

Subject: Studies in the News: (May 28, 2010)



Studies in the News for



California Department of Mental Health

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ATTITUDES TOWARDS MENTAL ILLNESS

Attitudes Towards Mental Illness-35 States, District of Columbia and Puerto Rico, 2007. By the Centers for Disease Control and Prevention. IN: MMWR Weekly Report, vol. 59, no. 20 (May 28, 2010) pp. 618-614.

[“Negative attitudes about mental illness often underlie stigma, which can cause affected persons to deny symptoms; delay treatment; be excluded from employment, housing, or relationships; and interfere with recovery. Understanding attitudes toward mental illness at the state level could help target initiatives to reduce stigma, but state-level data are scant. To study such attitudes, CDC analyzed data from the District of Columbia (DC), Puerto Rico, and the 35 states participating in the 2007 Behavioral Risk Factor Surveillance System (BRFSS) (the most recent data available), which included two questions on attitudes toward mental illness. Most adults (88.6%) agreed with a statement that treatment can help persons with mental illness lead normal lives, but fewer (57.3%) agreed with a statement that people are generally caring and sympathetic to persons with mental illness.”]

Full text at: **(NOTE: Go to page 618 on this website to read the article on mental illness attitudes.)**

<http://www.cdc.gov/mmwr/PDF/wk/mm5920.pdf>

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CHILDREN AND ADOLESCENTS

Addressing the Mental Health Needs of Young Children and their Families. By the U. S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. HHS Publication No. (SMA)-10-4547. (The Department, Washington, D.C.) May 2010. 4 p.

[“Young children experience mental health challenges that impact early learning, social interactions, and the overall well-being of their families. It is estimated that between 9%

and 14% of children from birth to 5 years of age experience social and emotional problems that negatively affect their functioning and development. Among babies, signs of depression can include inconsolable crying, slow growth, and sleep problems.

Mental health challenges among young children occur within the context of early childhood growth and development, during which children develop self-control and learn to tolerate frustration. For example, although temper tantrums may be developmentally normal for toddlers, tantrums characterized by self-destructive behaviors or aggressive behavior toward people or property can indicate that emotional and behavioral problems are present. A young child who withdraws regularly from social situations and experiences fear when interacting with others may have mental health needs...

Providing effective age-appropriate services and supports to young children and their families, however, has immediate as well as lifelong benefits. Young children who receive effective age-appropriate services and supports are more likely to complete high school, have fewer contacts with law enforcement, and improve their ability to live independently. This short report describes social and emotional outcomes for young children from birth through 8 years of age and their families, a subset of all children and youth who receive services in systems of care.”]

Full text at:

http://www.samhsa.gov/children/docs/MH_Needs_Children_Families.pdf

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"Client-Directed Wraparound: The Client as Connector in Community Collaboration." By Jacqueline A. Sparks, University of Rhode Island, and Michelle L. Muro, Southwest Behavioral Health Services. IN: Journal of Systematic Therapies, vol. 28, no.3 (Fall 2009) pp. 63-76.

["Systems of care emphasize the need for effective collaboration between community agencies assisting families where a child or adolescent is at risk of out-of-home placement. Unfortunately, community collaborations may not privilege the voices of family members, including the young person. Research affirms the critical importance of honoring clients' views in any change endeavor. *Wraparound* and client-directed, outcome-informed (CDOI) projects support this imperative, with CDOI offering client-report feedback measures to formally amplify clients' perspectives. The connection between these two distinct movements provides a philosophical and operational basis to create productive and even inspiring community partnerships."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45147507&site=ehost-live>

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Related article: “Evaluating wraparound services for seriously emotionally disturbed youth: Pilot study outcomes in Georgia.” (2007)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=28031054&site=ehost-live>

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Evidence-Based Appropriate Interventions: A Guide for Child and Adolescent Mental Health Services (CAMHS). 2nd Edition. By The Werry Centre for Child and Adolescent Mental Health Workforce Development. (The Centre, Auckland, New Zealand) May 2010. 106 p.

[“Welcome to this reference guide on Evidence-Based interventions for children and young people experiencing mental disorder. This guide has two main aims:

- To clarify for clinicians and managers, the range of child and youth mental health and addiction disorders that would be expected to be seen in primary, secondary and tertiary services, and the expected prevalence of these disorders.
- To identify the range of age-appropriate therapeutic skills/interventions that are needed to work effectively with children, young people and their family/whānau.

