

Subject: Studies in the News: (November 12, 2010)



Studies in the News for



California Department of Mental Health

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CONTENTS

ANTIPSYCHOTICS

[Impact of race on efficacy during treatment with olanzapine in Schizophrenia](#)

CHILDREN AND ADOLESCENTS

[Children of Parents with Affective and Non-affective Psychoses Externalizing behavior in early childhood and body mass index from age 2 to 12 years](#)

COMMUNITY HEALTH CENTERS

[Health Centers' Contributions to Training Tomorrow's Physicians](#)

CULTURAL COMPETENCY

[Cultural Competency in Mental Health Peer-run Programs and Self-Help Groups](#)

ELDERLY

[Public's View of Mental Health Services for the Elderly](#)

MEDICAL HOMES AND MENTAL HEALTH

[Making Room for Mental Health in the Medical Home](#)

MENTAL ILLNESS

["A Disease like Any Other"? A Decade of Change in Public Reactions](#)

POLICY ISSUES

[Health Reform and the Scope of Benefits for Mental Health](#)

[Health Care Reform and Care at the Behavioral Health-Primary Care Interface](#)

[No Health without Public Mental Health: The Case for Action](#)

[Reducing the treatment gap for mental disorders: a WPA survey](#)

PREVENTION AND EARLY INTERVENTION

[Early intervention services, cognitive-behavioral therapy and family intervention](#)

[Prevention and Early Intervention of Mental Illness in Infants and Children](#)

PRIMARY CARE

[Primary care doctors carrying heavier mental health load](#)

STIGMA

[WPA guidance on how to combat stigmatization of psychiatry and psychiatrists](#)

VETERANS

[Clinician's Perceptions of Virtual Reality to Assess and Treat Returning Veterans](#)

[Psychiatric diagnoses and punishment for misconduct: the effects of PTSD](#)

NON PROFIT RESOURCE CENTER-GRANT WRITING

CONFERENCES, MEETINGS, SEMINARS

[Annual Meeting of the American Society of Criminology](#)

[2nd Conference on Positive Aging](#)

[ZERO TO Three's 25th National Training Institute \(NTI\)](#)

ANTIPSYCHOTICS

“Impact of race on efficacy and safety during treatment with olanzapine in schizophrenia, schizophreniform or schizoaffective disorder.” By Virginia L. Stauffer and others, Lilly USA, Indianapolis, IN. IN: BMC Psychiatry, vol. 10, no. 89 (November 3, 2010) pp. 1-39.

[“To examine potential differences in efficacy and safety of treatment with olanzapine in patients with schizophrenia of white and black descent.

Methods

A post-hoc, pooled analysis of 6 randomized, double-blind trials in the treatment of schizophrenia, schizophreniform disorder, or schizoaffective disorder compared white (N=605) and black (N=375) patients treated with olanzapine (5 to 20 mg/day) for 24 to 28 weeks. Efficacy measurements included the Positive and Negative Syndrome Scale (PANSS) total score; and positive, negative, and general psychopathology scores; and the Clinical Global Impression of Severity (CGI-S) scores at 6 months. Safety measures included differences in the frequencies of adverse events along with measures of extrapyramidal symptoms, weight, glucose, and lipid changes over time.

Results

51% of black patients and 45% of white patients experienced early study discontinuation (P=.133). Of those who discontinued, significantly more white patients experienced psychiatric worsening (P=.002) while significantly more black patients discontinued for reasons other than efficacy or tolerability (P=.014). Discontinuation for intolerability was not different between groups (P=.320). For the estimated change in PANSS total score over 6 months, there was no significant difference in efficacy between white and black patients (P=.928), nor on the estimated PANSS positive (P=.435), negative (P=.756) or general psychopathology (P=.165) scores. Overall, there was no significant difference in the change in CGI-S score between groups from baseline to endpoint (P=.979). Weight change was not significantly different in white and black patients over 6 months (P=.127). However, mean weight change was significantly greater in black versus white patients at Weeks 12 and 20 only (P=.028 and P=.026, respectively). Additionally, a significantly greater percentage of black patients experienced clinically significant weight gain ([greater than or equal to] 7%) at anytime compared to white patients (36.1% vs. 30.4%, P=.021). Changes across metabolic parameters (combined fasting and random lipids and glucose) were also not significantly different between groups, with the exception of a greater categorical change in total cholesterol from borderline to high among white subjects and a categorical change from normal to low in high density lipoprotein (HDL) cholesterol among white males.

