

Subject: Studies in the News: (June 14, 2010)



Studies in the News for



California Department of Mental Health

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CHILDREN AND ADOLESCENTS

Early Childhood Intervention: A Promise to Children and Families for Their Future.” By Mary Beth Bruder, University of Connecticut. IN: *Exceptional Children*, vol. 76, no. 3 (Spring 2010) pp. 339-355.

[“The field of early childhood intervention for infants and young children with disabilities or delays has a rich history that spans many disciplines of practice. Both legislation and research has provided a foundation for how services are delivered to this population, and there are several recommended practices that govern service delivery to this group, the most prominent being family-centered care, team process, and natural and inclusive environments. Unfortunately, the field is facing many challenges because of the growing heterogeneity of children's and families' needs, the increasing complexity and variability of service systems, and dwindling resources available to support an infrastructure. Recommendations to address the future of early childhood intervention include adopting a culture of accountability across all dimensions of service provision, developing and instituting evidence-based practice, implementing comprehensive systems of professional development, and collaborating and merging with the early care and education movement that is growing rapidly across the country.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48897209&site=ehost-live>

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“Group Counseling Techniques for Teaching Social Skills to Students with Special Needs.” By Derk Stephens, University of Idaho, and others. IN: *Education*, vol. 130, no. 3 (Spring 2010) pp. 509-512.

[“This paper examines literature that supports the use of group counseling techniques in the school setting to teach social skills to children and adolescents with special needs. From the review of this literature it was found that group counseling is a very effective way of addressing a variety of social skills problems that can be displayed by very differing populations within the school setting. The implications of this research for the school counselor are included, as well as some cautions to consider before applying group counseling to students in the schools.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48753414&site=ehost-live>

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“Randomized Controlled Trial of School-Based Humanistic Counselling for Emotional Distress in Young People: Feasibility Study and Preliminary Indications of Efficacy.” By Mick Cooper, University of Strathclyde, Glasgow, UK, and others. IN: *Child and Adolescent Psychiatry and Mental Health*, vol. 4, no.12 (April 22, 2010) pp. 1-12

[“Aims: The purpose of this study was to test the feasibility of a randomised controlled trial comparing six weeks of humanistic school-based counselling versus waiting list in the reduction of emotional distress in young people, and to obtain initial indications of efficacy.

Methods: Following a screening procedure, young people (13 - 15 years old) who experienced emotional distress were randomised to either humanistic counselling or waiting list in this multi-site study. Outcomes were assessed using a range of self-report mental health measures, with the emotional symptoms subscale of the Strengths and Difficulties Questionnaire (SDQ) acting as the primary outcome indicator...

Conclusion: This study suggested that a randomised controlled trial of counselling in schools is acceptable and feasible, although initial indications of efficacy are mixed.”]

Full text at:

<http://www.capmh.com/content/pdf/1753-2000-4-12.pdf>

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What Works? A Study of Effective Early Childhood Mental Health Programs. By Francis Duran and others, Georgetown University Center for Child and Human Development. (The Center, Washington, D.C.) August, 2009. 232 p.

[“This report is targeted toward states and communities interested in data-driven guidance around the creation and implementation of childhood mental health consultation programs. Through visits to six consultation programs, the authors explore the essential components of effective mental health programs, such as the skills, competencies, and training of the mental health professionals, and detail the extent to which consultation efforts occur nationally.”]

Full text at:

<http://www.aecf.org/~media/Pubs/Topics/Education/Early%20Childhood%20and%20School%20Readiness/WhatWorksAStudyofEffectiveEarlyChildhoodMenta/ECMHCStudyReport.pdf>

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Youth Risk Behavior Surveillance-United States, 2009. By Department of Health and Human Services, Centers for Disease Control. Morbidity and Mortality Weekly Report. (MMWR) (The Centers, Atlanta, Georgia) June 4, 2010. 148 p.

