

**Subject:** Studies in the News: (April 15, 2010)

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## Studies in the News for



## California Department of Mental Health

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## CHILDREN AND ADOLESCENTS

**“An Ecological Analysis of Child Sexual Abuse Disclosure: Considerations for Child and Adolescent Mental Health.” By Ramona Alaggia, University of Toronto. IN: Journal of the Canadian Academy of Child & Adolescent Psychiatry, vol. 19, no. 1 (2010) pp. 32-39.**

[“Research continues to indicate a concerning number of children and youth, between 60-80%, withhold disclosure until adulthood suggesting that many children endure prolonged victimization or never receive necessary intervention. The study aim was to qualitatively identify factors that impede or promote child sexual abuse (CSA) disclosure.

Using a phenomenological design, forty adult survivors of CSA were interviewed about their disclosure experiences to provide retrospective accounts of their childhood and adolescent abuse experiences, disclosure attempts, and meaning-making of these experiences. Findings show that disclosure is determined by a complex interplay of factors related to child characteristics, family environment, community influences, and cultural and societal attitudes. An ecological analysis is offered to understand these complexities. Unless barriers to disclosure are eradicated, negative effects of CSA can persist manifesting in serious mental health issues.

Practitioners can expect to work with children, adolescents and adults who have withheld disclosure or attempted to tell over time having experienced a wide range of responses. Multi-level intervention is recommended at the individual, community and macrolevels. Future investigations should focus on how to identify and measure the impact of community and macro level factors on disclosure, aspects that have received much less attention.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47660008&site=ehost-live>

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**“Counseling Psychology for Children? The Questions of Training and Career Paths in an Emerging Profession.” By Annie Riha, Trainee Counseling Psychologist, Roehampton University, United Kingdom. IN: Counseling Psychology Review, vol. 25, no. 1 (2010) pp. 49-51.**

[“The article discusses the aims of the author's doctoral research on counseling psychology in Great Britain. The aims of the research include determining the experiences and challenges faced by qualified counseling psychologists when working with children, exploring the factors that lead to the shortage of child and adolescent

psychotherapists in the country and filling a gap that is fundamental for the emerging counseling psychology profession. The Office for National Statistics (ONS) Health Survey is also cited which found that one in every 10 children has clinically recognizable mental disorder.”]

Full text:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48314245&site=ehost-live>

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**“Dealing with Psychiatric Disabilities in Schools: A Description of Symptoms and Coping Strategies for Coping with Them.” By John Rowe, Massachusetts School 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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**“Suicidal Behavior in Adolescents with First Episode Psychosis.” By Tatiana Falcone, Cleveland Clinic, and others. IN: Clinical Schizophrenia & Related Psychoses, vol. 4, no.1 (April 2010) pp. 24-40.**

[“Background: Studies have reported an increased risk for suicide in adults with schizophrenia, but limited data on younger populations are available. Aims: We hypothesize that first-episode psychosis is associated with an increased risk of suicidal behavior in adolescents. Method: A retrospective study was conducted with patients (n=102) diagnosed with psychosis not otherwise specified (NOS), schizophreniform

disorder, schizoaffective disorder or schizophrenia within six months prior to admission. A control group consisting of ninety-eight patients with other (nonpsychosis) psychiatric diagnoses admitted to the same unit was matched by age, gender and ethnicity. All patients and controls were administered the Brief Psychiatric Rating Scale-Children version to assess severity of psychiatric symptoms and suicidality, and medical records were used to assess suicidal behavior and possible risk factors. Results: When compared to controls, patients with psychosis had over twice as many suicide attempts overall ( $p < 0.01$ ). The 32% incidence of suicide attempts reported in this cohort is nearly double what is reported in adults with psychosis. Depressive symptoms were significantly correlated with increased suicide attempts ( $p < 0.05$ ). Conclusions: There was no significant difference between the numbers of pediatric psychosis inpatients versus nonpsychotic psychiatric inpatients who attempted suicide. There was, however, a significant difference between the total number of attempts between groups, illustrating that children and adolescents with psychosis are more likely than nonpsychotic psychiatric inpatients to have repeat, or multiple, suicide attempts. Longer duration of untreated psychosis, ADHD and depressive symptoms were found to be the strongest risk factors for patients with psychosis.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48758847&site=ehost-live>

