

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



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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CONTENTS

ANTIPSYCHOTICS

[For What Diagnoses are Psychotropic Medications Being Prescribed?](#)
[Role of a Prescription in Anxiety Medication Use, Abuse, and Dependence](#)

CHILDREN AND ADOLESCENTS

[Engaging Families into Mental Health Treatment](#)
[The Mental and Emotional Well-Being of Children](#)
[Predictive Validity of Childhood Defiant Disorder and Conduct Disorder](#)
[Summary Health Statistics for U.S. Children](#)

CRIMINAL JUSTICE SYSTEM

[Reductions in Arrest under Assisted Outpatient Treatment in New York](#)

HOMELESSNESS

[Helping the Homeless](#)

INTEGRATED HEALTH CARE SYSTEMS

[Integrating Mental Health into Primary Health Care in Zambia](#)

POLICY

[Comparative Effectiveness Research in Mental Health](#)
[Involuntary Civil Commitments after Implementation of California's MHSA](#)
[State Legislative Mental Health Caucuses](#)

RURAL HEALTH

[Rural Mental Health Workforce Difficulties](#)
[The University of Hawai'i Rural Health Collaboration](#)

SUICIDE PREVENTION

[Baseline factors predictive of serious suicidality at follow-up](#)

VETERANS

[Effects of Childhood Abuse on Relapse in Homeless Veteran Population](#)
[Impact of PTSD, depression, and substance use on OEF/OIF veterans](#)
[Potential Costs of Veterans' Health Care.](#)

WELLNESS AND MENTAL ILLNESS

[Evolving Definitions of Mental Illness and Wellness](#)

NON PROFIT RESOURCE CENTER-GRANT WRITING

CONFERENCES, MEETINGS, SEMINARS

[The Emerging Neuroscience of Autism Spectrum Disorders](#)
[Annual Meeting of the American Society of Criminology](#)
[2nd Conference on Positive Aging](#)
[ZERO TO Three's 25th National Training Institute \(NTI\)](#)

ANTIPSYCHOTICS

“For What Diagnoses are Psychotropic Medications being prescribed?” By Tami L. Mark, Thompson Reuters. IN: CNS Drugs, vol. 24, no. 4 (2010) pp. 319-326.

[“Background: Psychoactive medications, such as antidepressants, are one of the most widely prescribed categories of drugs in the US; yet few studies have comprehensively examined the conditions for which psychoactive medications are prescribed. To our knowledge, no prior study has examined the extent to which psychoactive medications are prescribed for non-psychiatric somatic illnesses or the main types of psychiatric disorders for which psychoactive medications are being used.

Objective: To examine the diagnoses for which psychiatric medications are being prescribed in the US by analyzing data from a nationally representative survey of physicians. Methods: The data were obtained from the 2005 National Disease and Therapeutic Index (NDTI), a continuing survey of a US office-based panel of physicians. The 2005 physician panel consisted of approximately 4000 physicians reporting quarterly, which was projected to a universe of 500 722 physicians. The study focused on the diagnoses that were given as the primary reason for prescribing the following types of psychotropic medications: antidepressants, *antipsychotics* and anti-anxiety medications.

Results: Of the total number of antidepressant drug mentions, 92.7% were prescribed for psychiatric conditions. The most common (65.3%) were mood disorders (e.g. depression), followed by anxiety disorders (16.4%), which together comprised 81.7% of all antidepressant drug mentions. Of the total number of anti-anxiety drug mentions, 67.7% were prescribed for psychiatric conditions. The most common diagnosis was anxiety disorders (comprising 39.6% of all drug mentions), followed by mood disorders (comprising 18.9% of all drug mentions)....

Conclusions: This research provides a broad view of the nature of psychoactive medication prescribing, which may serve as a guide to future research, policy and education about these medications, their perceived benefits and risks, and their uses.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=50874077&site=ehost-live>

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

“The Role of a Prescription in Anxiety Medication Use, Abuse, and Dependence.” By Miriam C. Fenton and others, Columbia University. IN: American Journal of Psychiatry, vol. 167, no. 10 (October 2010) pp.1247-1253.