[**“Problem:** Priority health-risk behaviors, which are behaviors that contribute to the leading causes of morbidity and mortality among youth and adults, often are established during childhood and adolescence, extend into adulthood, and are interrelated and preventable.

Results: Results from the 2009 national YRBS indicated that many high school students are engaged in behaviors that increase their likelihood for the leading causes of death among persons aged 10–24 years in the United States. Among high school students nationwide, 9.7% rarely or never wore a seat belt when riding in a car driven by someone else. During the 30 days before the survey, 28.3% of high school students rode in a car or other vehicle driven by someone who had been drinking alcohol, 17.5% had carried a weapon, 41.8% had drunk alcohol, and 20.8% had used marijuana. During the 12 months before the survey, 31.5% of high school students had been in a physical fight and 6.3% had attempted suicide.

Substantial morbidity and social problems among youth also result from unintended pregnancies and STDs, including HIV infection. Among high school students nationwide, 34.2% were currently sexually active, 38.9% of currently sexually active students had not used a condom during their last sexual intercourse, and 2.1% of students had ever injected an illegal drug. Results from the 2009 YRBS also indicated that many high school students are engaged in behaviors associated with the leading causes of death among adults aged ≥ 25 years in the United States. During 2009, 19.5% of high school students smoked cigarettes during the 30 days before the survey. During the 7 days before the survey, 77.7% of high school students had not eaten fruits and vegetables five or more times per day, 29.2% had drunk soda or pop at least one time per day, and 81.6% were not physically active for at least 60 minutes per day on all 7 days. One-third of high school students attended physical education classes daily, and 12.0% were obese.

Interpretation: Since 1991, the prevalence of many health-risk behaviors among high school students nationwide has decreased. However, many high school students continue to engage in behaviors that place them at risk for the leading causes of morbidity and mortality. The prevalence of most risk behaviors does not vary substantially among cities and states.”]

Full text at:

<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>

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DISPARITIES

"Comparing Methods of Racial and Ethnic Disparities Measurement across Different Settings of Mental Health Care." By Benjamin Le Cook, Harvard Medical School, and others. IN: Health Services Research, vol. 45, no. 3 (June 2010) pp. 825-847.

["Introduction. The ability to track improvement against racial/ethnic disparities in mental health care is hindered by the varying methods and disparity definitions used in previous research. Data. Nationally representative sample of whites, blacks, and Latinos from the 2002 to 2006 Medical Expenditure Panel Survey. Dependent variables are total, outpatient, and prescription drug mental health care expenditure. Methods. Rank- and propensity score-based methods concordant with the Institute of Medicine (IOM) definition of health care disparities were compared with commonly used disparities methods. To implement the IOM definition, we modeled expenditures using a two-part GLM, adjusted distributions of need variables, and predicted expenditures for each racial/ethnic group.

Findings. Racial/ethnic disparities were significant for all expenditure measures. Disparity estimates from the IOM-concordant methods were similar to one another but greater than a method using the residual effect of race/ethnicity. Black–white and Latino–white disparities were found for any expenditure in each category and Latino–white disparities were significant in expenditure conditional on use.

Conclusions. Findings of disparities in access among blacks and disparities in access and expenditures after initiation among Latinos suggest the need for continued policy efforts targeting disparities reduction. In these data, the propensity score-based method and the rank-and-replace method were precise and adequate methods of implementing the IOM definition of disparity."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=50211677&site=ehost-live>

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"Disparities in Access to Substance Abuse Treatment among People with Intellectual Disabilities and Serious Mental Illness." By Elspeth M. Slayter, Salem State College. IN: Health and Social Work, vol. 35, no. 1 (February 2010) pp. 49.60.