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**Testimony: Children on the Homefront: The Experiences of Children from Military Families. By Anita Chandra, Director, RAND Corporation. Testimony presented before the House Armed Services Committee, Subcommittee on Military Personnel on March 9, 2010. (RAND, Santa Monica, California) 14 p.**

[“Multiple and extended deployments and the high operational pace of the current conflicts are unparalleled for the U.S. military’s all-volunteer force (Belasco, 2007; Bruner, 2006; Hosek, 2006). As a result, many youth from military families are experiencing significant periods of parental absence. In 2006, approximately 1.89 million children had one or both parents in the military; 1.17 million had parents in the Active Component and 713,000 had parents in the Reserve Components (Department of Defense, 2006). While there are positive aspects of deployment, including increased camaraderie, sense of family pride and financial benefits associated with deployment, deployments can take a heavy toll on families concerned for the safety of their loved ones (Tanielian & Jaycox, 2008; Hosek, 2006). Arguably the most vulnerable are the children and youth left at home. While younger children may not fully comprehend why a parent must leave, older children and adolescents must cope with parental deployment during a critical and rapid stage of social and emotional development, which is challenging in the most supportive and stable of environments.”]

Full text at:

[http://www.rand.org/pubs/testimonies/2010/RAND\\_CT341.pdf](http://www.rand.org/pubs/testimonies/2010/RAND_CT341.pdf)

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## DISPARITIES

**2009 National Healthcare Disparities Report. By the Agency for Healthcare Research and Quality. AHRQ Publication Number 10-0004. (The Department for Health and Human Services, Rockville, Maryland) March 2010. 302 p.**

[“Examining health care disparities is an integral part of improving health care quality. Health care disparities are the differences or gaps in care experienced by one population compared with another population. As the National Healthcare Quality Report (NHQR) shows, Americans too often do not receive care that they need or they receive care that causes harm.

The National Healthcare Disparities Report (NHDR) shows that some Americans receive worse care than other Americans. Within the scope of health care delivery, these disparities may be due to differences in access to care, provider biases, poor provider-patient communication, poor health literacy, or other factors. The purpose of the NHDR, as mandated by Congress, is to identify the differences or gaps where some populations receive poor or worse care than others and to track how these gaps are changing over time. Although the emphasis is on disparities related to race and socioeconomic status, the reporting mandate indicates an expectation that the Agency for Healthcare Research and Quality (AHRQ) will examine health care disparities across broadly defined “priority populations.” These include ethnic minorities and other groups or categories of individuals experiencing disparate and inadequate health care.

The NHDR and NHQR use the same measures, which are categorized across four dimensions of quality: effectiveness, patient safety, timeliness, and patient centeredness. This year’s report focuses on the state of health care disparities for a group of “core” measures that represent the most important and scientifically credible measures of health care quality for the Nation, as selected by the Department of Health and Human Services (HHS) Interagency Work Group. By focusing on core measures, the 2009 report provides a more readily understandable summary and explanation of the key results derived from the data.”]

Full text at:

<http://www.ahrq.gov/qual/nhdr09/nhdr09.pdf>

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**“Use of Specialty Mental Health Services by Asian Americans with Psychiatric Disorders.” By Oanh Le Meyer, University of California, Davis, and others. IN: Journal of Consulting and Clinical Psychology, vol. 77, no. 5 (2009) pp. 1000-1005.**