Conclusions

The findings did not demonstrate overall substantive differences in efficacy or safety between white and black patients diagnosed with schizophrenia or related disorders

treated with olanzapine. However, a significantly greater percentage of black patients (36.1%) experienced clinically significant weight gain compared to white patients (30.4%).”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-10-89.pdf>

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

CHILDREN AND ADOLESCENTS



(Click on above image for contents of current issue.)

“Children of Parents with Affective and Nonaffective Psychoses: A Longitudinal Study of Behavior Problems.” By Jo-Ann L. Donatelli, Brown University, and others. IN: The American Journal of Psychiatry, vol. 167, no. 11 (November 2010) pp. 1331-1338.

[“It is generally accepted that children of parents with schizophrenia or other forms of psychosis are at heightened risk for a range of behavioral problems. However, it remains unclear whether offspring of parents with different forms of psychosis (e.g., schizophrenia, other nonaffective psychoses, and affective psychoses) have distinct forms of behavioral problems (i.e., internalizing and externalizing). **Method:** Behavioral observations of children of parents with psychosis (N=281) and parents without psychosis (N=185) were conducted at ages 4 and 7 years. **Results:** There were no significant differences between groups in behavior observed at age 4 years. At age 7 years, compared with children of unaffected parents, children of parents with psychosis had an adjusted odds ratio of 2.8 (95% CI=1.5–5.6) for externalizing problems, in particular for children of parents with schizophrenia (adjusted odds ratio=4.4; 95% CI=1.7–12.5). This increase in risk for externalizing problems was observed for female children only (adjusted odds ratio=8.1; 95% CI=2.5–26.3). In contrast, male children were at increased risk for internalizing problems (adjusted odds ratio= 3.6; 95% CI=1.6–8.3). **Conclusions:** Children of parents with various forms of psychosis are at risk for internalizing and externalizing problems by age 7 years. This risk varies by gender of the offspring. Implications for treatment of parents with psychotic disorders and high-risk children are discussed.”]

Full text at:

<http://ajp.psychiatryonline.org/cgi/reprint/167/11/1331>

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

“Externalizing behavior in early childhood and body mass index from age 2 to 12 years: longitudinal analyses of a prospective cohort study.” By Sarah E. Anderson, Ohio State University, and others. IN: BMC Pediatrics, vol. 10, no. 49 (July 2010) pp. 1-8

[“Some evidence suggests that obesity and behavior problems are related in children, but studies have been conflicting and have rarely included children under age 4. An association between behavior problems in early childhood and risk for obesity could suggest that a common set of factors contribute to both. Our research objectives were to determine the extent to which externalizing behavior in early childhood is related to body mass index (BMI) in early childhood and through age 12, and to evaluate whether these associations differ by sex and race.

Methods: Data from the NICHD Study of Early Child Care and Youth Development were analyzed. Externalizing behaviors at 24 months were assessed by mothers using the Child Behavior Checklist. BMI was calculated from measured height and weight assessed 7 times between age 2 and 12 years. Linear mixed effects models were used to assess associations between 24 month externalizing behavior and BMI from 2 to 12 years, calculate predicted differences in BMI, and evaluate effect modification.

Results: Externalizing behavior at 24 months was associated with a higher BMI at 24 months and through age 12. Results from a linear mixed effects model, controlling for confounding variables and internalizing behavior, predicted a difference in BMI of approximately 3/4 of a unit at 24 months of age comparing children with high levels of externalizing behavior to children with low levels of externalizing behavior. There was some evidence of effect modification by race; among white children, the average BMI difference remained stable through age 12, but it doubled to 1.5 BMI units among children who were black or another race.

Conclusions: Our analyses suggest that externalizing behaviors in early childhood are associated with children's weight status early in childhood and throughout the elementary school years, though the magnitude of the effect is modest.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2431-10-49.pdf>

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

COMMUNITY HEALTH CENTERS

Health Centers’ Contributions to Training Tomorrow’s Physicians. By Krystal Knight and others, Division of Public Policy and Research, National Association of Community Health Centers, Inc. (The Association, Washington, D. C.) August 2010. 25 p.

