

Subject: Studies in the News: (June 30, 2010)



Studies in the News for



California Department of Mental Health

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CONTENTS

CHILDREN AND ADOLESCENTS

[An Employer's Guide to Child and Adolescent Mental Health](#)

[Dealing with Psychiatric Disabilities in Schools](#)

Related article: ["Students with Severe Challenging Behaviour in Regular Classrooms: Support and Impacts."](#)

[Intervention to Strengthen Emotional Self-Regulation in Children](#)

[Trauma Faced by Children of Military Families](#)

[Vulnerable Populations and the Transition to Adulthood](#)

DEPRESSION

[Immune function and health outcomes in women with depression](#)

HEALTH CARE REFORM

[Impact of Intermountain's Mental Health Integration Program](#)

[Ready, Set, Plan, Implement: Executing the Expansion of Medicaid](#)

HOMELESSNESS

[Use of Urban Emergency Departments by the U.S. Homeless Population](#)

[The 2009 Annual Homeless Assessment Report to Congress](#)

OLDER ADULTS

[Public Policy and the Provision of Psychological Services to Older Adults](#)

PRISONS

[Mentally ill individuals in limbo](#)

[More Mentally Ill Persons are in Jails and Prisons than in Hospitals](#)

RECOVERY AND MENTAL ILLNESS

[The Process of Recovery of People with Mental Illness](#)

[Professional Service Usage among Patients with Severe Mental Disorders](#)

STIGMA

[Evaluation of a brief anti-stigma campaign in Cambridge](#)

[Experiences of mental illness stigma, prejudice and discrimination](#)

SUICIDE PREVENTION

[Hospitals & community health services for suicide attempters in Norway](#)

[Dramatic Drop in Large HMO Population's Suicide Rate](#)

NON PROFIT RESOURCE CENTER-GRANT WRITING

CONFERENCES, MEETINGS, SEMINARS

[New Horizons for Systems of Care](#)

[Northwest Institute of Addictions Studies-Summer Institute](#)

Webinar: [How Young Adults Use the Internet to Access Mental Health Information](#)

[North American Brain Injury Society and the Alaska Brain Injury Network](#)

[Summer Institute of Neurodevelopmental Disorders.](#)

[Reinventing Quality Conference](#)

CHILDREN AND ADOLESCENTS

An Employer's Guide to Child and Adolescent Mental Health: Recommendations for the workplace, health plans and Employee Assistance Programs. By National Business Group on Health. (The Group, Washington, D.C.) March 2009. 44 p.

[“In 2005, the National Business Group on Health released *An Employer's Guide to Behavioral Health Services*. The *Guide* provided employers the information necessary to standardize the delivery of behavioral health services in the general medical and behavioral health settings. The Business Group is now expanding upon this *Guide* with information specific to child and adolescent behavioral health. Youth with behavioral health problems receive treatment from many different sectors, including child welfare, juvenile justice, mental health, general medical and education; unfortunately, each sector is fragmented from the others, overburdened, and lacking clear responsibility or accountability for providing services. As a result, few children receive the treatment needed.

Like other chronic health issues, the effects of child and adolescent mental health disorders can be far reaching. For the individual child, the disorder and its associated stigma can bring about lifelong challenges. Caring for a child with a mental health disorder can also have a significant impact on the family and the workplace. Parent caregivers are more likely to report increased work absences, reduced productivity and job termination.

In 2008, the National Business Group on Health convened the Advisory Council on Child and Adolescent Behavioral Health to develop recommendations for the comprehensive delivery of employer-sponsored child and adolescent mental health benefits. The Advisory Council identified common barriers to care that should be addressed as well as employer-based strategies to help reduce caregiver burden.”]

Full text at:

http://www.businessgrouphealth.org/pdfs/CAMH_Guide_LoRes.pdf

[\[Back to Top\]](#)

Dealing with Psychiatric Disabilities in Schools: A Description of Symptoms and Coping Strategies for Dealing with Them. By John Rowe, Massachusetts College of Pharmacy and Health Sciences, Manchester, NH. 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>

[\[Back to Top\]](#)

Related article: “Students with Severe Challenging Behaviour in Regular Classrooms: Support and Impacts.” (2008)

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=35826362&site=ehost-live>

[\[Back to Top\]](#)

“Intervention to Strengthen Emotional Self-Regulation in Children with Emerging Mental Health Problems: Proximal Impact on School Behavior.” By Peter A. Wyman, University of Rochester School of Medicine and Dentistry and others. IN: Journal of Abnormal School Psychology, vol. 38, no. 5 (July 2010) pp. 707-720.