[“**Objective:** Prescriptions for anxiety medications have increased substantially in recent years. Individuals with anxiety disorders are at risk of nonmedical use of these medications, but information about whether this risk is elevated among patients with a prescription for such medications is lacking. The authors compared risk of nonmedical use in individuals in a national sample with and without a prescription for anxiety medication and identified characteristics associated with nonmedical use. **Method:** Data were drawn from face-to face surveys of 34,653 adult participants in the National Epidemiologic Survey on Alcohol and Related Conditions. The risk of nonmedical use of prescription anxiety medication and associated drug use disorders was computed for individuals who had or had not ever received a prescription for anxiety medication; among those who had received a prescription, characteristics associated with nonmedical use were analyzed. **Results:** Prescription of anxiety medication was associated with lifetime and past-year nonmedical use (odds ratios, 1.6 and 1.9, respectively) and lifetime DSM-IV abuse or dependence (odds ratio, 2.6). Among respondents who received a prescription (N=4,294), nonmedical use was associated with male sex, younger age, white race, history of use of illicit drugs, history of other drug use disorders, and history of illegal behaviors. **Conclusions:** These results indicate that prescription for anxiety medications is associated with nonmedical use of these medications, although the direction of causality cannot be determined in this study. Although anxiety medications have clinical utility, greater clinical attention should be given to the potential for their abuse among patients at particular risk.”]

Full text at:

<http://ajp.psychiatryonline.org/cgi/reprint/167/10/1247>

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

CHILDREN AND ADOLESCENTS

“Engaging Families into Mental Health Treatment: Updates and Special Considerations.” By Geetha Gopalan, Mount Sinai School of Medicine, and others. **IN: Journal of the Canadian Academy of Child & Adolescent Psychiatry, vol. 19, no. 3 (2010) pp. 182-196.**

[“**Objective:** The current paper reviews recent findings regarding how to conceptualize engagement and factors influencing engagement, treatment attendance rates, and interventions that work. **Method:** Research related to the definition of engagement, predictors of engagement and treatment termination, attendance rates, and engaging interventions are summarized as an update to the McKay and Bannon (2004) review. **Results:** Despite ongoing advances in evidence-based treatments and dissemination strategies, engaging families into *mental* health treatment remains a serious challenge. Within the last several years, a number of technological advances and interventions have emerged to address this problem. Families with *children* who present disruptive behavior challenges and symptoms of trauma are considered in terms of the unique barriers they

experience regarding engagement in treatment. Conclusions: Potential solutions to increase treatment utilization and further research in this area are discussed.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=53528680&site=ehost-live>

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

The Mental and Emotional Well-Being of Children: A Portrait of the States and the Nation 2007. A National Survey of Children’s Health. By the U.S. Department of Health and Human Services. Health Resources and Services Administration. (U.S. Department of Health and Human Services, Rockville Maryland.) June 2010. 58 p.

[“Children, like adults, may have mental health problems, including depression and anxiety. They may also have behavioral conditions, such as conduct disorders; cognitive disorders, such as autism spectrum disorder; or neurological conditions, such as Tourette Syndrome. Children may also be affected by delays in their physical, cognitive, or emotional development. The 2007 National Survey of Children’s Health asked parents whether their children had ever been diagnosed with, and currently had, any of these seven conditions. (The exact wording of the questions asked in the survey is presented in Appendix B.) This chartbook addresses the health and well-being of the population of children whose parents reported that their children had at least one of these conditions. Note, however, that these data are based entirely on parental reports and have not been independently verified; in addition, they only include children whose parents reported that they have been told that they have one of these conditions by a doctor or other health care provider”]

Full text at:

<http://www.mchb.hrsa.gov/nsch/07emohealth/moreinfo/pdf/nsch07.pdf>

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

“Predictive Validity of Childhood Oppositional Defiant Disorder and Conduct Disorder: Implications for the DSM-V.” By Jeffrey D. Burke, University of Pittsburg, and others. IN: Journal of Abnormal Psychology, vol. 10, (September 20, 2010) pp. 1-14.