The guide is offered as an alternative to lengthy searches of the literature that might otherwise be undertaken to identify age-appropriate interventions. In the formulation of this guide there is recognition that children and young people with mental health concerns often present with a complexity that must be taken into consideration when planning interventions. This complexity may be a result of co-morbid disorders which are frequently present for children and young people with mental health difficulties. The document therefore also has a strong focus on the age-appropriate interventions that have been described as effective in the treatment of children and young people with one or more mental health disorder. The guide also recognizes the importance of including a focus on interventions for children and young people experiencing alcohol and other drug concerns, and for this reason, interventions for this range of disorders are also included.”]

Full text at:

http://www.werrycentre.org.nz/site_resources/library/Workforce_Development_Publications/FINAL_EBP_Document_12_May_2010.pdf

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Related article: “Identifying and implementing prevention programmes for childhood mental health problems.” (2007)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=27550543&site=ehost-live>

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Fostering Solutions: Bringing Brief-Therapy Principles and Practices to the Child Welfare System. By Douglas Flemons, Nova Southeastern University, and others. IN: *Journal of Marital and Family Therapy*, vol. 36, no. 1 (January 2010) pp. 80-95

["This article describes a 15-month university-community collaboration that was designed to fast-track children out of foster care. The developers of the project initiated resource-oriented "systems facilitations," allowing *wraparound* professionals and families to come together in large meetings to solve problems and find solutions. Families also participated in strength-based brief-therapy sessions. The authors describe the history, structure, and process of the project, and they provide a case study to illustrate the approach and exemplify the kinds of changes that occurred throughout the system. In the final section of the article, the authors reflect on what they learned about their university-community partnership, what they would do differently the next time, and the implications of such larger-system involvements for American Association for Marriage and Family Therapy's Core Competencies."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=f5h&AN=47444831&site=ehost-live>

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"A Preliminary Analysis of the Receipt of Mental Health Services Consistent With National Standards among *Children* in the *Child Welfare* System." By Ramesh Raghavan, Washington University, School of Medicine, and others. IN: *American Journal of Public Health*, vol. 100, no. 4 (April 2010) pp.742-749.

["Objectives. We sought to examine the extent to which *children* in the *child welfare* system receive mental health care consistent with national standards. Methods. We used data from 4 waves (3 years of follow-up) of the National Survey of *Child* and Adolescent Well-Being, the nation's first longitudinal study of *children* in the *child welfare* system, and the Area Resource File to examine rates of screening, assessment, and referral to mental health services among 3802 youths presenting to *child welfare* agencies. Weighted population-averaged logistic regression models were used to identify variables associated with standards-consistent care. Results. Only half of all *children* in the sample received care consistent with any 1 national standard, and less than one tenth received care consistent with all of them. Older *children*, those exhibiting externalizing behaviors, and those placed in foster care had, on average, higher odds of receiving care consistent with national standards. Conclusions. Adverse consequences of childhood disadvantage cannot be reduced unless greater collaboration occurs between *child welfare* and mental health agencies. Current changes to Medicaid regulations that weaken entitlements to screening and assessment may also worsen mental health disparities among these vulnerable *children*."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48905887&site=ehost-live>

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CURRENT NEWS ON THE CA BUDGET CRISIS AND MENTAL HEALTH

Mental Health Experts Flummoxed by Gov.'s Proposed Budget Cuts. California Healthline: The Daily Digest of News, Policy, and Opinion. (May 21, 2010) pp.1-3.

[“What's a state to do? California is facing an additional budget deficit of more than \$19 billion. As a result, Gov. Arnold Schwarzenegger (R) proposed a revised budget last week with monumental cuts to social services.

The revised budget would cut about \$750 million in funding from In-Home Supportive Services and another \$532 million from Medi-Cal, California's Medicaid program. The budget cuts also hit Healthy Families, California's Children's Health Insurance Program, and slash health care spending in state prisons.

Given the size and scope of all of those proposed budget cuts, the plan to scale back state mental health services seems like a minor budget detail. But according to mental health advocates, the idea to shift \$435 million in mental health service costs to the counties would be a disaster.”]

Full text at:

<http://www.californiahealthline.org/theweekly.aspx?theweeklydate=5/21/2010>

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DISABILITIES

Media Guidelines for the Portrayal of Disability. By the International Labor Office: Skills and Employability Department. (The Office, Geneva, Switzerland.) 2010. 21 p.

[“The media - television, radio, newspapers, magazines, the Internet, social media and other forms - play an important role in influencing public opinion and attitudes. The choice of words, images and messages can determine perceptions, attitudes and behaviours. It can also define what does or does not matter to individuals and the world around them.