["People with intellectual disabilities (ID) have experienced increasing levels of community participation since deinstitutionalization. This freedom has facilitated community inclusion, access to alcohol and drugs, and the potential for developing

substance abuse (SA) disorders. People with ID, who are known to have high rates of co-occurring serious *mental illness* (SMI), may be especially vulnerable to the consequences of this disease and less likely to use SA treatment. Using standardized performance measures for SA treatment access (initiation, engagement), rates were examined retrospectively for *Medicaid* beneficiaries with ID/SA/ SMI ages 12 to 99 (N = 5,099) and their counterparts with no ID/SA/SMI (N = 221,875). Guided by the sociobehavioral model of health care utilization, age-adjusted odds ratios and logistic regression models were conducted. People with ID/SA/SMI were less likely than their counterparts to access treatment. Factors associated with initiation included being nonwhite, living in a rural area, and not being dually eligible for Medicare; factors associated with engagement included all of the same and having a fee-for-service plan, a chronic SA-related disorder, or both. Social work policy and practice implications for improving the health of people with ID/SA/SMI through policy change, cross-system collaboration, and the use of integrated treatment approaches are discussed. "]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=48835594&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, 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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EVIDENCE-BASED CARE

"Evidence That Consumers Are Skeptical About Evidence-Based Health Care." By Kristin L. Carman, American Institutes for Research, and others. IN: Health Affairs, vol. 29, no. 7, (July, 2010) pp. 1-7.

["We undertook focus groups, interviews, and an online survey with health care consumers as part of a recent project to assist purchasers in communicating more effectively about health care evidence and quality. Most of the consumers were ages 18–64; had health insurance through a current employer; and had taken part in making decisions about health insurance coverage for themselves, their spouse, or someone else. We found many of these consumers' beliefs, values, and knowledge to be at odds with what policy makers prescribe as evidence based health care. Few consumers understood terms such as "medical evidence" or "quality guidelines." Most believed that more care meant higher-quality, better care. The gaps in knowledge and misconceptions point to serious challenges in engaging consumers in evidence-based decision making." **NOTE: If you would like an electronic copy of this article, please request it from the California State Library.**]

Full text at:

<http://content.healthaffairs.org/cgi/reprint/hlthaff.2009.0296v1>

RESEARCH

"The Subjective Experience of Participation in Schizophrenia Research: A Practical and Ethical Issue." by Peter James Taylor and others, University of Manchester, Manchester, United Kingdom. IN: The Journal of Nervous and Mental Disease, vol. 198, no. 5 (May 2010) pp. 343-348.

["Mental health research may pose a risk to those who participate in it, especially for potentially vulnerable groups such as those diagnosed with schizophrenia. The current study aimed to investigate the subjective experience of research participation in this group. Seventy-nine individuals with diagnoses of schizophrenia spectrum disorders who had taken part in research looking at suicide were asked to provide feedback about their experiences. Responses were analyzed using qualitative and quantitative methods. Results indicate that negative feedback concerning participation was rare, occurring in 2.5% to 15.2% of responses. Positive feedback was more frequent, occurring in 45.6% to 60.8% of responses. Qualitative thematic analysis identified 5 key themes in participants' responses: Altruism, Value of being involved in research, Therapeutic effect, Enjoyable experience and Negative experiences. The results support the view that mental health research in this group can be ethically viable." **NOTE: If you would like a hard copy of this article, please request from the California State Library.**]

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STIGMA

From Discrimination to Social Inclusion: A Review of the Literature on Anti-Stigma Initiatives in Mental Health. By Neasa Martin, the Queensland Alliance. (The Alliance, Spring Hill, Australia) 2009. 48 p.

[“People identified as having mental health problems are one of the most marginalised groups in society. Equal citizenship and active community participation remain highly desired but elusive goals. Stigma is a major barrier and people feel its sting in terms of lost relationships, opportunities denied or their own unwillingness to pursue life’s goals for fear of rejection or failure. Stigma refers to the negative internal attitudes and beliefs people hold, discrimination is the external behaviour and institutional arrangements that deny people their rights or limit their social inclusion. For many, the rejection they experience is more disabling than the psychiatric condition itself. Discrimination is experienced when support is withdrawn by family and friends, by being shunned, shamed, through name-calling, being denied employment or having one’s rights abused. It is a problem borne of ignorance and bred by fear.”]