[“A model for teaching children skills to strengthen emotional self-regulation is introduced, informed by the developmental concept of scaffolding. Adult modeling/instruction, role-play and in vivo coaching are tailored to children’s level of understanding and skill to promote use of skills in real life contexts. Two-hundred twenty-six kindergarten—3rd grade children identified with elevated behavioral and social classroom problems from a population-based screening participated in a waitlisted randomized trial of the Rochester Resilience Project derived from this model. In 14 lessons with school-based mentors, children were taught a hierarchical set of skills: monitoring of emotions; self control/ reducing escalation of emotions; and maintaining control and regaining equilibrium. Mentors provided classroom reinforcement of skill use. Multi-level modeling accounting for the nesting of children in schools and classrooms showed the following effects at post-intervention: reduced problems rated by teachers in behavior control, peer social skills, shy-withdrawn and off-task behaviors (ES 0.31–0.47). Peer social skills improved for girls but not for boys. Children receiving the intervention had a 46% mean decrease in disciplinary referrals and a 43% decrease in

suspensions during the 4-month intervention period. Limitations and future directions to promote skill transfer are discussed.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=51134752&site=ehost-live>

[\[Back to Top\]](#)

Trauma Faced by Children of Military Families: What Every Policy Maker Should Know. By Fianna Sagomonyan and Janice Cooper, National Center for Children in Poverty, Columbia University Mailman School of Public Health. (The Center, New York, New York) May 2010. 12 p.

[“Active duty military personnel and National Guard and reservists experience multiple deployments as a result of the conflicts that comprise the *War on Terror*. A large body of research has accumulated on the behavioral health problems faced by military personnel as a result of these conflicts. After nearly a decade of war, a growing area of research shows the negative impact on children, youth and families of U.S. military personnel. Children of military families often experience multiple stressors before and during their parent’s deployment and when they come home. Without appropriate mental health support systems, children of military personnel may be at a significant disadvantage compared with their peers in non-military families.”]

Full text at:

http://nccp.org/publications/pdf/text_938.pdf

[\[Back to Top\]](#)

Vulnerable Populations and the Transition to Adulthood. By Wayne D. Osgood, Pennsylvania State University, and others. IN: Future of Children, vol. 20, no. 1 (Spring 2010) pp. 209-229.

[“D. Wayne Osgood, E. Michael Foster, and Mark E. Courtney examine the transition to adulthood for youth involved in social service and justice systems during childhood and adolescence. They survey the challenges faced by youth in the mental health system, the foster care system, the juvenile justice system, the criminal justice system, and special education, and by youth with physical disabilities and chronic illness, as well as runaway and homeless youth. One problem is that the services these vulnerable populations receive from these systems as children and adolescents often end abruptly as they transition to adulthood, even though the need for them continues. Youth must leave systems tailored for clients their age and, if they are eligible for further services at all, enter adult systems that are not equipped to address their needs. One exception is the special education system, whose services extend into early adulthood and are designed for individuals’ needs.

The authors review current public policies directed toward vulnerable youth in transition and find problems in four areas: eligibility criteria that exclude youth from services that might benefit them, inadequate funding for transition services, a lack of coordination across service systems, and inadequate training about young-adult developmental issues for service professionals. The authors then discuss policy options that can help create a developmentally appropriate and socially inclusive system of support for vulnerable youth. Among the options are strengthening all programs for youth in transition, improving the existing systems of care for children and adolescents, addressing the loss of access to services at the age of majority, and coordinating today's multiple systems into a single coherent system. The authors see heightened governmental interest in better supports for vulnerable young adults, both through expanding the federal role in their lives and through improving coordination of the systems that serve them. The Fostering Connections Act of 2008, for example, extended services to adolescents in foster care from the age of eighteen to the age of twenty-one.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=49893071&site=ehost-live>

[\[Back to Top\]](#)

DEPRESSION

“Immune function and health outcomes in women with depression.” By Cherie Howk and Mary Bennett, Western Kentucky University, School of Nursing. IN: *Biopsychosocial Medicine*, vol. 4, no. 3 (May 3, 2010) pp. 1-9.