[“Research suggests that Asian Americans underutilize mental health services but an understanding of the multiple factors involved in utilization has not been examined in a

nationally representative sample. The current study analyzed data from the National Latino and Asian American Study (NLAAS) and examined 368 individuals with disorders to understand utilization and what factors were related to the utilization of specialty mental health services. Significant underutilization was found for Asian Americans; moreover, underutilization was especially acute among Asian American immigrants. For U.S.-born Asian Americans, use of primary care services was significantly associated with use of mental health services, but for foreign-born Asian Americans, use of primary care services was unrelated to mental health services use. For both U.S.-born and foreign-born Asian Americans, use of alternative services appeared to significantly affect whether Asian Americans with disorders utilize mental health services, but the nature of the influence varied depending on the individual's level of English-language proficiency. These findings revealed that a major mental health disparity, the underutilization of mental health services by Asian Americans, was nuanced by use of other health-related services and immigration-related factors.”]

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## **DRUGS AND MENTAL HEALTH**

**“Psychiatrists’ Relationship with Pharmaceutical Companies: Part of the Problem or Part of the Solution?” By Thomas R. Insel, National Institute of Mental Health. IN: Journal of the American Medical Association, vol. 303, no. 12 (April 12, 2010) pp. 1192-1193.**

[“PSYCHIATRISTS HAVE RARELY ENJOYED A SURPLUS OF PUBLIC trust. During the past 3 years, public trust in psychiatry has been further undermined with accusations that several leading academic psychiatrists failed to disclose financial conflicts of interest. Sen. Charles Grassley (R, Iowa), ranking member of the Finance Committee, has thus far accused 7 psychiatrists of failing to disclose income from pharmaceutical companies. As public trust in the pharmaceutical industry has plummeted, the close connection between leading psychiatrists and the pharmaceutical industry, once a sign of progress for the profession, is now cited as evidence of corrupt influence.

The investigations spawned by these allegations already have had major effects, including restrictions on outside income, removal of investigators from National Institutes of Health (NIH) grants, and the resignation of the chair of a prestigious psychiatry department. Conflict of interest policies at many US universities have been enhanced to provide more rigorous requirements for disclosure. The National Institute of Mental Health (NIMH), which funded some of the accused individuals, has initiated an internal review system to detect potential problems with the management of financial conflicts of interest and has implemented changes to minimize possible bias in its funded studies. More broadly, the NIH is substantively revising its regulations on financial conflict of interest, which were originally adopted in 1995. The proposed new regulations are slated to be available for public comment in early spring 2010. But one of the largest effects of this scandal has been to raise a difficult and still unanswered question about the

integrity of psychiatrists. Is the financial conflict of interest problem worse for psychiatrists or are psychiatrists just an easy target? A review of evidence is in order.”

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## ELDERLY

**Researchers Identify Secrets to Happiness and Depression in the Oldest of the Old. By Chris Fisher, Managing Editor of the Behavioral Medicine Report. IN: The Behavioral Medicine Report (April 11, 2010) pp. 1-2.**

[“Researchers from Iowa State University’s gerontology program have helped identify what predicts happiness and long life in centenarians, as well as what causes depression in 80-somethings and above. In a study of 158 Georgia centenarians, the researchers found that past satisfaction with life – even if it’s simply recalling isolated career accomplishments – is the key to happiness in our oldest years.”]

Full text at:

[http://www.bmedreport.com/archives/11569?utm\\_source=feedburner&utm\\_medium=email&utm\\_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29](http://www.bmedreport.com/archives/11569?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29)

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## HEALTH CARE REFORM

**New Option for Coverage of Individuals under Medicaid. By Department of Health and Human Services, Centers Medicare and Medicaid Services. (The Department, Baltimore, Maryland) April 9, 2010. 4 p.**

[“ This letter is one of a series intended to provide guidance on the implementation of the health insurance reform legislation, the Patient Protection and Affordable Care Act (PPACA); P. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010; P. L. 111- 152. Specifically, this letter provides initial guidance on *Section 2001 of PPACA: Medicaid Coverage for the Lowest Income Populations*, which establishes a new eligibility group and the option for States to begin providing medical assistance to individuals eligible under this new group as of April 1, 2010. Under the law, for the first time since the Medicaid program was established, States will receive Federal Medicaid payments to provide coverage for the lowest income adults in their States, without regard to disability, parental status or most other categorical limitations, under their State Medicaid plans.