How people with disabilities are portrayed and the frequency with which they appear in the media has an enormous impact on how they are regarded in society. While there are some disability-specific media programmes, such as television documentaries, disabled people rarely appear as part of mainstream programmes. When they do appear, they are often stigmatized or stereotyped, and may appear as either objects of pity or super heroic accomplishment and endurance. Including them in regular programmes on television and radio in addition to other types of media can help provide fair and balanced

representation and helps to counter commonplace stereotypes that perpetuate negative perceptions of disabled persons.”]

Full text at:

http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---ifp_skills/documents/publication/wcms_127002.pdf

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DISPARITIES

Meeting the Health Equity Challenge: State Case Studies. By the Association of State and Territorial Health Officials. (The Association, Arlington, Virginia) 2010. 48 p.

[“This past year, state public health departments successfully mobilized to protect tens of millions against the HINI virus, but a much more insidious and intractable problem remains: How to reduce health disparities that exist within every state.

In recent years, a raft of studies have shown that health outcomes, whether it be average lifespan, infant mortality, or rates of chronic diseases, are closely linked to what the World Health Organization in 2005 first described as the “social determinants of health.” Income, education, race, environment, access to good housing and safe neighborhoods – all shape an individual’s chances for a long, healthy life.

It’s not a new notion. Social reformers like Jane Addams toiled early in the century to improve living conditions and economic prospects among immigrants in urban slums. Even more significant was the series of life-changing government programs that emerged from the Great Depression, WWII, and the civil rights movement. Social Security, the GI bill, FHA/VA home loans, Medicare, Medicaid, Head Start, WIC, Pell Education Grants – all directly or indirectly impacted the nation’s health.

Yet despite these and other programs, sharp differences still remain in the health prospects of Americans. That fact came through loud and clear in the 2008 PBS series, “Unnatural Causes: Is Inequality Making Us Sick?” Segments dealt with problems ranging from premature births among black women to the alarming rates of diabetes in Native American communities and the surge in depression-related illness among victims of plant closings in Michigan. Conclusion: The social environment in which we are born, live and work profoundly affects our well-being and longevity.”]

Full text at:

<http://www.astho.org/Display/AssetDisplay.aspx?id=4204>

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“Paying for Performance in Primary Care: Potential Impact on Practices and Disparities.” By Mark W. Friedberg, RAND Corporation, and others. IN: *Health Affairs*, vol. 29, no. 5 (May 2010) pp. 926-932.

[“Performance-based payments are increasingly common in primary care. However, given the persistent disparities in the quality of care that different populations receive, such payments may actually take resources away from the care of racial and ethnic minorities and people of low socioeconomic status. RAND investigators simulated performance-based payments to practices serving higher and lower shares of patients from these vulnerable communities in Massachusetts. Typical practices serving higher shares of vulnerable populations would receive less per practice compared to others, by amounts of more than \$7,000. These findings suggest that pay-for-performance programs should monitor and address the potential impact of performance-based payments on health care disparities.”]

Full text at:

<http://content.healthaffairs.org/cgi/reprint/29/5/926>

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Related article: Racial and ethnic disparities in the treatment of the Medicaid population with schizophrenia. (2009)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45163297&site=ehost-live>

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ELDERLY

“Home-Based Activity Program for Older People with Depressive Symptoms: DeLLITE – A Randomized Controlled Trial.” By Ngaire Kerse, University of Auckland, Auckland, New Zealand, and others. IN: *Annals of Family Medicine*, vol. 8, no. 3 (May/June 2010) pp. 214-223.

[“We wanted to assess the effectiveness of a home-based physical activity program, the Depression in Late Life Intervention Trial of Exercise (DeLLITE), in improving function, quality of life, and mood in older people with depressive symptoms.

METHODS We undertook a randomized controlled trial involving 193 people aged 75 years and older with depressive symptoms at enrollment who were recruited from primary health care practices in Auckland, New Zealand. Participants received either an individualized physical activity program or social visits to control for the contact time of the activity intervention delivered over 6 months. Primary outcome measures were function, a short physical performance battery comprising balance and mobility, and the Nottingham Extended Activities of Daily Living scale. Secondary outcome measures were quality of life, the Medical Outcomes Study 36-item short form, mood, Geriatric Depression Scale (GDS-15), physical activity, Auckland Heart Study Physical Activity Questionnaire, and self-report of falls. Repeated measures analyses tested the differential impact on outcomes over 12 months’ follow-up.