[“This research reports immune function and health outcomes in women with depression, as compared with a non depressed control group. Using Psychoneuroimmunology theory and a descriptive comparison design, scores on the Beck Depression Inventory (BDI) were used to divide 40 non-hospitalized Caucasian women between the ages of 18 and 65 years into either the control or depression comparison group. Women with depression were found to report significantly more incidences of illness over the previous two months and they were found to have significantly more indicators of illness at the time of the exam as compared to the controls. However, contrary to what has been documented in some earlier studies of depression, women with depression were not found to have significantly different immune function measures as compared to the control group. There was also no significant correlation between scores on the BDI and natural killer cell cytotoxicity in this study. While these findings support a connection between depression and both increased self-report of illness and increased signs and symptoms of minor illness or inflammation on physical exam, this study was not able to document that these effects were related to decreased immune function, as measured by natural killer cell activity or white blood cell counts.”]

Full text at:

<http://www.bpsmedicine.com/content/pdf/1751-0759-4-3.pdf>

[\[Back to Top\]](#)

HEALTH CARE REFORM

“Cost and Quality Impact of Intermountain's Mental Health Integration Program.”
By Brenda Reiss-Brennan and others, Intermountain Healthcare Medical Group.
IN: Journal of Healthcare Management, vol. 55, no. 2 (March/April 2010) pp. 97-114.

[“Most patients with mental health (MH) conditions, such as depression, receive care for their conditions from a primary care physician (PCP) in their health/medical home. Providing MH care, however, presents many challenges for the PCP, including (1) the difficulty of getting needed consultation from an MH specialist; (2) the time constraints of a busy PCP practice; (3) the complicated nature of recognizing depression, which may be described with only somatic complaints; (4) the barriers to reimbursement and compensation; and (5) associated medical and social comorbidities. Practice managers, emergency departments, and health plans are stretched to provide care for complex patients with unmet MH needs. At the same time, payment reform linked to accountable care organizations and/or episodic bundle payments, MH parity rules, and increasing MH costs to large employers and payers all highlight the critical need to identify high-quality, efficient, integrated MH care delivery practices.

Over the past ten years, Intermountain Healthcare has developed a team-based approach-known as mental health integration (MHI)-for caring for these patients and their families. The team includes the PCPs and their staff, and they, in turn, are integrated with MH professionals, community resources, care management, and the patient and his or her family. The integration model goes far beyond co-location in its team-based approach; it is operationalized at the clinic, thereby improving both physician and staff satisfaction. Patients treated in MHI clinics also show improved satisfaction, lower costs, and better quality outcomes. The MHI program is financially sustainable in routinized clinics without subsidies. MHI is a successful approach to improving care for patients with MH conditions in primary care health homes.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=49186595&site=ehost-live>

[\[Back to Top\]](#)

“Ready, Set, Plan, Implement: Executing the Expansion of Medicaid.” By Leighton Ku, George Washington University, Washington, D.C. IN: *Health Affairs*, vol. 29, no. 6 (June 2010) pp. 1173-1177.

[“Federal and state governments must soon begin planning and developing systems to implement the expansion of Medicaid for low-income adults, as prescribed in the Patient Protection and Affordable Care Act of 2010. States will have to establish enrollment and coordination procedures, determine benefit packages, and update arrangements with

providers. Federal estimates indicate that states will bear relatively little of the new cost, but some states disagree. State planning efforts will be challenged by current budget shortfalls and, in many states, political opposition. Paradoxically, many of the states opposing expansions are those whose Medicaid-eligible patient populations have the most to gain from health reform.” **NOTE: If you would like an electronic copy of this article, please contact the California State Library with your request.]**

[\[Back to Top\]](#)

HOMELESSNESS

“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 (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 54 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: If you would like an electronic copy of this article, please contact the California State Library to request it.]**

[\[Back to Top\]](#)

The 2009 Annual Homeless Assessment Report to Congress. By the U.S. Department of Housing and Urban Development. Office of Community Planning and Development. (The Department, Washington, D.C.) June 2010. 198 p.