[Data are presented from 3 studies of *children* and adolescents to evaluate the predictive validity of childhood oppositional defiant disorder (ODD) and conduct disorder (CD) as defined in the Diagnostic and Statistical Manual of *Mental* Disorders, 4th edition (DSM–IV; American Psychiatric Association, 1994) and the International Classification of Diseases, Version 10 (ICD-10; World *Health* Organization, 1992). The present analyses strongly support the predictive validity of these diagnoses by showing that they predict both future psychopathology and enduring functional impairment. Furthermore, the present findings generally support the hierarchical developmental hypothesis in DSM–IV that some *children* with ODD progress to childhood-onset CD, and some youth with CD

progress to antisocial personality disorder (APD). Nonetheless, they reveal that CD does not always co-occur with ODD, particularly during adolescence. Importantly, the present findings suggest that ICD-10 diagnostic criteria for ODD, which treat CD symptoms as ODD symptoms when diagnostic criteria for CD are not met, identify more functionally impaired *children* than the more restrictive DSM-IV definition of ODD. Filling this “hole” in the DSM-IV criteria for ODD should be a priority for the DSM-V. In addition, the present findings suggest that although the psychopathic trait of interpersonal callousness in childhood independently predicts future APD, these findings do not confirm the hypothesis that callousness distinguishes a subset of *children* with CD with an elevated risk for APD.

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=abn-2010-19345-001&site=ehost-live>

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

Summary Health Statistics for U.S. Children: National Health Interview Survey 2009. By the U.S. Department of Health. (The Department, Hyattsville, Maryland) August 2010. 149 p.

[“This report presents both age-adjusted and unadjusted statistics from the 2009 National Health Interview Survey (NHIS) on selected health measures for children under 18 years of age, classified by sex, age, race, Hispanic origin, family structure, parent education, family income, poverty status, health insurance coverage, place of residence, region, and current health status. The topics covered are asthma, allergies, learning disability, Attention Deficit Hyperactivity Disorder (ADHD), prescription medication use, respondent-assessed health status, school-loss days, usual place of health care, time since last contact with a health care professional, selected measures of health care access and utilization, and dental care.”]

Full text at:

http://www.cdc.gov/nchs/data/series/sr_10/sr10_247.pdf

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

CRIMINAL JUSTICE

“Reductions in Arrest Under Assisted Outpatient Treatment in New York.” By Allison R. Gilbert, Duke University, and others. IN: *Psychiatric Services*, vol. 61, no. 10 (October 2010) pp. 996-999.

[“Individuals with serious mental illness have a relatively high risk of criminal justice involvement. Assisted outpatient treatment (AOT) is a legal mechanism that mandates treatment for individuals with serious mental illness who are unlikely to live safely in the community without supervision and who are also unlikely to voluntarily participate in

treatment. Under an alternative arrangement, some individuals for whom an AOT order is pursued sign a voluntary service agreement in lieu of a formal court order. This study examined whether AOT recipients have lower odds of arrest than persons with serious mental illness who have not yet initiated AOT or signed a voluntary service agreement. *Methods:* Interview data from 2007 to 2008 from an evaluation of AOT in New York State were matched with arrest records from 1999 to 2008 for 181 individuals and analyzed using multivariable logistic regression. *Results:* The odds of arrest for participants currently receiving AOT were nearly two-thirds lower (OR=.39, $p<.01$) than for individuals who had not yet initiated AOT or signed a voluntary service agreement. The odds of arrest among individuals currently under a voluntary service agreement (OR=.64) were not significantly different than for individuals who had not yet initiated either arrangement. The adjusted predicted probabilities of arrest in any given month were 3.7% for individuals who had not yet initiated AOT or a voluntary agreement, 1.9% for individuals currently on AOT, and 2.8% for individuals currently under a voluntary agreement. *Conclusions:* AOT may be an important part of treatment efforts to reduce criminal justice involvement among people with serious mental illness.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/10/996.pdf>

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

HOMELESSNESS

“Helping the Homeless.” By Christian Jarrett M.D., Staff Journalist, The Psychologist. IN: The Psychologist, vol. 23, no. 4 (April 2010) pp. 284-287.

[“This article examines psychology’s response to the disturbing social problem of homelessness. Until recently, research on homelessness was focused on economic issues and social policy. But gradually psychology and society are waking up to the psychological processes that lead many people to become *homeless* in the first place. Researchers are trying to pin down how people end up with nothing and how to get them back on their feet. Therapists are listening to *homeless* people’s stories, equipping them with the skills to cope and move on. The article looks at ways of breaking the cycle of homelessness, and offers several examples of programs to raise awareness around the psychological needs of this □marginalized group.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-06745-001&site=ehost-live>

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

INTEGRATED HEALTH CARE SYSTEMS

“Integrating Mental Health into Primary Health Care in Zambia: A Care Provider’s Perspective.” By Lonia Mwape, College of Health Services, Zambia, and

others. IN: International Journal of Mental Health systems, vol. 4, no. 21 (2010) pp. 1-9.