Full text at:

<http://www.cms.gov/smdl/downloads/SMD10005.PDF>

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## HOMELESS

**“Factors Associated with Use of Urban Emergency Departments by the U.S. Homeless Population.” By Bon S. Ku, Thomas Jefferson University, and others. IN: Public Health Reports, vol. 125, no. 3 (May-June 2010) pp. 398-405.**

[“Objective. Homeless individuals frequently use emergency departments (EDs), but previous studies have investigated local rather than national ED utilization rates. This study sought to characterize homeless people who visited urban EDs across the U.S.

Methods. We analyzed the ED subset of the National Hospital Ambulatory Medical Care Survey (NHAMCS-ED), a nationally representative probability survey of ED visits, using methods appropriate for complex survey samples to compare demographic and clinical characteristics of visits by homeless vs. non-homeless people for survey years 2005 and 2006.

Results. Homeless individuals from all age groups made 550,000 ED visits annually (95% confidence interval [CI] 419,000, 682,000), or 72 visits per 100 homeless people in the U.S. per year. Homeless people were older than others who used EDs (mean age of homeless people 5 44 years compared with 36 years for others). ED visits by homeless people were independently associated with male gender, Medicaid coverage and lack of insurance and Western geographic region. Additionally, homeless ED visitors were more likely to have arrived by ambulance, to be seen by a resident or intern, and to be diagnosed with either a psychiatric or substance abuse problem. Compared with others, ED visits by homeless people were four times more likely to occur within three days of a prior ED evaluation, and more than twice as likely to occur within a week of hospitalization.

Conclusions. Homeless people who seek care in urban EDs come by ambulance, lack medical insurance, and have psychiatric and substance abuse diagnoses more often than non-homeless people. The high incidence of repeat ED visits and frequent hospital use identifies a pressing need for policy remedies.” **NOTE: To order an electronic copy of this article, please contact the California State Library.]**

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## POSTTRAUMATIC STRESS DISORDER

**“Ethnic Differences in Posttraumatic Distress: Hispanics’ Symptoms Differ in Kind and Degree.” By Grant N. Marshall and others, RAND Corporation. IN: Journal of Consulting and Clinical Psychology, vol. 77, no. 6 (2009) pp. 1169-1178.**

[“The longitudinal study of physical injury survivors examined the degree to which Hispanic and non-Hispanic Caucasians reported similar posttraumatic stress disorder (PTSD) symptoms. Adult physical trauma survivors (N=677) provided information

regarding posttraumatic distress by completing an interview-administered version of the PTSD Symptom Checklist (Civilian version) at 3 time points: within days of trauma exposure and again at 6 and 12 months posttrauma.... Relative to non-Hispanic Caucasians, Hispanics tended to report higher levels of symptoms that could be regarded as exaggerated or intensified cognitive and sensory perceptions (e.g., hypervigilance, flashbacks). In contrast, few differences were observed for symptoms characteristic of impaired psychological functioning (e.g., difficulty concentrating, sleep disturbance). Findings suggest that the pattern of PTSD symptoms experienced most prominently by Hispanics differs in kind and not merely in degree. Results have implications for theory aimed at explaining this ethnic disparity in posttraumatic psychological distress as well as for clinical intervention with trauma-exposed Hispanics.”] **NOTE: If you would like a hard copy of this article, please contact the California State Library.**

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## STIGMA

**“Symbolic Interactions: A Theoretical Approach to Understanding Stigma and Recovery.”** By Jim Roe and others, University of Nottingham, UK. IN: *Mental Health Review Journal*, vol. 15, no. 1 (March 2010) pp. 29-36.