[“The U.S. Department of Housing and Urban Development (HUD) is pleased to present the 2009 Annual Homeless Assessment Report (AHAR), the fifth in a series of reports on homelessness in the United States. The reports respond to a series of Congressional directives calling for the collection and analysis of data on homelessness.

The AHAR reports provide the latest counts of homelessness nationwide—including counts of individuals, persons in families, and special population groups such as veterans and chronically homeless people. The report also covers the types of locations where people use emergency shelter and transitional housing; where people were just before they entered a residential program; how much time they spend in shelters over the course of a year; and the size and use of the U.S inventory of residential programs for homeless people.

With the 2009 AHAR, we now have three complete years of data on the numbers and characteristics of sheltered homeless people, how they became homeless, and how they used the homeless services system. This is important, because we can begin to see discernable trends in homelessness, including the effects of the recession and of changes over time to the homeless services system.”]

Full text at:

<http://www.hudhre.info/documents/5thHomelessAssessmentReport.pdf>

[\[Back to Top\]](#)

OLDER ADULTS

“Public Policy and the Provision of Psychological Services to Older Adults.” By Gregory A. Hinrichsen, Albert Einstein School of Medicine. IN: Professional Psychology: Research and Practice, vol. 41, no. 2 (April 2010) pp. 97-103.

[“Public policy shapes who delivers *health* care, how care is delivered, and how much providers are paid. The impact of public policy will become even more important to psychologists who serve *older adults* as 76 million members of the so called "baby boom" generation enter their later years. Armed with basic public policy facts, psychologists can better maneuver the systems created by public policy and even change policy. This article reviews how Medicare works since it is the primary payer of *mental health* services for *older adults*. The article then turns to the question of how many *health* care professionals (including psychologists) will be required to meet the needs of a rapidly growing *older* population and concurrent challenges of training and building that work force. Finally, different policy visions for a better *mental health* care system for *older adults* are summarized since they may be roadmaps to what the future of *mental health* care will look like. The article closes with practical recommendations on how psychologists can influence *mental health* and aging public policy.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=49603774&site=ehost-live>

[\[Back to Top\]](#)

PRISONS

“Mentally ill individuals in limbo: obstacles and opportunities for providing psychiatric services to corrections inmates with mental illness.” By Maureen C. Olley and others. IN: Behavioral Sciences and the Law, vol.

[“For more than two millennia, *prison* reformers and inmate advocates have lamented the ethical and humanitarian injustices experienced by persons with mental illness in correctional settings; yet, we continue to see *mentally ill* individuals stuck in limbo between health care and custody. Using a case study that exemplifies the challenges that can prevent the provision of efficient mental health care in correctional settings, we identify the gaps and failures in service delivery, and provide specific strategies for streamlining inmates' access to psychiatric assessment and treatment. As a backdrop, we present a brief overview of the reasons why correctional centres experience difficulties in ensuring expedient care (e.g., competence, mental health legislation, waitlists) as well as reviewing the prevalence of mental health needs in correctional settings. Using the partnership and strategic alignment that have been developed for several years between our forensic psychiatric system and our provincial correctional system, we provide a roadmap to successfully reducing wait times and enhancing service delivery to *mentally ill* inmates. In our view, custody admissions provide a rare opportunity to provide mental health (and other services) to marginalized individuals who often slip through the cracks. imPROVE and related programs and strategies have been found to be effective means of preventing these opportunities from being lost.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=44435575&site=ehost-live>

[\[Back to Top\]](#)

More Mentally Ill Persons are in Jails and Prisons than in Hospitals: A Survey of the States. By E. Fuller Torrey, Stanley Medical Research Institute, and others. National Sheriffs Association. (The Association, Alexandria, Virginia) May 2010. 22 p.

[“Using 2004–2005 data not previously published, we found that in the United States there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals.... Recent studies suggest that at least 16 percent of inmates in jails and prisons have a serious mental illness. In 1983 a similar study reported that the percentage was 6.4 percent. Thus, in less than three decades, the percentage of seriously mentally ill prisoners has almost tripled....

These findings are consistent with studies reporting that 40 percent of individuals with serious mental illnesses have been in jail or prison at some time in their lives. It is now extremely difficult to find a bed for a seriously mentally ill person who needs to be hospitalized. In 1955 there was one psychiatric bed for every 300 Americans. In 2005 there was one psychiatric bed for every 3,000 Americans. Even worse, the majority of the existing beds were filled with court-ordered (forensic) cases and thus not really available...