[“Despite the 1991 reforms of the health system in Zambia, mental health is still given low priority. This is evident from the fragmented manner in which mental health services are provided in the country and the limited budget allocations, with mental health services receiving 0.4% of the total health budget. Most of the mental health services provided are curative in nature and based in tertiary health institutions. At primary health care level, there is either absence of, or fragmented health services. Aims: The aim of this paper was to explore health providers’ views about mental health integration into primary health care. Methods: A mixed methods, structured survey was conducted of 111 health service providers in primary health care centers, drawn from one urban setting (Lusaka) and one rural setting (Mumbwa). Results: There is strong support for integrating mental health into primary health care from care providers, as a way of facilitating early detection and intervention for mental health problems. Participants believed that this would contribute to the reduction of stigma and the promotion of human rights for people with mental health problems. However, health providers felt they require basic training in order to enhance their knowledge and skills in providing health care to people with mental health problems. Recommendations: It is recommended that health care providers should be provided with basic training in mental health in order to enhance their knowledge and skills to enable them provide mental health care to patients seeking help at primary health care level. Conclusion: Integrating mental health services into primary health care is critical to improving and promoting the mental health of the population in Zambia.”]

Full text at:

<http://www.ijmhs.com/content/pdf/1752-4458-4-21.pdf>

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

POLICY

“Comparative Effectiveness Research in Mental Health: An Advocate’s Perspective.” By David L. Shern, Mental Health America, and others. IN: Health Affairs, vol. 29, no. 10 (October 2010) pp. 1-6.

[“Comparative effectiveness research holds great promise for improving the care of people with mental health conditions and disorders related to substance abuse. But inappropriate application of such research can threaten the quality of that care. We examine the controversy surrounding a large real-world trial of schizophrenia treatments and conclude that the initial presentation of results led to overly simplistic policy suggestions that had the potential to harm patients. Patient advocacy groups helped illuminate these consequences and helped stimulate further discussion and analysis. Researchers must engage stakeholders, especially patients, in all aspects of comparative effectiveness research and translate the findings into sound mental health policy and practice.”]

Full text at:

<http://content.healthaffairs.org/cgi/reprint/29/10/1857.pdf>

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

‘Involuntary Civil Commitments after the Implementation of California’s Mental Health Services Act.’ By Tim A. Bruckner, University of California, Irvine, and others. IN: *Psychiatric Services*, vol. 61, no. 10 (October 2010) pp. 1006-1011.

[“As of fiscal year 2008–2009, California’s Mental Health Services Act (MHSA) has distributed \$3.2 billion in new tax revenues to county mental health systems. This voter-approved act attempts to address the needs of unserved and underserved consumers with severe mental illness by implementing a “whatever it takes” approach. The research literature indicates that the incidence of involuntary treatment may gauge the overall functioning of the public mental health system. Consistent with the notion that the MHSA may facilitate effective treatment of severe mental illness, the authors tested the hypothesis that the incidence of two types of involuntary treatment—72-hour holds and 14-day psychiatric civil commitments—declines as the enhancement of service access and quality is supported by MHSA funds. *Methods:* The investigators obtained quarterly counts of involuntary 72-hour holds (N=593,751) and 14-day psychiatric hospitalizations (N=202,554) for 28 counties, with over 22 million inhabitants, from July 2000 to June 2007. A fixed-effects regression approach adjusted for temporal patterns in treatment. *Results:* The petitions for involuntary 14-day hospitalizations, but not involuntary 72-hour holds, fell below expected values after disbursement of MHSA funds. In these counties, 3,073 fewer involuntary 14-day treatments—approximately 10% below expected levels—could be attributed to disbursement of MHSA funds. Results remained robust to alternative regression specifications. *Conclusions:* Fewer than expected involuntary 14-day holds for continued hospitalization may indicate an important shift in service delivery. MHSA funds may have facilitated the discharge of clients from the hospital by providing enhanced resources and access to a range of less-restrictive community-based treatment alternatives.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/10/1006.pdf>

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

State Legislative Mental Health Caucuses. By the Council of State Governments. Capitol Facts and Figures. (The Council, Lexington, Kentucky) September 2010. 2 p.

[“Ten state legislatures have formed caucuses to educate legislators about mental health policy issues. While the stigma associated with mental illness and substance abuse has decreased, understanding of the diseases and appropriate treatment necessary for recovery is still inadequate.