[“Access to primary care has progressively weakened across the United States (U.S.) since the 1960’s. The primary care physician shortage is due to several factors, including the growth and aging of the U.S. population. Additionally, the number of medical students accepting placements in primary care residency programs continues to decline, and many current physicians are nearing retirement. **Thus, the primary care workforce is shrinking as demand for primary care increases. As a means of recruiting primary care professionals to provide care for their patients, health centers participate in a variety of health professions training (HPT) programs at all levels.** Residents, for instance, provide care to health center patients; in turn, health centers offer valuable and unique training opportunities given their range of services and diverse, complex patient populations. Most recently, the Affordable Care Act (ACA) authorizes a new Teaching Health Center (THC) program that provides payments to eligible ‘teaching health centers’ to cover the direct and indirect costs of primary care residency training. While there is widespread involvement in residency programs among Community Health Centers (CHCs), there is very little published information on the programs themselves.”]

Full text at:

<http://www.nachc.com/client/FINAL%20THC%20REPORT%20-%2010222010-1.pdf>

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

CULTURAL COMPETENCY

Cultural Competency in Mental Health Peer-run Programs and Self-help Groups: A Tool to Assess and Enhance your Services. By The National Alliance on Mental Illness (NAMI) Star Center. (The Center, Arlington, Virginia) 2010. 36 p.

[“This tool was created to help mental health, consumer-operated programs and self-help groups assess their own cultural competency. By using it, you’ll identify the ways in which your activities are already responsive to culturally diverse peers and areas where you could use some improvement. You’ll also create specific action plans to enhance your cultural competency in five important areas.”]

Full text at:

<http://www.cmhsrp.uic.edu/download/CulturalCompetencyTool.pdf>

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

ELDERLY



(Click on above image for current contents)

**“Public’s View of Mental Health Services for the Elderly: Responses to Dear Abby.”
By Stephen Koh and others, Committee on Aging of the Group for the
Advancement of Psychiatry. IN: Psychiatric Services, vol. 61, no. 11 (November
2010) pp. 1146-1149**

[“The need for adequate mental health services for older adults is an increasingly urgent issue as the life expectancy of Americans continues to extend; yet there are unresolved questions regarding the public's perception of service needs. The Group for the Advancement of Psychiatry collaborated with advice columnist Jeannie Phillips of "Dear Abby" to invite public feedback on mental health services for the elderly. Feedback was invited on access to services as well as perceived need for improvement in the quality or quantity of those services. The effort resulted in 800 responses that identified three primary issues: problems in accessing care, inadequate detection of mental health conditions by general practitioners, and a need for more psychotherapy services. It is hoped that this Open Forum will stimulate discussion throughout the country for the benefit of older persons with mental health needs as the country grapples with changes to come after the passage of health care reform.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/11/1146>

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

MEDICAL HOMES AND MENTAL HEALTH



About this image:

<http://www.cdc.gov/pcd/issues/2010/nov/cover.htm>

“Making Room for Mental Health in the Medical Home.” By Michael F. Hogan, New York State Office of Mental Health, and others. IN: **Preventing Chronic Disease: Public Research Practice and Policy. Vol. 7, no. 6 (November 2010) pp. 1-7.**

[“Discussions of health care reform emphasize the need for coordinated care, and evidence supports the effectiveness of medical home and integrated delivery system models. However, mental health often is left out of the discussion. Early intervention approaches for children and adolescents in primary care are important given the increased rates of detection of mental illness in youth. Most adults also receive treatment for mental illness from non specialists, underscoring the role for mental health in medical home models. Flexible models for coordinated care are needed for people with serious mental illness, who have high rates of comorbid medical problems. Programs implemented in the New York State public mental health system are examples of efforts to better coordinate medical and mental health services.”]

Full text at:

http://www.cdc.gov/pcd/issues/2010/nov/pdf/09_0198.pdf

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

MENTAL ILLNESS

“A Disease Like Any Other”? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence.” By Bernice A. Pescosolido, Indiana University, and others. IN: **American Journal of Psychiatry, vol. 167, no. 11 (November 2010) pp. 1321-1330.**

[“Clinicians, advocates, and policy makers have presented mental illnesses as medical diseases in efforts to overcome low service use, poor adherence rates, and stigma. The authors examined the impact of this approach with a 10-year comparison of public endorsement of treatment and prejudice. **Method:** The authors analyzed responses to