[“Recent years have seen the emergence of the recovery perspective. However, as yet there is no overriding theoretical framework which supports our understanding of recovery and its counterpart, stigma. In large part this is because discourses concerning *mental* health remain dominated by the medical model and an *illness* ideology, even though there is growing interest in more socially defined determinants of disability. We propose symbolic interaction as a theoretical framework which might address this shortcoming. Published literature concerning the use of this approach in the *mental* health field is reviewed and we discuss the implications and ways forward for future research on *mental* health, stigma and recovery. In particular, we consider how this approach can help identify ways in which contemporary practices and conventions might inadvertently hinder recovery and contribute towards a disabled self.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48950835&site=ehost-live>

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## SUBSTANCE ABUSE

**“Adoption Practice Guidelines and Assessment Tools in Substance Abuse Treatment.”** By Traci R. Rieckmann, Oregon Health & Science University, and others. IN: *Substance Abuse Treatment, Prevention, and Policy*, vol.5, no. 4 (March 26, 2010) pp. 1-28.

[“The gap between research and practice limits utilization of relevant, progressive and empirically validated strategies in substance abuse treatment.

## Methods

Participants include substance abuse treatment programs from the Northeastern United States. Structural equation models were constructed with agency level data to explore two outcome variables: adoption of practice guidelines and assessment tools at two points in time; models also included organizational, staffing and service variables.

## Results

In 1997, managed care involvement and provision of primary care services had the strongest association with increased use of assessment tools, which, along with provision of counseling services, were associated with a greater use of practice guidelines. In 2001, managed care involvement, counseling services and being a stand-alone drug treatment agency were associated with a greater use of assessment tools, which was in turn related to an increase in the use of practice guidelines.

## Conclusions

This study provides managers, clinicians and policy-makers with a framework for understanding factors related to the adoption of new technologies in substance abuse treatment.”]

Full text at:

<http://www.substanceabusepolicy.com/content/pdf/1747-597x-5-4.pdf>

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## SUICIDE PREVENTION

**“Method of Suicide in the Mentally Ill: A National Clinical Survey.” By Isabelle M. Hunt and others, University of Manchester, Manchester, UK. IN: Suicide & Life Threatening Behavior, vol. 40, no. 1 (February 2010) pp. 22-34.**

[“Comparisons of psychiatric patients who die by *suicide* using different methods are scarce. We aimed to establish the methods of *suicide* used by those who are currently or have recently been in contact with mental health services in England and Wales (N= 6,203), and describe the social and clinical characteristics of *suicides* by different methods. We found that hanging, self-poisoning, and jumping (from a height or in front of a moving vehicle) were the most common methods of *suicide*, accounting for 79% of all deaths. The implications of these and other findings are discussed.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48750098&site=ehost-live>

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**“The Trend in Mental-Health Mortality Rates in Australia 1916-2004: Implications for Policy.” By Darrel Doessel, Griffith University, and others. IN: Australia and New Zealand Health Policy, vol. 7, Special Section, (2010) pp. 1-10.**

[“Background: This study determines the trend in mental health-related mortality (defined here as the aggregation of *suicide* and deaths coded as "mental/behavioural disorders"), and its relative numerical importance, and to argue that this has importance to policy-makers. Its results will have policy relevance because policy-makers have been predominantly concerned with cost-containment, but a re-appraisal of this issue is occurring, and the trade-off between health expenditures and valuable gains in longevity is being emphasised now. This study examines longevity gains from mental health-related interventions, or their absence, at the population level. The study sums mortality data for *suicide* and mental/behavioural disorders across the relevant ICD codes through time in Australia for the period 1916-2004. There are two measures applied to the mortality rates: the conventional age-standardised headcount; and the age-standardised Potential Years of Life Lost (PYLL), a measure of premature mortality. Mortality rates formed from these data are analysed via comparisons with mortality rates for All Causes, and with circulatory diseases, cancer and motor vehicle accidents, measured by both methods. Results: This study finds the temporal trend in mental health-related mortality rates (which reflects the longevity of people with mental illness) has worsened through time. There are no gains. This trend contrasts with the (known) gains in longevity from All Causes, and the gains from decreases achieved in previously rising mortality rates from circulatory diseases and motor vehicle accidents. Also, PYLL calculation shows mental health-related mortality is a proportionately greater cause of death compared with applying headcount metrics. Conclusions: There are several factors that could reverse this trend. First, improved access to interventions or therapies for mental disorders could decrease the mortality analysed here. Second, it is important also that new efficacious therapies for various mental disorders be developed. Furthermore, it is also important that *suicide prevention* strategies be implemented, particularly for at-risk groups. To bring the mental health sector into parity with many other parts of the health system will require knowledge of the causative factors that underlie mental disorders, which can, in turn, lead to efficacious therapies. As in any case of a knowledge deficit, what is needed are resources to address that knowledge gap. Conceiving the problem in this way, i.e. as a knowledge gap, indicates the crucial role of research and development activity. This term implies a concern, not simply with basic research, but also with applied research. It is commonplace in other sectors of the economy to emphasise the trichotomy of invention, innovation and diffusion of new products and processes. This three-fold conception is also relevant to addressing the knowledge gap in the mental health sector.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48492153&site=ehost-live>