- Seven states—Colorado, Georgia, Louisiana, Minnesota, New Mexico, Ohio and Oregon—have established caucuses through formal legislative resolutions or action.
- Three states, Delaware, Iowa and Montana, have informal caucuses.

- Another five states—Illinois, Maryland, Missouri, New York, and North Carolina—have a legislative committee with a stated mental health policy or budget function.”]

Full text at:

http://knowledgecenter.csg.org/drupal/system/files/CR_mental_health.pdf

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

RURAL HEALTH SERVICES

Rural Mental Health Workforce Difficulties: A Management Perspective. By T. Moore and others, Monash University, Victoria, Australia. IN: Rural and Remote Health, vol. 10, no. 1519 (October 4, 2010) pp. 1-10.

[“The recruitment, retention and training of mental health workers is of major concern in rural Australia, and the Gippsland region of Victoria is no exception. Previous studies have identified a number of common factors in these workforce difficulties, including rurality, difficulties of access to professional development and training, and professional and personal isolation. However, those previous studies have often focused on medicine and been based on the perspectives of practitioners, and have almost ignored the perspectives of managers of rural mental health services. The study reported in this article sought to contribute to the development of a more sustainable and effective regional mental health workforce by complementing earlier insights with those of leading administrators, managers and senior clinicians in the field.

Methods: The study took a qualitative approach. It conducted semi-structured in-person interviews with 24 managers of health/mental-health services and senior administrators and clinicians working in organizations of varying sizes in the public and private sectors. Thematic content analysis of the transcribed interviews identified core difficulties these managers experienced in the recruitment, retention and training of employees.

Results: The study found that some of the issues commonly resulting in difficulties in recruiting, retaining and developing a trained workforce in rural areas, such as rurality (implying personal and professional isolation, distances to deliver service and small organizations) and a general shortage of trained personnel, are significant in Gippsland. Through its focus on the perspectives of leaders in the management of rural mental health services, however, the study found other key issues that contribute to workforce difficulties. Many, including the unattractive nature of mental health work, the fragmented administration of the mental health system, short-term and tied funding, and shortcomings in training are external to organizations. Interviewees indicated that these issues make it difficult for organizations to support personnel in ways that enhance personal and professional satisfaction and so retention and, in turn, the capacity to recruit new employees....

Conclusion: The approach taken by the study, particularly its focus on a management perspective, revealed that the difficulties experienced are the product of a core tension between a growing demand for mental health care, emerging specialties and

technological advances in the field, and a diminished systemic capacity to support organizations in meeting the demand....”]

Full text at:

http://www.rrh.org.au/publishedarticles/article_print_1519.pdf

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

“The University of Hawai’i Rural Health Collaboration: Partnerships to Provide Adult Telepsychiatry Services.” By Susana Helm and others, University of Hawai’i. IN: Psychiatric Services, vol. 61, no. 10, (October 2010) pp. 961-963.

[“To address the twofold problem of mental health disparities and limited access to health resources in rural areas, the University of Hawai’i Rural Health Collaboration aims to increase access to behavioral health services to rural areas across the state, primarily via telepsychiatry. The authors highlight lessons learned in regard to forging a university-community partnership, specifically community engagement for patient referral, the shift toward integrated services and away from a specialty clinic model, the importance of community diversity and contextual relevance, and ethical research and practice with indigenous communities.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/10/961.pdf>

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

SUICIDE PREVENTION

“Baseline factors predictive of serious suicidality at follow-up: findings focusing on age and gender from a community-based study.” By A.K. Schmidt-Fairweather, University of Adelaide, and others. IN: BMC Psychiatry, vol. 10, no. 41 (June 2010) pp. 1-10.

[“Background: Although often providing more reliable and informative findings relative to other study designs, longitudinal investigations of prevalence and predictors of suicidal behavior remain uncommon. This paper compares 12-month prevalence rates for suicidal ideation and suicide attempt at baseline and follow-up; identifies new cases and remissions; and assesses the capacity of baseline data to predict serious suicidality at follow-up, focusing on age and gender differences.

Methods: 6,666 participants aged 20-29, 40-49 and 60-69 years were drawn from the first (1999-2001) and second (2003-2006) waves of a general population survey. Analyses involved multivariate logistic regression.