vignettes in the mental health modules of the 1996 and 2006 General Social Survey describing individuals meeting DSM-IV criteria for schizophrenia, major depression, and alcohol dependence to explore whether more of the public 1) embraces neurobiological understandings of mental illness; 2) endorses treatment from providers, including psychiatrists; and 3) reports community acceptance or rejection of people with these disorders. Multivariate analyses examined whether acceptance of neurobiological causes increased treatment support and lessened stigma. **Results:** In 2006, 67% of the public attributed major depression to neurobiological causes, compared with 54% in 1996. High proportions of respondents endorsed treatment, with general increases in the proportion endorsing treatment from doctors and specific increases in the proportions endorsing psychiatrists for treatment of alcohol dependence (from 61% in 1996 to 79% in 2006) and major depression (from 75% in 1996 to 85% in 2006). Social distance and perceived danger associated with people with these disorders did not decrease significantly. Holding a neurobiological conception of these disorders increased the likelihood of support for treatment but was generally unrelated to stigma. Where associated, the effect was to increase, not decrease, community rejection. **Conclusions:** More of the public embraces a neurobiological understanding of mental illness. This view translates into support for services but not into a decrease in stigma. Reconfiguring stigma reduction strategies may require providers and advocates to shift to an emphasis on competence and inclusion.”]

Full text at:

<http://ajp.psychiatryonline.org/cgi/reprint/167/11/1321>

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

POLICY ISSUES

“Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services.” By Rachel L. Garfield and others, University of Pittsburgh. **IN: Psychiatric Services, vol. 61, no. 11 (November 2010) pp. 1081-1086.**

[“The Patient Protection and Affordable Care Act will expand insurance coverage to millions of Americans with mental disorders. One particularly important implementation issue is the scope of mental health and substance abuse services under expanded health insurance coverage. This article examines current public and commercial insurance coverage of the range of services used by individuals with mental illnesses and substance use disorders and assesses the implications of newly mandated standards for benefit packages offered by public and private plans. The authors note that many services needed by individuals with mental or substance use disorders fall outside the scope of benefits currently covered by a typical private insurance plan. Compared with other insurers, Medicaid currently covers a broader range of behavioral health services; however, individuals moving into Medicaid under new eligibility pathways will receive “benchmark” or “benchmark-equivalent” coverage rather than full Medicaid benefits. If behavioral health benefits are set at those currently available in typical private plans or in benchmark coverage, some newly insured individuals with mental illnesses or substance use disorders who are covered by private plans or Medicaid expansions are still likely to

face gaps in covered services. Policy makers have several options for addressing these likely gaps in coverage, including requiring states to maintain coverage of some support services, including certain behavioral health services in the “essential benefits package,” and expanding eligibility for full Medicaid benefits.”]

Full text at;

<http://psychservices.psychiatryonline.org/cgi/reprint/61/11/1081>

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

“Health Care Reform and Care at the Behavioral Health–Primary Care Interface.”
By Benjamin G. Druss, Emory University, and Barbara J. Maurer, MCPPP Consulting, Seattle, Washington. IN: Psychiatric Services, vol. 61, no. 11 (November 2010) pp. 1087-1092.

[“The historic passage of the Patient Protection and Affordable Care Act in March 2010 offers the potential to address long-standing deficits in quality and integration of services at the interface between behavioral health and primary care. Many of the efforts to reform the care delivery system will come in the form of demonstration projects, which, if successful, will become models for the broader health system. This article reviews two of the programs that might have a particular impact on care on the two sides of that interface: Medicaid and Medicare patient centered medical home demonstration projects and expansion of a Substance Abuse and Mental Health Services Administration program that collocates primary care services in community mental health settings. The authors provide an overview of key supporting factors, including new financing mechanisms, quality assessment metrics, information technology infrastructure, and technical support, that will be important for ensuring that initiatives achieve their potential for improving care.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/11/1087>

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

No Health without Public Mental Health: The Case for Action. By the Royal College of Psychiatrists. Position Statement PS4. (The College, London, United Kingdom) October 2010. 48 p.

[“Mental health is a public health issue. Mental illness is the largest single source of burden of disease in the UK. No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact.¹ Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behavior. Mental illness has not only a

human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year.²

Despite the impact of mental illness across a broad range of functional, economic and social outcomes, and despite ample evidence that good mental health underlies all health, mental health is not prominent across public health actions and policy. Public health strategies concentrate on physical health and overlook the importance of both mental illness and mental well-being. Positioning mental health at the heart of public health policy is essential for the health and well-being of the nation. It will lead to healthy lifestyles and reduce health-risk behaviors, thereby both preventing physical illness and reducing the burden of mental illness.”]

Full text at:

<http://www.rcpsych.ac.uk/pdf/Position%20Statement%204%20website.pdf>

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

“Reducing the treatment gap for mental disorders: a WPA survey.” By Vikram Patel, London School of Hygiene and Tropical Medicine, and others. IN: World Psychiatry, vol. 9, no. 3 (October 2010) pp. 169-176.

