequent substance dependence. Simulations based on the models estimated effect sizes in several hypothetical intervention scenarios.

Results

Although successful intervention aimed at mental disorders might prevent some proportion of substance dependence, the number of cases of mental disorder that would have to be treated to prevent a single case of substance dependence is estimated to be so high that this would not be a cost-effective way to prevent substance dependence (in the range 76-177 for anxiety-mood disorders and 40-47 for externalizing disorders).

Conclusions

Treatment of prior mental disorders would not be a cost-effective way to prevent substance dependence. However, prevention of substance dependence might be considered an important secondary outcome of interventions for early-onset mental disorders.”]

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2705467/?tool=pmcentrez>

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Substance Use Treatment Need and Receipt among People Living in Poverty. By Substance Abuse and Mental Health Services Administration. The NSDUH Report. (The National Survey on Drug Use and Health, Rockville, Maryland) January 14, 2010.

[“Substance use disorders affect people in all economic circumstances, and all face challenges in trying to overcome these disorders. The difficulties faced by persons living in poverty, however, may be even more formidable as they may lack health insurance coverage. Considering that the number of people living in poverty has increased for 3 consecutive years—reaching a near record high of 39.8 million in 2008 —understanding the gap between service needs and service receipt may help policy makers and program managers ensure that the gap does not widen in the future.

The National Survey on Drug Use and Health (NSDUH) collects information that can contribute to this effort. NSDUH gathers data on family income, size, and composition (i.e., number of children) and respondent's age. This information is used to determine the respondent's poverty level. The poverty level is calculated as a percentage of the U.S. Census Bureau's poverty threshold by dividing the respondent's reported total family income by the appropriate poverty threshold amount. If a family's total income is less than the Census Bureau's poverty threshold for the corresponding size and composition, then that family and every individual in it is considered to be living in poverty (i.e., less than 100 percent of the U.S. census poverty threshold).

This issue of *The NSDUH Report* examines the need for and receipt of substance use treatment among persons aged 12 or older who are living in poverty. All findings in the report are annual averages based on combined 2006 to 2008 data.”]

Full text at:

<http://www.oas.samhsa.gov/2k10/173/173Poverty.htm>

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SUICIDE PREVENTION

**“Attitudes and Beliefs of Adolescents and Parents Regarding Adolescent Suicide.”
By Kimberly A. Schwartz, UMASS Memorial Children Medical Center, and others.
IN: *Pediatrics*, vol. 125, no. 2 (February 2010) pp. 221-227**

[“The goal was to understand the attitudes, beliefs, and perceptions of adolescents and parents of adolescents, from a variety of backgrounds, regarding adolescent suicide. **METHODS:** This qualitative study used focus groups to elicit the thoughts of distinct sociodemographic groups. A professional moderator guided the sessions by using a semistructured script. All groups were audiotaped. The transcripts and transcript summaries were analyzed for recurrent themes. The study was performed in community centers and schools in Chicago, Illinois (urban), and the Kansas City, Kansas, area (suburban and rural). A total of 66 adolescents (13–18 years of age) and 30 parents of adolescents participated in 13 focus groups.

RESULTS: Both adolescents and parents recognized adolescent suicide as a major problem, but not for their own communities. All parent and adolescent groups identified many risk factors for suicide. Most adolescents reported drug and alcohol use as risk factors for suicide. However, parents often viewed drug and alcohol use as normal adolescent behavior. Both adolescent and parent groups suggested securing or removing guns if an adolescent was known to be suicidal. All participants requested information about adolescent suicide.

CONCLUSIONS: Adolescents and parents need help understanding that suicide is an underidentified problem in their own communities. Both adolescents and parents are interested in learning more about how to identify and to intervene with a suicidal adolescent. Pediatricians are well positioned to provide this information in the office and in the community.”]

Full text at:

<http://pediatrics.aappublications.org/cgi/reprint/125/2/221>

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VETERANS

“Mental Health Care for Iraq and Afghanistan War Veterans.” By M.Audrey Burman and others, RAND Research Center. IN: Health Affairs, vol.28, no. 1 (2009) 771-782.