Mental health issues are very common, almost half of us will experience them in our lifetimes, and one in four will have had at least one mental health problem in the last 12 months. People’s willingness to share their experience is exceedingly rare. Positive personal contact is a critical means of changing negative beliefs. Ironically, we are in daily contact with people affected by mental health problems. They run our banks, police our communities, and teach our children – they are our friends, neighbours, and family. What we don’t have is disclosure. The result of this secrecy is that the myths of violence and incompetence go unchallenged, slights go unchecked, people won’t seek out the support they need and many will be rejected or withdraw from their communities. People will continue to accept a reduced share of resources, suffer the loss of their rights, and live a diminished life often without protest. Creating a dialogue between those who have experienced mental health problems and the broader community plants the seeds of change.”]

Full text at:

<http://www.qldalliance.org.au/news/items/314431-upload-00002.pdf>

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Stigma and Depression Treatment Utilization among Latinos: Utility of Four Stigma Measures. By Alejandro Interian, Robert Wood Johnson Medical School, and others. IN: Psychiatric Services, vol. 61, no. 4 (April 2010) pp. 373-379.

[“Stigma associated with mental illness is an important yet understudied issue among Latinos. This study examined the psychometric properties of four stigma measures with a sample of Spanish-speaking Latino primary care patients. The study evaluated the scale for Perceived Discrimination Devaluation (PDD), the Stigma Concerns About Mental

Health Care (SCMHC) scale, the Latino Scale for Antidepressant Stigma (LSAS), and the Social Distance (SD) scale.

Methods: Participants (N=200) were low-income Latinos who were screened for depression with the Patient Health Questionnaire (PHQ-2) and asked about their depression treatment history, and they completed the four stigma measures at two time points (25 and 30 months from baseline). The four stigma measures were examined for internal consistency, convergent validity, construct validity, and criterion-related validity.

Results: The factor-analytic results generally provided support for the construct validity of the measures. The four stigma measures also demonstrated internal consistency between two time points. Patients who reported greater social distance from individuals with depression were more likely to have been receiving treatment for emotional care in the past three months (odds ratio [OR] =.70, $p < .05$). Also, Latinos who scored high on the SCMHC (OR=.64, $p < .05$) and LSAS (OR=.77, $p < .05$) were less likely to have been taking antidepressant medications.

Conclusions: The SCMHC, LSAS, and SD scales received support for their reliability and construct validity. Results also showed some support for their criterion related validity. A more mixed picture emerged for the PDD. Stigma ratings were associated with depression treatment utilization. Stigma ratings changed over time and were associated with treatment experiences.” **NOTE: If you would like an electronic copy of this article, please contact the California State Library.)**

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SUICIDE PREVENTION

“Suicide Intervention Skills and Related Factors in Community and Health Professionals.” By Gert Scheerder, Catholic University, Louvain, Belgium, and others. **IN: Suicide & Life Threatening Behavior, vol. 40, no. 2 (April 2010) pp. 115-124.**

[“Health and community professionals have considerable exposure to suicidal people and need to be well skilled to deal with them. We assessed suicide intervention skills with a Dutch version of the SIRI in 980 health and community professionals and psychology students. Suicide intervention skills clearly differed among professional groups and were strongly related to experience, especially suicide-specific experience. Some community professionals scored below acceptable levels on their ability to respond appropriately to suicidal people they encounter, and tended to overestimate their skills level. Training is therefore indicated for these groups, and may be useful to more highly experienced groups too.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=51009799&site=ehost-live>

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TRAUMATIC BRAIN INJURY

Army Responds to NPR-ProPublica Brain Injury Investigation. By T. Christian Miller, ProPublica and Daniel Zwerdling, National Public Radio (NPR). (June 10, 2010) pp. 1-4.

[“In an interview on NPR's *Talk of The Nation* on Wednesday, Gen. Peter Chiarelli, the vice chief of staff to the Army, defended the military's treatment of troops that suffered mild traumatic brain injuries in Iraq and Afghanistan.