[“The treatment gap for people with mental disorders exceeds 50% in all countries of the world, approaching astonishingly high rates of 90% in the least resourced countries. We report the findings of the first systematic survey of leaders of psychiatry in nearly 60 countries on the strategies for reducing the treatment gap. We sought to elicit the views of these representatives on the roles of different human resources and health care settings in delivering care and on the importance of a range of strategies to increase the coverage of evidence-based treatments for priority mental disorders for each demographic stage (childhood, adolescence, adulthood and old age). Our findings clearly indicate three strategies for reducing the treatment gap: increasing the numbers of psychiatrists and other mental health professionals; increasing the involvement of a range of appropriately trained non-specialist providers; and the active involvement of people affected by mental disorders. This is true for both high income and low/middle income countries, though relatively of more importance in the latter. We view this survey as a critically important first step in ascertaining the position of psychiatrists, one of the most influential stakeholder communities in global mental health, in addressing the global challenge of scaling up mental health services to reduce the treatment gap.”]

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2953637/pdf/wpa030169.pdf>

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

PREVENTION AND EARLY INTERVENTION

“Early intervention services, cognitive–behavioral therapy and family intervention in early psychosis: systematic review.” By V. Bird, Royal College of Psychiatrists” Research and Training Unit, and others. IN: British Journal of Psychiatry, vol. 197 (2010) pp. 350-356.

[“Early intervention services for psychosis aim to detect emergent symptoms, reduce the duration of untreated psychosis, and improve access to effective treatments.

Aims

To evaluate the effectiveness of early intervention services, cognitive–behavioral therapy (CBT) and family intervention in early psychosis.

Method

Systematic review and meta-analysis of randomized controlled trials of early intervention services, CBT and family intervention for people with early psychosis.

Results

Early intervention services reduced hospital admission, relapse rates and symptom severity, and improved access to and engagement with treatment. Used alone, family intervention reduced relapse and hospital admission rates, whereas CBT reduced the severity of symptoms with little impact on relapse or hospital admission.

Conclusions

For people with early psychosis, early intervention services appear to have clinically important benefits over standard care. Including CBT and family intervention within the service may contribute to improved outcomes in this critical period. The longer-term benefits of this approach and its component treatments for people with early and established psychosis need further research.”]

Full text at:

<http://bjp.rcpsych.org/cgi/reprint/197/5/350>

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



Prevention and Early Intervention of Mental Illness in Infants, Children and Adolescents: Planning Strategies for Australia and New Zealand. By Faculty of Child and Adolescent Psychiatry, The Royal Australian and New Zealand College of Psychiatrists. (The College, Melbourne, Australia) 2010. 40 p.

[“A significant number of infants, children and adolescents experience some form of mental illness. Mental illness in infancy, childhood or adolescence can have enduring consequences if left unresolved. Those affected bear a major burden in suffering, lost opportunities and reduced social and economic outcomes in adulthood, including reduced workforce participation. Among the many adverse outcomes are reduced self-esteem or confidence, reduced educational and occupational opportunity, increased risk of substance abuse and other mental disorders, as well as increased family conflict, family breakdown and homelessness.

The development and implementation of early intervention and prevention strategies for the prevention of mental illness in infants, children and adolescents is imperative to addressing these adverse outcomes and preventing or reducing mental disorders in adulthood. This report determines key strategies to promote and develop cohesive and evidence based prevention and early intervention strategies with the aim of decreasing the prevalence and harmful impact of mental illness in infants, children and adolescents.

Critical to the success of the prevention and early intervention of mental illness in childhood, is broadening the roles and priorities of child and adolescent psychiatrists and general psychiatrists to include the provision of leadership to multidisciplinary teams, training of other professionals, and advocating for improvements in service delivery.”]

Full text at:

http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/peips_report.pdf

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

PRIMARY CARE

“Primary care doctors carrying heavier mental health load.” By Christine S. Moyer, American Medical News Staff. In: American Medical News, (October 25, 2010) pp. 1-2.

“As an internist, Charles Cutler, MD, was trained primarily to detect and treat physical problems. But he sees many patients for mental health issues at his practice in Norristown, Pa.

Because psychiatrists in the area frequently do not have openings for new patients, Dr. Cutler often provides mental health treatment.

He is among a growing number of primary care physicians who say they are handling a greater load of mental health care. A report from the Center for American Progress, a public policy and advocacy organization, shows that more than a third of patients who receive treatment for mental health disorders rely solely on primary care physicians.”