[“Despite recent efforts to increase access to appropriate mental health care for veterans returning from conflicts in Iraq and Afghanistan, many challenges remain. These include veterans’ reluctance to seek care, insufficient mental health workforce capacity and competency in evidence-based practice, and inadequate systems support for improving care. These broad challenges must be addressed across the Veterans Health Administration, the Department of Defense, and community-based care. Policy reform will require federal leadership to engage health plans, professional organizations, states, and local communities in strategies to improve veterans’ access to high-quality services.”]

Full text at:

<http://content.healthaffairs.org/cgi/reprint/28/3/771>

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“A Separate Peace: Specialized courts for Veterans work Wonders. But why stop veterans?” By Dahlia Lithwick, Slate. IN: Slate. (February 10, 2010) pp. 1-3.

“The problem is hardly a new one: Veterans return from war having seen and survived unspeakable things, then try to adjust to civilian life with inadequate resources and support. Depending on the study you read, somewhere between 20 percent and 50 percent of Iraq and Afghanistan war veterans are suffering from post-traumatic stress and other mental disorders. Fifty percent of veterans with PTSD or major depression don't seek

mental health care, and those who do don't always receive the kind of care they need. The results of these systemic failures are increased instances of rape, assault, addiction, and other criminal acts that can tangle up veterans in the criminal courts. The Department of Veterans Affairs estimates that veterans account for 10 percent of the people with criminal records.

Veterans are also disproportionately among the country's homeless. The V.A. estimates that 131,000 veterans are homeless each night. (One of every 10 homeless veterans under the age of 45 is a woman, often with a child.) And if you are homeless, it's likely that you will quickly amass fines and citations for such trivial offenses as sleeping in public. If you can't pay those fines, you develop a record that makes finding housing and jobs close to impossible. Whether you find yourself in court for minor offenses or major ones, the best place to deal with issues of homelessness, addiction, or PTSD is not jail. Thus the country's first "veterans' courts" were born.”]

Full text at:

<http://www.slate.com/id/2244158/>

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“Do Older Rural and Urban Veterans Experience Different Rates of Unplanned Readmission to VA and non-VA Hospitals?” By W.B. Weeks, VA National Center for Patient Safety, and others. IN: Journal of Rural Health, vol. 25, no. 1 (Winter 2009) pp. 62-69.

[“Unplanned readmission within 30 days of discharge is an indicator of hospital quality. PURPOSE: We wanted to determine whether older rural *veterans* who were enrolled in the VA had different rates of unplanned readmission to VA or non-VA hospitals than their urban counterparts. METHODS: We used the combined VA/Medicare dataset to examine 3,513,912 hospital admissions for older *veterans* that occurred in VA or non-VA hospitals between 1997 and 2004. We calculated 30-day readmission rates and odds ratios for rural and urban *veterans*, and we performed a logistic regression analysis to determine whether living in a rural setting or initially using the VA for hospitalization were independent risk factors for unplanned 30-day readmission, after adjusting for age, sex, length of stay of the index admission, and morbidity. Findings: Overall, rural *veterans* had slightly higher 30-day readmission rates than their urban counterparts (17.96% vs. 17.86%; OR 1.006, 95% CI: 1.0004, 1.013). For both rural- and urban-dwelling *veterans*, readmission after using a VA hospital was more common than after using a non-VA hospital (20.7% vs. 16.8% for rural *veterans*, 21.2% vs. 16.1% for urban *veterans*). After adjusting for other variables, readmission was more likely for rural *veterans* and following admission to a VA hospital. CONCLUSIONS: Our findings suggest that VA should consider using the unplanned readmission rate as a performance metric, using the non-VA experience of *veterans* as a performance benchmark, and helping rural *veterans* select higher performing non-VA hospitals.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=19166563&site=ehost-live>

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WORK AND DISABILITIES

The Abilities of Improved Schizophrenia Patients to Work and Live Independently in the Community: A 10-year long-term outcome study from Mumbai, India. By Amresh Kumar Srivastava, University of Western Ontario, and others. IN: Annals of General Psychiatry, vol. 8, no. 24 (October 2009) pp. 1-8.