Results: At follow-up, prevalence of suicidal ideation and suicide attempt had decreased (8.2%-6.1%, and 0.8%-0.5%, respectively). However, over one quarter of those reporting serious suicidality at baseline still experienced it four years later. Females aged 20-29 never married or diagnosed with a physical illness at follow-up were at greater risk of

serious suicidality (OR = 4.17, 95% CI = 3.11-5.23; OR = 3.18, 95% CI = 2.09-4.26, respectively). Males aged 40-49 not in the labor force had increased odds of serious suicidality (OR = 4.08, 95% CI = 1.6-6.48) compared to their equivalently aged and employed counterparts. Depressed/anxious females aged 60-69 were nearly 30% more likely to be seriously suicidal.

Conclusions: There are age and gender differentials in the risk factors for suicidality. Life-circumstances contribute substantially to the onset of serious suicidality, in addition to symptoms of depression and anxiety. These findings are particularly pertinent to the development of effective population-based suicide prevention strategies.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-10-41.pdf>

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

VETERANS

“Effects of Childhood Abuse on Relapse in a Recently Homeless Substance-Dependent Veteran Population.” By Elizabeth A. Garcia-Rea, St. Louis Veterans Affairs Medical Center, and others. IN: **Psychological Trauma: Theory, Research, Practice, and Policy**, vol. 2, no. 3 (September 2010) pp. 201-205.

[“The impact of childhood abuse, both childhood sexual abuse (CSA) and childhood physical abuse (CPA), is well documented. Both CSA and CPA have been associated with a number of *mental health* difficulties, including substance dependence. Though the association between abuse and *mental health* problems is well documented, what has received little attention is the impact that abuse histories may have on the ability to complete treatment for these problems. This study evaluates the association between abuse and failure to complete treatment due to substance relapse in 70 substance-dependent *homeless* men served by a Veterans Affairs Domiciliary Residential Rehabilitation and Treatment Program. Demographic and *mental health* variables were compared with incident rates of sexual and physical abuse as well as with rates of relapse prior to program completion. Contrary to predictions, results found that physical abuse, not sexual abuse, was associated with higher relapse rates. Limitations, implications, and future directions are discussed.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=tra-2-3-201&site=ehost-live>

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

“The impact of PTSD, depression, and substance use disorders on disease burden and health care utilization among OEF/OIF veterans.” By Kyle Passemato and others, Syracuse Veterans’ Affairs Medical Center. IN: **Psychological Trauma: Theory, Research, Practice, and Policy**, vol. 2, no. 3 (September 2010) pp. 218-223.

[“Growing evidence suggests that posttraumatic stress disorder (PTSD) is associated with poorer health status (e.g., more medical disease, physical symptoms, and sick visits to health care professionals) among veterans who served in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) in Iraq. We investigated whether PTSD, depression, and substance use disorders independently predicted health status over time among OEF/OIF veterans. Information regarding psychiatric and medical conditions and health care utilization was culled for 4,463 OEF/OIF veterans enrolled in Veterans Administration primary care for a period of 6 years. Data were analyzed using multilevel modeling and generalized estimating equations. Results suggest that PTSD, depression, and substance use disorders are independently associated with increased medical disease burden and mental health care utilization but not increased medical health care utilization. The association between PTSD and medical disease burden strengthened over time. These data suggest that OEF/OIF veterans with PTSD may be at risk for increasingly poorer physical health in terms of medical disease burden over time.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=tra-2-3-218&site=ehost-live>

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

Potential Costs of Veterans’ Health Care. By the Congressional Budget Office. (The Office, Washington, D.C.) October 2010. 50 p.

[“The Department of Veterans Affairs (VA) provides health care at little or no charge to more than 5 million veterans annually. Medical services are provided through the inpatient and outpatient facilities run by the Veterans Health Administration. Those services include routine health assessments, readjustment counseling, surgery, hospitalization, and nursing home care.

The Congressional Budget Office (CBO) projects that the future costs for VA to treat enrolled veterans will be substantially higher (in inflation-adjusted dollars) than recent appropriations for that purpose, partly because more veterans are likely to seek care in the VA system but mostly because health care costs per enrolled veteran are projected to increase faster than the overall price level.

Under two scenarios that CBO examined, the total real resources (in 2010 dollars) necessary to provide health care services to all veterans who seek treatment at VA would range from \$69 billion to \$85 billion in 2020, representing cumulative increases of roughly 45 percent to 75 percent since 2010. Although veterans from recent conflicts will represent a fast-growing share of enrollments in VA health care over the next decade, the share of VA’s resources devoted to the care of those veterans is projected to remain small through 2020, in part because they are younger and healthier than other veterans served by VA.”]