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## TRANSITIONS CLINICS FOR RELEASED PRISONERS

**“Transitions Clinic: Creating a Community-Based Model of Health Care for Recently Released California Prisoners.” By Emily A. Wang, San Francisco Department of Public Health, and others. IN: Public Health Reports, vol. 125, no. 2 (March-April 2010) pp. 171-177.**

[“Most California prisoners experience discontinuity of health care upon return to the community. In January 2006, physicians working with community organizations and representatives of the San Francisco Department of Public Health’s safety-net health system opened the Transitions Clinic (TC) to provide transitional and primary care as well as case management for prisoners returning to San Francisco. This article provides a complete description of TC, including an illustrative case, and reports information about the recently released individuals who participated in the program. From January 2006 to October 2007, TC saw 185 patients with chronic medical conditions. TC patients are socially and economically disenfranchised; 86% belong to ethnic minority groups and 38% are homeless. Eighty-nine percent of patients did not have a primary care provider prior to their incarceration. Preliminary findings demonstrate that a community-based model of care tailored to this disenfranchised population successfully engages them in seeking health care.” **NOTE: To order an electronic copy of this article, please contact the California State Library.**]

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## VETERANS

**Children of Combat-Deployed Parents Show Increased Worries Even After Parent Returns.** By Chris Fisher, Managing Editor, *The Behavioral Medicine Report*. IN: *The Behavioral Medicine Report* (April 10, 2010) pp. 1-2.

[“The current conflicts in Iraq and Afghanistan have resulted in extended and repeated combat-related deployments of U.S. military service members. While much has been reported about the problems, both physical and psychological, many bring back with them, new research out of UCLA shows that the family back home can have issues as well. The suddenly single parents left at home and their children must quickly adjust to altered family roles and the stress of having a loved one in a distant and dangerous land, in addition to dealing with potential psychological or physical health problems the active-duty parent may have upon their return.”]

Full text at:

[http://www.bmedreport.com/archives/11537?utm\\_source=feedburner&utm\\_medium=email&utm\\_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29](http://www.bmedreport.com/archives/11537?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29)

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**“Panel Urges Long-Term Planning to Care for Vets.”** By Kimberly Hefling, Associated Press. Associated Press. (April 1, 2010) pp. 1-2.

[“Looking decades ahead, the Institute of Medicine is urging the Veterans Affairs Department to begin planning now for the long-term health care needs of the estimated 1.9 million veterans of the Iraq and Afghanistan wars.

Specifically, the institute says in a report released Wednesday, not enough is known about what works best in the long term to treat veterans with traumatic brain injuries, often caused by roadside bombs.

While a multitude of public and private programs is available to help the men and women who have served in the recent conflicts, there is little coordination and sparse information about which ones are effective, the report said.”]