Any state can solve this problem if it has the political will by using assisted outpatient treatment and mental health courts and by holding mental health officials responsible for outcomes. The federal government can solve this problem by conducting surveys to compare the states; attaching the existing federal block grants to better results; and fixing the federal funding system by abolishing the “institutions for mental diseases” (IMD) Medicaid restriction.”]

Full text at:

<http://www.sheriffs.org/userfiles/file/FinalJailsvHospitalsStudy.pdf>

[\[Back to Top\]](#)

RECOVERY FROM MENTAL ILLNESS

“The Process of Recovery of People with Mental Illness: The Perspectives of Patients, Family Members and Care Providers: Part I.” By Sylvie Noiseux, Research Centre of the University of Montreal Hospital Centre, and others. IN: Health Services Research, vol. 10, no.161 (June 11, 2010) pp. 1-36.

[“ It is a qualitative design study that examines points of divergence and convergence in the perspectives on recovery of 36 participants or 12 triads. Each triad comprising a patient, a family member/friend, a care provider and documents the procedural, analytic of triangulating perspectives as a means of understanding the recovery process which is illustrated by four case studies. Variations are considered as they relate to individual characteristics, type of participant (patient, family, member/friend and care provider), and mental illness. This paper which is part of a larger study and is based on a qualitative research design documents the process of recovery of people with mental illness: Developing a Model of Recovery in Mental Health: A middle range theory.

Methods: Data were collected in field notes through semi-structured interviews based on three interview guides (one for patients, one for family members/friends, and one for caregivers). Cross analysis and triangulation methods were used to analyse the areas of convergence and divergence on the recovery process of all triads....

Conclusion: The perspectives of the three participants (patients, family members/friends and care providers) suggest that recovery depends on constructing meaning around mental illness experiences and that the process is based on each person’s dynamic context (e.g., social network, relationship), life experiences and other social determinants (e.g.,

symptoms, environment). The findings of this study add to existing knowledge about the determinants of the recovery of persons suffering with a mental illness and significant other utilizing public mental health services in Montreal, Canada.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-10-161.pdf>

[\[Back to Top\]](#)

Professional Service Utilisation among Patients with Severe Mental Disorders. By Marie-Josée Fleury and others, McGill University, Montreal, Canada. IN: BMC Health Services Research, vol. 10, no. 141 (May 27, 2010) pp.1-32.

[“Generally, patients with serious mental disorders (SMD) are frequent users of services that generate high care-related costs. Current reforms aim to increase service integration and primary care for improved patient care and health-care efficiency. This article identifies and compares variables associated with the use by patients with SMD of services offered by psychiatrists, case managers, and general practitioners (GPs). It also compares frequent and infrequent service use.

Method: One hundred forty patients with SMD from five regions in Quebec, Canada, were interviewed on their use of services in the previous year. Patients were also required to complete a questionnaire on needs-assessment. In addition, data were collected from clinical records. Descriptive, bivariate, and multivariate analyses were conducted.

Results: Most patients used services from psychiatrists and case managers, but no more than half consulted GPs. Most patients were followed at least by two professionals, chiefly psychiatrists and case managers. Care access, continuity of care, and total help received were the most important variables associated with the different types of professional consultation. These variables were also associated with frequent use of professional service, as compared with infrequent service use. In all, enabling factors rather than need factors were the core predictors of frequency of service utilisation by patients with SMD.

Conclusion: This study reveals that health care system organisation and professional practice – rather than patient need profiles – are the core predictors of professional consultation by patients with SMD. The homogeneity of our study population, i.e. mainly users with schizophrenia, recently discharged from hospital, may partly account for these results. Our findings also underscored the limited involvement of GPs in this patient population’s care. As comorbidity is often associated with serious mental disorders, closer follow-up by GPs is needed. Globally, more effort should be directed at increasing shared care initiatives, which would enhance coordination among psychiatrists, GPs, and psychosocial teams (including case managers). Finally, there is a need to increase awareness among health care providers, especially GPs, of the level of care required by patients with disabling and serious mental disorders.”]

Full text at:

STIGMA

“Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work?” By Sara Evans-Lacko and others, King’s College, London. IN: **BMC Public Health**, vol. 10, no. 339 (June 11, 2010) pp. 1-21.