RESULTS The mean age of the participants was 81 years, and 59% were women. All participants scored in the at-risk category on the depression screen, 53% had a *Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases, Tenth Revision* diagnosis of major depression or scored more than 4 on the GDS-15 at baseline, indicating moderate or severe depression. Almost all participants, 187 (97%), completed the trial. Overall there were no differences in the impact of the 2 interventions on outcomes. Mood and mental health related quality of life improved for both groups.

CONCLUSION The DeLLITE activity program improved mood and quality of life for older people with depressive symptoms as much as the effect of social visits. Future social and activity interventions should be tested against a true usual care control.”]

Full text at:

<http://www.annfammed.org/cgi/reprint/8/3/214?maxtoshow=&hits=10&RESULTFORMAT=1&author1=hayman%2C+k&andorexacttitle=and&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HW CIT>

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Related article: Prevalence of anxiety disorders among elderly people. (2009)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=43784376&site=ehost-live>

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Older Americans in Poverty: A Snapshot. By Ellen O’Brien and others, AARP Public Policy Institute. (The Institute, Washington, DC) April 2010. 76 p.

[“Older Americans in Poverty: A Snapshot is a chartbook and policy primer that examines the persistent problem of elderly poverty in the United States. This chartbook provides valuable data on older adults in poverty—who they are, where they live, and the challenges they face affording basics like food, housing, and health care. It describes the reliance of older poor and low-income families on Social Security, their use of public benefits, and their assets.

The chartbook highlights wide variation in poverty rates by race and ethnicity, age, sex, and marital status. For example, despite the sizable overall decline in elderly poverty since the 1960s, poverty remains unacceptably high for many, including older black and Hispanic women, more than a third of whom have incomes below poverty or just above the poverty line.

The chartbook also examines the problems with the official poverty statistic. It explains what’s wrong with the current measure and describes the proposal to modernize the poverty measure to provide a more accurate assessment of how many people—including

older adults—face severe economic hardship. The chartbook closes with a discussion of policy options for reducing poverty at older ages.”]

Full text at:

<http://assets.aarp.org/rgcenter/ppi/econ-sec/2010-03-poverty.pdf>

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MEDICAL HOMES

“Specialty Care Medical Homes for People with Severe, Persistent Mental Disorders.” By Vidiya Alakeson, U.S. Department of Health and Human Services, and others. IN: *Health Affairs*, vol. 29, no. 5 (May 2010) pp. 867-873.

[“The patient-centered medical home concept is central to discussions about the reform of the health care delivery system. Most descriptions of the concept assume that a primary care practice would serve as the hub of the medical home. However, for people with severe and persistent mental disorders, specialty health care settings serve as the principal point of contact with the health care system. For them, a patient-centered medical home in a specialty setting would be the most expedient way to address their urgent health care needs. Among other issues, implementing this idea would mean reimbursement strategies to support the integration and coordination of primary care in specialty settings.”]

Full text at:

<http://content.healthaffairs.org/cgi/reprint/29/5/867>

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Related article: From concierge medicine to patient centered medical homes: International lessons and the search for a better way to deliver primary health care in the U.S. (2009)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48307164&site=ehost-live>

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MULTIPLE ANXIETY DISORDERS

Delivery of Evidence-Based Treatment for Multiple-Anxiety Disorders in Primary Care: A Randomized Controlled Trial. By Peter Roy-Bryne, University of Washington School of Medicine, and others. IN: *Journal of American Medical Association*, vol. 303, no. 19 (May 19, 2010) pp. 1921-1928.

[“Improving the quality of mental health care requires moving clinical interventions from controlled research settings into real-world practice settings. Although such advances have been made for depression, little work has been performed for anxiety disorders.

Objective: To determine whether a flexible treatment-delivery model for multiple primary care anxiety disorders (panic, generalized anxiety, social anxiety, and posttraumatic stress disorders) would be better than usual care (UC).

Design, Setting, and Patients A randomized controlled effectiveness trial of Coordinated Anxiety Learning and Management (CALM) compared with UC in 17 primary care clinics in 4 US cities. Between June 2006 and April 2008, 1004 patients with anxiety disorders (with or without major depression), aged 18 to 75 years, English- or Spanish-speaking, were enrolled and subsequently received treatment for 3 to 12 months. Blinded follow-up assessments at 6, 12, and 18 months after baseline were completed in October 2009.