[“**The** outcome of first episode schizophrenia has several determinants. Socioecological factors, particularly living conditions, migration, community and culture, not only affect the level of risk but also the outcome. Mega cities around the world show a unique socioecological condition that has several challenges for mental health. The present study reports on the long-term status of patients with schizophrenia in such a mega city: Mumbai, India.

Aim: This study aims to reveal the long-term outcome of patients suffering from schizophrenia with special reference to clinical symptoms and social functioning.

Methods: The cohort for this study was drawn from a 10-year follow-up of first episode schizophrenia. Patients having completed 10 years of consistent treatment after first hospitalisation were assessed on psychopathological and recovery criteria. Clinical as well as social parameters of recovery were evaluated. Descriptive statistics with 95% confidence intervals are provided.

Results: Of 200 patients recruited at the beginning of this study, 122 patients (61%) were present in the city of Mumbai at the end of 10-year follow-up study period. Among 122 available patients, 101 patients (50.5%) were included in the assessment at the end of 10-year follow-up study period, 6 patients (3.0%) were excluded from the study due to changed diagnosis, and 15 patients (7.5%) were excluded due to admission into long-term care facilities. This indicates that 107 out of 122 available patients (87.7%) were living in the community with their families. Out of 101 (50.5%) patients assessed at the end of 10 years, 61 patients (30.5%) showed improved recovery on the Clinical Global Impression Scale, 40 patients (20%) revealed no improvement in the recovery, 43 patients (72.9%) were able to live independently, and 24 patients (40%) were able to find employment.

Conclusion: With 10 years of treatment, the recovery rate among schizophrenia patients in Mumbai was 30.5%. Among the patients, 87.7% of patients lived in the community, 72.9% of patients lived independently, and 40% of patients obtained employment. However, 60% of patients were unable to return to work, which highlights the need for continued monitoring and support to prevent the deterioration of health in these patients. It is likely that socioecological factors have played a role in this outcome.”]

Full text at:

<http://www.annals-general-psychiatry.com/content/pdf/1744-859X-8-24.pdf>

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The Demonstration to Maintain Independence and Employment: Implications for National Health Care Reform. By Noelle Deny-Brown, Mathematica Policy Research Inc. and others. Working with Disability: Work and Insurance in Brief. No. 10. (Mathematica, Washington, D.C.) December 2009. 6 p.

[“Individuals with potentially disabling conditions have distinct health care needs, which if left unmet, can lead to the onset of a disability and enrollment in a federal disability benefit program. The Demonstration to Maintain Independence and Employment (DMIE), a grant program administered by the Centers for Medicare & Medicaid Services (CMS) and authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), awards funds to states to develop, implement, and evaluate interventions for workers with potentially disabling conditions. For instance, states may provide Medicaid-equivalent coverage or “wrap-around” coverage to supplement an individual’s existing health insurance. They may also offer employment-support and case-management services that increase the likelihood of sustained employment and reduced use of federal disability benefits. Four states received DMIE funding under the 2004 and 2006 solicitations—Hawaii, Kansas, Minnesota, and Texas. Federal funding for DMIE services expired on September 30, 2009.

This issue brief, the tenth in a series on workers with disabilities, describes the four DMIE interventions and discusses what they might tell us about designing policy initiatives for workers with potentially disabling conditions in the context of national health care reform.”]

Full text at:

http://www.mathematica-mpr.com/publications/PDFs/disability/WWD_DMIE.pdf

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CALL FOR PAPERS FOR PRESENTATIONS FOR DEPLOYMENT FOR DEPLOYMENT HEALTH CARE TRACK, FORCE HEALTH PROTECTION CONFERENCE AUGUST 2010

13th Annual Force Health Protection Conference "*Military Preventive Medicine and Public Health*" Core Conference: 10-13 August 2010 Preconference Workshops: 7-9 August 2010 Phoenix Convention Center Phoenix, AZ

Call for Deployment Healthcare Track Presentations

[“The Force Health Protection Conference, hosted by the US Army Public Health Command (Provisional) or USAPHC (Prov), formerly US Army Center for Health Promotion and Preventive Medicine (USACHPPM), is the largest public health conference conducted within the Army Medical Department and has an annual registration of more than 3000 professionals from the Army, Air Force, Navy, Public Health Service, Veteran’s Administration, academia, non-government organizations, and foreign military medical services.