"We are taking this extremely seriously," Chiarelli said, responding to the findings of an NPR and ProPublica investigation which found the military is failing to diagnose soldiers with so-called mild traumatic brain injuries. "There's no reason for us not to try to diagnose it."

Mild traumatic brain injuries, which are frequently caused by roadside blasts, leave no visible scars, but can cause lingering mental and physical damage. Officially, military figures show that about 115,000 soldiers have suffered mild traumatic brain injury since 2002. But we talked to military doctors and reviewed unpublished studies that suggest far more soldiers could have sustained such wounds. While most recover quickly, estimates suggest that between 5 to 15 percent go on to develop lingering cognitive problems.”]

Full text at:

<http://www.npr.org/templates/story/story.php?storyId=127596798>

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Military Still Failing to Diagnose, Treat Brain Injuries. By T. Christian Miller and Steve Swinderling, National Public Radio (NPR). NPR News Investigations. (June 8, 2010) pp. 1-4.

[“The military medical system is failing to diagnose brain injuries in troops who served in Iraq and Afghanistan, many of whom receive little or no treatment for lingering health problems, an investigation by NPR and [ProPublica](#) has found.

So-called mild traumatic brain injury has been called one of the wars' signature wounds. Shock waves from roadside bombs can ripple through soldiers' brains, causing damage that sometimes leaves no visible scars but may cause lasting mental and physical harm. Officially, military figures say about 115,000 troops have suffered mild traumatic brain injuries since the wars began. But top Army officials acknowledged in interviews that those statistics likely understate the true toll. Tens of thousands of troops with such wounds have gone uncounted, according to unpublished military research obtained by NPR and ProPublica.”]

Full text at:

<http://www.npr.org/templates/story/story.php?storyId=127402993&ft=1&f=1003>

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"Rates of Major Depressive Disorder and Clinical Outcomes Following Traumatic Brain Injury." By Charles H. Bombardier, University of Washington, School of Medicine, and others. IN: Journal of the American Medical Association, vol. 303, no. 19 (May 2010) pp. 1938-1945.

[“Uncertainties exist about the rates, predictors, and outcomes of major depressive disorder (MDD) among individuals with traumatic brain injury (TBI).

Objective To describe MDD-related rates, predictors, outcomes, and treatment during the first year after TBI....

Participants Five hundred fifty-nine consecutively hospitalized adults with complicated mild to severe TBI.

Main Outcome Measures The Patient Health Questionnaire (PHQ) depression and anxiety modules were administered at each assessment and the European Quality of Life measure was given at 12 months....

Conclusions Among a cohort of patients hospitalized for TBI, 53.1% met criteria for MDD during the first year after TBI. Major depressive disorder was associated with history of MDD and was an independent predictor of poorer health-related quality of life.” **NOTE: If you would like an electronic copy of this article, please contact the California State Library.]**

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VETERANS

Military Deployment May Affect Kids Health Care. By Alan Mozes, Healthday Reporter. IN: Bloomberg BusinessWeek, Executive Health (June 7, 2010) pp. 1-3.

[“The young children of a single parent deployed for military service are less likely to get medical care than the children of married service men and women, a new study has found.

"The bottom line is that military deployment of parents does affect the health care of their kids," said study co-author Dr. Gregory Gorman, a military-based commander and assistant professor of pediatrics at the Uniformed Services University of the Health Sciences in Bethesda, Md.

"Because there are so many demands on military personnel in this particularly high military tempo we have -- with two wars going on -- that routine care for their children very well might get deferred until when really needed," he added.”]

Full text at:

"Reintegration Problems and Treatment Interests among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care." By Nina A. Sayer, VA Medical Center, Minneapolis, and others. IN: Psychiatric Services, vol. 61, no. 6 (June 2010) pp. 589-597.