Intervention CALM allowed choice of cognitive behavioral therapy (CBT), medication, or both; included real-time Web-based outcomes monitoring to optimize treatment decisions; and a computer-assisted program to optimize delivery of CBT by non expert care managers who also assisted primary care clinicians in promoting adherence and optimizing medications.

Main Outcome Measures Twelve-item Brief Symptom Inventory (BSI-12) anxiety and somatic symptoms score. Secondary outcomes included proportion of responders ($\geq 50\%$ reduction from pretreatment BSI-12 score) and remitters (total BSI-12 score ≤ 6)...

Conclusion For patients with anxiety disorders treated in primary care clinics, CALM compared with UC resulted in greater improvement in anxiety symptoms, depression symptoms, functional disability, and quality of care during 18 months of follow-up.”

NOTE: If you would like an electronic copy of this article, please contact the CA State Library.]

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RESEARCH INFORMATION

“The Annals of Family Medicine Research Summary and Tip Sheet.” By Christopher Fisher, M.A. IN: The Behavioral Medicine Report. (May/June 2010) pp. 1-4.

[“The Annals of Family Medicine released a research summary / health-care provider tip sheet for May/June based on recent studies with patient populations that range from children to the elderly. This summary covers topics from mental health, including health psychology and behavioral medicine, and physical health that psychologists and physicians alike may be interested in. Hopefully, The Annals of Family Medicine continues to publish these useful research summaries.”]

Full text at:

http://www.bmedreport.com/archives/12820?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29

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TECHNOLOGY

“Mobile Therapy: Case Study Evaluations of a Cell Phone Application for Emotional Self-Awareness.” By Margaret E. Morris, Digital Health Group, Intel Corporation, and others. IN: *Journal of Medical Internet Research*, vol. 12, no. 2 (2010) pp. 1-8.

Background: Emotional awareness and self-regulation are important skills for improving mental health and reducing the risk of cardiovascular disease. Cognitive behavioral therapy can teach these skills but is not widely available.

Objective: This exploratory study examined the potential of mobile phone technologies to broaden access to cognitive behavioral therapy techniques and to provide in-the-moment support.

Methods: We developed a mobile phone application with touch screen scales for mood reporting and therapeutic exercises for cognitive reappraisal (i.e., examination of maladaptive interpretations) and physical relaxation. The application was deployed in a one-month field study with eight individuals who had reported significant stress during an employee health assessment. Participants were prompted via their mobile phones to report their moods several times a day on a Mood Map—a translation of the circumplex model of emotion—and a series of single-dimension mood scales. Using the prototype, participants could also activate mobile therapies as needed. During weekly open-ended interviews, participants discussed their use of the device and responded to longitudinal views of their data. Analyses included a thematic review of interview narratives, assessment of mood changes over the course of the study and the diurnal cycle, and interrogation of this mobile data based on stressful incidents reported in interviews.

Results: Five case studies illustrate participants' use of the mobile phone application to increase self-awareness and to cope with stress. One example is a participant who had been coping with longstanding marital conflict. After reflecting on his mood data, particularly a drop in energy each evening, the participant began practicing relaxation therapies on the phone before entering his house, applying cognitive reappraisal techniques to cope with stressful family interactions, and talking more openly with his wife. His mean anger, anxiety and sadness ratings all were lower in the second half of the field study than in the first ($P \leq .01$ for all three scales). Similar changes were observed among other participants as they used the application to negotiate bureaucratic frustrations, work tensions and personal relationships. Participants appeared to understand the mood scales developed for this experience sampling application and responded to them in a way that was generally consistent with self-reflection in weekly interviews. Interview accounts of mood changes, associated with diurnal cycles, personal improvement over the course of the study, and stressful episodes, could be seen in the experience sampling data. Discrepancies between interview and experience-sampling data highlighted the ways that individuals responded to the two forms of inquiry and how they calibrated mood ratings over the course of the study.

Conclusions: Participants quickly grasped the Mood Mapping and therapeutic concepts, and applied them creatively in order to help themselves and empathize with others. Applications developed for mobile phones hold promise for delivering state-of-the-art

psychotherapies in a nonstigmatizing fashion to many people who otherwise would not have access to therapy.”]

Full text at:

<http://www.jmir.org/2010/2/e10>

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VETERANS

“Consultation as a Means of Veteran Suicide Prevention.” By Peter M. Gutierrez and others, Denver VA Medical Center. IN: Professional Psychology: Research and Practice, vol. 40, no. 6 (December 2009) pp. 586-592.