Starting annually in 2004, the Deployment Health Clinical Center (DHCC) has sponsored a Deployment Healthcare Track (DHCT) within the Force Health Protection Conference (FHPC). The primary objective of the DHCT is to disseminate cutting edge research and information to enhance post-deployment healthcare for Service members and their families. We especially want to encourage primary care providers, physician assistants and nurses who are the first line of healthcare assistance for returning combat veterans and families to attend and/or present at this Conference.”]

Further Information found at:

http://www.pdhealth.mil/downloads/2010_Call_Presentations.pdf

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GRANT/FUNDING OPPORTUNITIES

[BJA Now Accepting Applications for the 2010 Justice and Mental Health Collaboration Program](#)

The Bureau of Justice Assistance (BJA) is currently seeking grant applications for its 2010 Justice and Mental Health Collaboration Program. The Program, authorized by the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, focuses on improving access to effective treatment for adults and juveniles with mental health problems in contact with the justice system by facilitating collaboration among the justice and treatment systems. Three categories of grants are available: 1) Planning Grants; 2) Planning and Implementation Grants; and 3) Implementation and Expansion Grants. Applications are due April 8, 2010. For additional information visit the BJA website at <http://www.ojp.usdoj.gov/BJA/grant/10JMHCPsol.pdf>.

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The CDC's National Center for Injury Prevention and Control (NCIPC) has a new funding opportunity (also available on www.grants.gov):

[Prevention of Suicidal Behavior through the Enhancement of Connectedness](#) (RFA-CE-10-006):

This funding opportunity announcement (FOA) solicits applications from applicant organizations that target one or more modifiable risk factors for suicidal behavior with a primary prevention strategy that is designed to enhance connectedness and to rigorously assess the efficacy or effectiveness of that strategy. **Awards will be up to \$40,000 per year for 5 years, and the application deadline date is April 29, 2010.**

Eligible organizations include: public and private nonprofit organizations; for profit organizations; small, minority, and women-owned businesses; universities; colleges; research institutions; hospitals; community-based organizations; faith-based organizations; federally recognized or state-recognized American Indian/Alaska Native tribal governments; American Indian/Alaska Native tribally designated organizations;

Alaska Native health corporations; urban Indian health organizations; tribal epidemiology centers; and state and local governments.

To access the full announcement and application package, please go to:

<http://www07.grants.gov/search/search.do;jsessionid=75hPLjDHzlFyhZglFstZ93wvmy1wJdsYLxGSGRYpynKsqRKgrgM!-1299818899?oppId=51411&mode=VIEW>.

(Funding Opportunity Number: RFA-CE-10-006; Catalog of Federal Domestic Assistance (CFDA) number: 93.136.). If you have difficulty accessing the full announcement electronically, please contact CDC's Procurement and Grants Office, Technical Information Management, at 770-488-2700 or PGOTIM@cdc.gov

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ONLINE COURSES ON MENTAL HEALTH ISSUES

Information and registration:

<http://www.cehd.umn.edu/ceed/profdev/onlinecourses/2010OnlineCourseSchedule.pdf>

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CONFERENCES, MEETINGS AND SEMINARS

Association for Applied Psychophysiology and Biofeedback Annual Conference 2010

March 24-27, 2010
San Diego, California

For information:

http://www.bmedreport.com/archives/9593?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29

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American Society of Addiction Medicine's 41st Annual Medical-Scientific Conference.

April 15-18, 2010
San Francisco, California

For information:

<http://www.asam.org/pdf/conferences/2010%20Conference%20Program%20&%20Registration.pdf>

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43rd American Association of Suicidology Annual Conference: *Families, Community Systems and Suicide*

April 21st - 24th, 2010

Orlando, Florida

For more information: <http://www.suicidology.org/web/guest/education-and-training/annual-conference>

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Summer Institute of Neurodevelopmental Disorders.

August 6, 2010

Sacramento, CA

For more information:

http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/MND2011_SaveDate.pdf

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