Full text at:

http://www.cbo.gov/ftpdocs/118xx/doc11811/2010_10_7_VAHealthcare.pdf

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

WELLNESS AND MENTAL ILLNESS

“Evolving Definitions of Mental Illness and Wellness.” By Ronald Manderscheid, Johns Hopkins University, and others. IN: Preventing Chronic Disease: Public Health Research, Practice, and Policy, vol. 7, no. 1 (January 2010) pp. 1-6.

[“Understanding of the definitions of wellness and illness as changed from the mid-20th century to modern times, moving from a diagnosis-focused to a person-focused definition of mental illnesses, and from an “absence of disease” model to one that stresses positive psychological function for mental health. Currently, wellness refers to the degree to which one feels positive and enthusiastic about oneself and life, whereas illness refers to the presence of disease. These definitions apply to physical as well as mental illness and wellness. In this article, we build on the essential concepts of wellness and illness, discuss how these definitions have changed over time, and discuss their importance in the context of health reform and health care reform. *Health reform* refers to efforts focused on health, such as health promotion and the development of positive well-being. *Health care reform* refers to efforts focused on illness, such as treatment of disease and related rehabilitation efforts.”]

Full text at:

http://www.cdc.gov/PCD/issues/2010/jan/pdf/09_0124.pdf

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

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.

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More information about grant-writing at:

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

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

CONFERENCES, MEETINGS AND SEMINARS

The Emerging Neuroscience of Autism Spectrum Disorders

San Diego, California
November 11 and 12, 2010

[This meeting will review current knowledge about the molecular and cellular basis of autism spectrum disorders (ASDs). ASDs, which include autism, Asperger syndrome, Rett syndrome, and pervasive developmental disorder – not otherwise specified, typically present with social and language deficits, in addition to proscribed interests and/or stereotyped behaviors. Behavioral interventions remain the first-line treatment for ASDs and can ameliorate symptoms in some individuals. Molecular genetic approaches have begun to identify chromosomal abnormalities and smaller genetic variants that confer high risk for ASDs. These abnormalities can be explored in model systems and are leading to novel rational therapies. Concurrent studies in patients are identifying systems-level changes that implicate neuronal pathways related to specific symptoms of the ASDs. Leading world experts will review all aspects of current research including the possible causes and current treatments of ASDs at this two-day meeting.”]

For more information:

<http://www.brainresearch2010.com/>

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

American Society of Criminology **Crime and Social Institutions**

San Francisco, California
November 17-20, 2010

“The 2010 meeting will take place **November 17-20, 2010 in San Francisco, California** at the San Francisco Marriott Marquis Hotel. The theme for the meeting is *Crime and Social Institutions*. The American Society of Criminology is an international organization whose members pursue scholarly, scientific, and professional knowledge concerning the measurement, etiology, consequences, prevention, control, and treatment of crime and delinquency.”

For more information:

<http://www.asc41.com/annualmeeting.htm>

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

**2nd Conference on Positive Aging
An Interdisciplinary Team Approach for Health Professionals**

**Vancouver, BC, Canada
November 26, & 27, 2010**

[“The aim of the 2nd national conference on positive aging is to bring together an interdisciplinary audience of health professionals and researchers to address some of the issues and challenges facing the aging population today. Hear about the most current research findings from leading experts, learn how research can be translated into practice, and discover useable resources to promote healthier, more positive living for Canada’s older adult population. The importance of purpose and meaning of the later life as well as lessons for health and longevity will be emphasized. The conference will provide informative lectures, discussions, workshops, poster sessions and ample networking opportunities. A highlight of this conference will be to hear from the Older Adults.”]

For more information:

http://www.interprofessional.ubc.ca/Positive_Aging_2010.html

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

ZERO TO THREE’s 25th National Training Institute (NTI) Connecting *Science, Policy and Practice*

**December 9–11, 2010 (Pre-Institute December 8)
JW Marriott Desert Ridge Resort and Spa, Phoenix, AZ**

[“Every year, ZERO TO THREE provides an opportunity for professionals to enhance their knowledge about early childhood development through our National Training Institute (NTI). The NTI is the most comprehensive multidisciplinary conference in the infant-family field, focusing on cutting-edge research, best practices, and policy issues for infants, toddlers, and families.”]

For more information:

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

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