Full text at:

<http://www.google.com/hostednews/ap/article/ALeqM5gA306xup4oajexh--M6fF2PkkaCQD9EPPHM00>

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**Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members and their Families. By the Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families; Board on the Health of Selected Populations; Institute of Medicine. (National Academies of Science, Washington, D.C.) March 31, 2010. 192 p.**

[“To help current and former military personnel of the wars in Iraq and Afghanistan and their families readjust to post-deployment life, the U.S. departments of Defense and Veterans Affairs need to gather information to answer many uncertainties, including how many mental health care providers are needed and where, what works best in treating traumatic brain injury (TBI) over the long term, and whether giving service members time to decompress before returning home would be beneficial, says a new report from the Institute of Medicine. VA also needs to institute a process of forecasting the amount and types of resources necessary to meet the needs of the veterans and their families in the next 30 years or more when their demand for health care and disability compensation is likely to peak.

In addition, VA and DOD should oversee coordination and communication among the dozens of public and private programs created to serve current and former Iraq and Afghanistan service members, veterans, and their families, said the committee that wrote the report. The agencies should organize an independent evaluation of the programs, given that it is unclear whether they are all effective and whether redundancy among the programs helps ensure the needs of service members, veterans, and their families are met.

This report presents preliminary findings of a two-phase study of the readjustment needs of current and former service members deployed to Iraq and Afghanistan and their families. In this first phase, the committee sought to identify the most pressing needs of this population through an initial review of the limited scientific literature available as well as media reports and testimony from veterans and their families at town-hall meetings. The second-phase report will present more detailed findings and recommendations based on an in-depth review of additional information, including data anticipated from several ongoing studies.”]

**Full text at:**

<http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=12812>

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**Veteran’s Health Administration: Community-Based Outpatient Clinics. By Sidath Viranga Panangala, Specialist in Veterans Policy, and Bryce H.P.Mendez. Congressional Research Service. CRS Report for Congress 7-5700 (The Service, Washington, D.C.) January 28, 2010. 17 p.**

[“In the early 1990s, the Veterans Health Administration (VHA)—one of the three administrations of the Department of Veterans Affairs (VA)—began developing a strategy to expand its capacity to provide outpatient primary care, especially for veterans who had to travel long distances to receive care at VA facilities. To facilitate access to primary care closer to where veterans reside, VHA began implementing a system for approving and establishing Community-Based Outpatient Clinics (CBOCs).

A CBOC is a fixed health care site that is geographically distinct or separate from its parent VA medical facility. A CBOC can be either VA-owned or VA-staffed or contracted to Healthcare Management Organizations (HMO). Regardless of how it is administered, a CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for current or eligible veteran patients. VA policies require all CBOCs to be operated in a manner that provides veterans with consistent, safe, high-quality health care.

CBOCs are managed at the Veterans Integrated Service Network (VISN) level, and planning and development of a new CBOC is based on the VA’s need, available resources, local market circumstances, and veteran preference.

In FY2010, VA expects to have a total of 833 operational CBOCs throughout the United States and its territories to serve over 2.8 million veteran patients. In addition to primary care, CBOCs provide mental health services, management of acute and chronic medical conditions, and pharmacy benefits, among other services. It should be noted that the type of medical services available at a CBOC can vary from clinic to clinic.

This report provides an overview of VA’s rationale in establishing CBOCs, describes how they are managed and administered, discusses medical services provided at CBOCs, and summarizes what is known about the quality and cost of providing care in CBOCs compared to primary care clinics at VA Medical Centers. Lastly, it describes the process for developing a new CBOC. This report will be updated if events warrant. “]

Full text at:

[http://assets.opencrs.com/rpts/R41044\\_20100128.pdf](http://assets.opencrs.com/rpts/R41044_20100128.pdf)

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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

### California Health Cities and Communities Speakers' Forum

April 22, 2010

Oakland, California

For more information:

<http://events.constantcontact.com/register/event?oeidk=a07e2r277et106395ea>

**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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### North American Brain Injury Society and the Alaska Brain Injury Network

Alaska Brain Injury Conference

July 28-30, 2010.

For more information:

<http://www.nabis.org/node/84>

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

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