[“ The objectives of this study were to describe the prevalence and types of community reintegration problems among Iraq and Afghanistan combat veterans who receive U.S. Department of Veterans Affairs (VA) medical care, identify interests in interventions or information to promote readjustment to community life, and explore associations between probable posttraumatic stress disorder (PTSD) and reintegration problems and treatment interests.

Methods: A national, stratified sample of Iraq-Afghanistan combat veterans receiving VA medical care responded to a mailed survey focused on community reintegration. Of 1,226 veterans surveyed, 754 (62%) responded. Prevalence and proportions were adjusted for potential non response bias.

Results: An estimated 25% to 56% of combat veterans who use VA services reported “some” to “extreme” difficulty in social functioning, productivity, community involvement, and self-care domains. At least one-third reported divorce, dangerous driving, increased substance use, and increased anger control problems since deployment. Almost all (96%) expressed interest in services to help readjust to civilian life (95% confidence interval [CI]=93%–99%). The most commonly preferred ways to receive reintegration services or information were at a VA facility, through the mail, and over the Internet. An estimated 41% (95% CI=36%–46%) screened positive for PTSD, and probable PTSD was associated with reporting more readjustment difficulties and expressing interest in more types of services, including traditional mental health services.

Conclusions: Iraq- Afghanistan combat veterans who already receive VA medical care reported multiple current reintegration problems and wanted services and information to help them readjust to community life. These concerns were particularly prevalent among those with probable PTSD. Research is needed to explore nontraditional modes of service delivery, including the Internet." **NOTE: If you would like an electronic copy of this article, please contact the California State Library.]**

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"Stigma, Barriers to Care, and Use of Mental Health Services, among Active Duty, and National Guard Soldiers after Combat." By Paul Y. Kim, Walter Reed Institute of Research, and others. IN: Psychiatric Services, vol. 61, no. 6 (June 2010) pp. 572-588.

["This study examined rates of utilization of mental health care among active duty and National Guard soldiers with mental health problems three and 12 months after they returned from combat in Iraq. Stigma and barriers to care were also reported for each component (active duty and National Guard). *Methods:* Cross-sectional, anonymous

surveys were administered to 10,386 soldiers across both time points and components. Mean scores from 11 items measuring stigma and barriers to care were computed. Service utilization was assessed by asking soldiers whether they had received services for a mental health problem from a mental health professional, a medical doctor, or the Department of Veterans Affairs in the past month. Risk of mental problems was measured using the Patient Health Questionnaire, the PTSD Checklist, and items asking about aggressive behaviors and “stress, emotional, alcohol, or family” problems within the past month. *Results:* A higher proportion of active duty soldiers than National Guard soldiers reported at least one type of mental health problem at both three months (45% versus 33%) and 12 months (44% versus 35%) post deployment. Among soldiers with mental health problems, National Guard soldiers reported significantly higher rates of mental health care utilization 12 months after deployment, compared with active duty soldiers (27% versus 13%). Mean stigma scores were higher among active duty soldiers than among National Guard soldiers. *Conclusions:* Active duty soldiers with a mental health problem had significantly lower rates of service utilization than National Guard soldiers and significantly higher endorsements of stigma. Current and future efforts to improve care for veterans should work toward reducing the stigma of receiving mental health care." **NOTE: If you would like an electronic copy of this article, please contact the California State Library.** [\[Back to Top\]](#)

Related article: "Perceived Stigma and Barriers to Care for Psychological Treatment: Implications for Reactions to Stressors in Different Contexts." (2008)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=31971563&site=ehost-live>

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Related article: "Soldier Attitudes toward Mental Health Screening and Seeking Care upon Return from Combat." (2008)

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CONFERENCES, MEETINGS AND SEMINARS

Western Conference on Behavioral Health and Addictive Disorders

June 17-19, 2010
Newport Beach, California

For more information:

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Summer Institute of Neurodevelopmental Disorders.

August 6, 2010
Sacramento, CA

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Reinventing Quality 2010

Reinventing Quality Conference
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Baltimore, Maryland

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