[“The development and implementation of a suicide consultation service being run by an interdisciplinary team in a metropolitan *Veteran's* Administration (VA) medical center is described. This service is grounded in a collaborative theoretical framework. An overview of the consultation process and theoretical and empirical literature to support the framework used by the service are provided. Some of the interventions commonly recommended to referring clinicians to reduce client suicide risk are reviewed. Although there are many challenges to running a service such as this, the authors conclude that the model presented is flexible enough to be applied in a variety of settings.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47145169&site=ehost-live>

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“A Multidimensional Wellness Group Therapy Program for Veterans with Comorbid Psychiatric and Medical Conditions.” By Lawrence M. Perlman, University of Michigan, and others. IN: Professional Psychology: Research and Practice, vol. 41, no. 2 (April 2010) pp. 120-127.

[“Development of a healthy lifestyle is an important aspect of *mental health* that is infrequently targeted in outpatient *mental health* settings. Although the interrelationship of psychological and physical factors has often been noted, interventions frequently focus on just one aspect of functioning. This project demonstrated the feasibility of a multidimensional weekly wellness group program focused on the overall *health* behaviors of patients in a *Veterans* Affairs *mental health* clinic.

The modal participant was a male in his mid-50s, living alone, not employed, depressed, obese, and with many chronic medical problems. Eighty-three patients participated in a 15-week program promoting changes in such areas as stress management (abdominal breathing, muscle relaxation, visualization, and mindfulness), physical *health* care

(exercise, nutrition, sleep routine, and substance use), and behavioral activation (activity scheduling, social affiliation, and use of community resources). Substantial improvement was found for most patients, in both psychosocial and physical functioning domains, and was maintained over time.

The melding of psychoeducational and skills training into a positive psychology orientation appears to have been beneficial. In addition, the group process was quite effective in encouraging change in these highly comorbid, chronically ill *veterans*. The feasibility and importance of integrating psychosocial and physical interventions is underscored by this study.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=pro-41-2-120&site=ehost-live>

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“The Role of Psychologists in the Care of Iraq and Afghanistan Veterans in Primary Care Settings.” By Shera Maguen and others, San Francisco VA Medical Center. **IN: Professional Psychology: Research and Practice, vol. 41, no. 2 (April 2010) pp. 135-142.**

[“Although military personnel serving in Iraq and Afghanistan are at high risk of developing *mental health* problems, many report significant barriers to care and few seek help. Integrated primary care is a comprehensive model of *health* care that aims to improve access to care and provides a framework to assess and meet the complex psychiatric needs of newly returning *veterans* by embedding *mental health* specialists within primary care.

We describe the role of psychologists in a Department of *Veterans* Affairs (VA) integrated primary care clinic that serves *veterans* of Iraq and Afghanistan. Psychologists based in primary care can assist *veterans* with reintegration to civilian life by providing rapid *mental health* assessment, normalizing re-adjustment concerns, planning for *veterans*’ safety, implementing brief interventions within primary care, facilitating transition to additional *mental health* care, and informing *veterans* of other available psychosocial *services*.

A case example demonstrating the psychologist’s role highlights the benefits of an integrated care model. Implications of employing this model include reduction of symptoms and impairment by reducing stigma and barriers to seeking *mental health* care, increased motivation to engage in treatment, and implementation of early interventions. This model may also be beneficial in the civilian *health* care sector with groups that are at high risk for *mental health* problems, yet experience barriers to care, particularly stigma.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=pro-41-2-135&site=ehost-live>

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NON PROFIT RESOURCE CENTER-GRANT WRITING

["Our mission is to enhance the resources and improve the management of nonprofit organizations, primarily within California's northern Central Valley and Sierra Nevada regions.

We invite you to visit us often to find resources that will help your nonprofit grow stronger and be more successful -- from information on training opportunities, consultation and technical assistance, to building connections with your peers.

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More information about grant-writing at:

<http://www.nprcenter.org/>

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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

Mental Health America's Annual Conference

June 9-12, 2010
Washington, D.C.

For more information at:

<http://www.mentalhealthamerica.net/go/conference2010/schedule/>

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Western Conference on Behavioral Health and Addictive Disorders

June 17-19, 2010
Newport Beach, California

For more information:
<http://www.usjt.com/ca-training-addictive-disorders10/>

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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

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Reinventing Quality 2010

Reinventing Quality Conference
August 8-10, 2010
Baltimore, Maryland

For more information:
<http://www.reinventingquality.org/upcoming/>

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