[“In view of the high costs of mass-media campaigns, it is important to understand whether it is possible for a media campaign to have significant population effects over a short period of time. This paper explores this question specifically in reference to stigma and discrimination against people with mental health problems using the *Time to Change* Cambridge anti-stigma campaign as an example.

Methods: 410 face-to-face interviews were performed pre, during and post campaign activity to assess campaign awareness and mental health-related knowledge, attitudes and behaviours.

Results: Although campaign awareness was not sustained following campaign activity, significant and sustained shifts occurred for mental health-related knowledge items. Specifically, there was a 24% ($p < 0.001$) increase in persons agreeing with the statement: *If a friend had a mental health problem, I know what advice to give them to get professional help*, following the campaign. Additionally, for the statement: *Medication can be an effective treatment for people with mental health problems*, there was a 10% rise ($p = 0.05$) in the proportion of interviewees responding ‘agree’ or ‘strongly agree’ following the campaign. These changes, however, were not evident for attitudinal or behaviour related questions

Conclusions: Although these results only reflect the impact of one small scale campaign, these preliminary findings suggest several considerations for mass-media campaign development and evaluation strategies such as: (1) Aiming to influence outcomes pertaining to knowledge in the short term; (2) Planning realistic and targeted outcomes over the short, medium and long term during sustained campaigns and (3) Monitoring indirect campaign effects such as social discourse or other social networking/contact in the evaluation.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-10-339.pdf>

[\[Back to Top\]](#)

“Experiences of mental illness stigma, prejudice and discrimination: a review of measures.” By Elaine Brohan and others, King's College, London. IN: **BMC Health Services Research**, vol. 10, no. 80 (2010) pp. 1-11.

[“There has been a substantial increase in research on mental illness related stigma over the past 10 years, with many measures in use. This study aims to review current practice in the survey measurement of mental illness stigma, prejudice and discrimination

experienced by people who have personal experience of mental illness. We will identify measures used, their characteristics and psychometric properties.

Method: A narrative literature review of survey measures of mental illness stigma was conducted. The databases Medline, PsychInfo and the British Nursing Index were searched for the period 1990-2009.

Results: 57 studies were included in the review. 14 survey measures of mental illness stigma were identified. Seven of the located measures addressed aspects of perceived stigma, 10 aspects of experienced stigma and 5 aspects of self-stigma. Of the identified studies, 79% used one of the measures of perceived stigma, 46% one of the measures of experienced stigma and 33% one of the measures of self-stigma. All measures presented some information on psychometric properties.

Conclusions: The review was structured by considering perceived, experienced and self stigma as separate but related constructs. It provides a resource to aid researchers in selecting the measure of mental illness stigma which is most appropriate to their purpose.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-10-80.pdf>

[\[Back to Top\]](#)

SUICIDE PREVENTION

“Collaboration between general hospitals and community health services in the care of suicide attempters in Norway: a longitudinal study.” By Erlend Mork, University of Oslo, Norway, and others. IN: Annals of General Psychiatry, vol. 9, no. 26 (June 11, 2010) pp. 1-21.

[“The aim of this paper was to study the collaboration between emergency departments (EDs) in general hospitals and community health services (CHS) in Norway when providing psychosocial care and aftercare to patients treated in EDs following a suicide attempt. We wanted to explore the extent to which quality indicators at the hospital level measured in 1999 and 2006 could predict the presence or absence of a chain of care structure in the CHS in 2006.

Methods

Data were collected through structured interviews with informants from 95% of all general hospitals in Norway in 1999 and 2006, and informants from CHS, in a stratified sample of Norwegian municipalities in 2006 (n = 47).

Results

In 15 of the 47 municipalities (32%), the CHS reported having a chain of care structure in 2006. A discriminant function analysis revealed that the hospitals that in 1999 had: (a) a collaboration agreement with aftercare providers, and (b) written guidelines, including a quality assurance system, were significantly more likely to have municipalities with a chain of care structure in their catchment area in 2006.

Conclusions

Hospitals' and municipalities' self-reported provision of aftercare services for patients treated after a suicide attempt was markedly below the recommendations given in national standards. Systems at the hospital level for the management and care of patients admitted after a suicide attempt and systematic collaboration between hospitals and aftercare providers seem to be important elements in the long-term maintenance of continuity of care for suicide attempters.”]

Full text at:

<http://www.annals-general-psychiatry.com/content/pdf/1744-859X-9-26.pdf>

[\[Back to Top\]](#)

“Depression Care Effort Brings Dramatic Drop in Large HMO Population’s Suicide Rate.” By Tracy Hampton, Senior Staff Writer at Journal of American Medical Association (JAMA). IN: JAMA, vol. 303, no. 19 (May 19, 2010) pp. 1903-1905.

[“While physicians and other health care workers may not be able to predict which of their patients will attempt suicide, they can implement preventive strategies that markedly lower the risk of such tragedies. Now, one pioneering program has demonstrated the importance of pursuing 2 key approaches at once: carefully assessing patients for risk of suicide and adopting measures to reduce the likelihood that a patient will attempt suicide.

The example comes from a quality improvement initiative that succeeded in substantially bringing down the rate of suicide in a population of about 200, 000 members of a large health maintenance organization (HMO). Through the second quarter of last year, the Perfect Depression Care program of the Behavioral Health Services (BHS) division of the Henry Ford Health System resulted in 9 consecutive quarters without any suicides, a dramatic contrast to the annual rate of 89 suicides per 100 000 members at baseline and approximately 230 suicides per 100 000 individuals expected in a patient population.” **NOTE: If you would like an electronic copy of this article, please contact the California State Library]**

[\[Back to Top\]](#)

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.

The Nonprofit Resource Center...building a strong, vibrant nonprofit community.”]

More information about grant-writing at:

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

[\[Back to Top\]](#)

CONFERENCES, MEETINGS AND SEMINARS

New Horizons for Systems of Care: Effective practice and performance for children and youth with mental health challenges and their families.

July 14-18, 2010

Washington, DC

“The National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development is offering Training Institutes on local systems of care for children and adolescents with or at risk for mental health challenges and their families. The biennial Training Institutes are organized in partnership with the Child, Adolescent and Family Branch of the federal Center for Mental Health Services and The Annie E. Casey Foundation.”

For more information at:

<http://gucchd.georgetown.edu/training/88504.html>

[\[Back to Top\]](#)

Northwest Institute of Addictions Studies-Summer Institute Recovery in Practice: Tool for Success

July 21st-July 23rd-2010

Clackamas, Oregon (near Portland, Oregon)

“This conference is designed to meet the ongoing training needs of addictions, criminal justice, mental health, prevention, education and health professionals. During this three-day conference, choose from a wide range of workshops.

Conference presenters are practitioners committed to advancing professionalism and best practices in the field of addictions.

Questions? Please contact the Center for Community Engagement at cce@lclark.edu or 503-768-6040. If you require a special accommodation or have dietary restrictions please contact our office.”

Program:

<http://legacy.lclark.edu/~ccps/nwais/schedule.html>

Details:

<http://legacy.lclark.edu/~ccps/nwais/index.html>

[\[Back to Top\]](#)

Webinar: How Young Adults Use the Internet to Access Mental Health Information and Support. July 27th 10:am-11:00am PST

“According to Pew Internet research, “every day, more people go online for medical advice than actually visit health care professionals.” This may be especially true for young adults, as their access to health care and other supports is more limited than other populations. Using the latest research as well as results from focus groups conducted by Pathways to Positive Futures, this webinar will address how young adults use the Internet to manage their mental health.”

July 27th-10:am-11:00am PST

Register:

<https://www1.gotomeeting.com/register/249429568>

[\[Back to Top\]](#)

North American Brain Injury Society and the Alaska Brain Injury Network

Alaska Brain Injury Conference
July 28-30, 2010
Anchorage, Alaska

For more information:

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

[\[Back to Top\]](#)

Summer Institute of Neurodevelopmental Disorders.

August 6, 2010
Sacramento, CA

For more information:

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

[\[Back to Top\]](#)

Reinventing Quality Conference 2010

August 8-10, 2010
Baltimore, Maryland

“The Reinventing Quality Conference is the premier gathering place for people with intellectual/developmental disabilities, family members, direct support professionals, administrators of community support agencies, advocates, and government leaders – all committed to a vision of a better future for people with intellectual/developmental disabilities.”

For more information:

<http://www.reinventingquality.org/upcoming/>

[\[Back to Top\]](#)