Full text at:

<http://www.ama-assn.org/amednews/2010/10/25/prl21025.htm>

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

STIGMA

**“WPA guidance on how to combat stigmatization of psychiatry and psychiatrists.”
By Norman Sartorius, Association for the Improvement of Mental Health
programmers, Geneva, Switzerland, and others. IN: World Psychiatry, vol. 9, no. 3
(September 9, 2010) pp. 131-144.**

“In 2009 the WPA (World Psychiatry Association) President established a Task Force that was to examine available evidence about the stigmatization of psychiatry and psychiatrists and to make recommendations about action that national psychiatric societies and psychiatrists as professionals could do to reduce or prevent the stigmatization of their discipline as well as to prevent its nefarious consequences. This paper presents a summary of the Task Force’s findings and recommendations. The Task Force reviewed the literature concerning the image of psychiatry and psychiatrists in the media and the opinions about psychiatry and psychiatrists of the general public, of students of medicine, of health professionals other than psychiatrists and of persons with mental illness and their families. It also reviewed the evidence about the interventions that have been undertaken to combat stigma and consequent discrimination and made a series of recommendations to the national psychiatric societies and to individual psychiatrists. The Task Force laid emphasis on the formulation of best practices of psychiatry and their application in health services and on the revision of curricula for the training of health personnel. It also recommended that national psychiatric societies establish links with other professional associations, with organizations of patients and their relatives and with the media in order to approach the problems of stigma on a broad front. The Task Force also underlined the role that psychiatrists can play in the prevention of stigmatization of psychiatry, stressing the need to develop a respectful relationship with patients, to strictly observe ethical rules in the practice of psychiatry and to maintain professional competence.”]

Full text at:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2948719/pdf/wpa030131.pdf>

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

VETERANS

“Clinician’s Perceptions of Virtual Reality to Assess and Treat Returning Veterans.” By Theresa L. Kramer, University of Arkansas for Medical Sciences, and others. IN: Psychiatric Services, vol. 61, no. 11 (November 2010) pp. 1153-1156.

[“Implementation of evidence- based, innovative treatments is necessary to address posttraumatic stress disorder (PTSD) and related mental health problems of Operation Enduring Freedom and Operation Iraqi Freedom (OEF-OIF) military service personnel. The purpose of this study was to characterize mental health clinicians’ perceptions of

virtual reality as an assessment tool or adjunct to exposure therapy. *Methods:* Focus groups were conducted with 18 prescribing and nonprescribing mental health clinicians within the Veterans Health Administration. Group discussion was digitally recorded, downloaded into Ethnograph software, and coded to arrive at primary, secondary, and tertiary themes. *Results:* Most frequently mentioned barriers pertained to aspects of virtual reality, followed by veteran characteristics. Organizational barriers were more relevant when implementing virtual reality as a treatment adjunct. *Conclusions:* Although the study demonstrated that use of virtual reality as a therapy was feasible and acceptable to clinicians, successful implementation of the technology as an assessment and treatment tool will depend on consideration of the facilitators and barriers that were identified.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/11/1153>

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



Journals A-Z:

<http://www.biomedcentral.com/browse/journals/>

“Psychiatric diagnoses and punishment for misconduct: the effects of PTSD in combat-deployed Marines.” By Robyn M. Highfill-McRoy, Naval Health Research Center, San Diego, and others. IN: *BMC Psychiatry*, vol. 10, no. 88 (October 25, 2010) pp. 1-26.

[“Research on Vietnam veterans suggests an association between psychological problems, including posttraumatic stress disorder (PTSD), and misconduct; however, this has rarely been studied in veterans of Operation Iraqi Freedom or Operation Enduring Freedom. The objective of this study was to investigate whether psychological problems were associated with three types of misconduct outcomes (demotions, drug-related discharges, and punitive discharges.)

Methods

A population-based study was conducted on all U.S. Marines who entered the military between October 1, 2001, and September 30, 2006, and deployed outside of the United States before the end of the study period, September 30, 2007. Demographic, psychiatric, deployment, and personnel information was collected from military records. Cox proportional hazards regression analysis was conducted to investigate associations between the independent variables and the three types of misconduct in war deployed (n = 77 998) and non-war deployed (n = 13 944) Marines.

Results

Marines in both the war-deployed and non-war-deployed cohorts with a non-PTSD psychiatric diagnosis had an elevated risk for all three misconduct outcomes (hazard

ratios ranged from 3.93 to 5.65). PTSD was a significant predictor of drug-related discharges in both the war-deployed and non-war-deployed cohorts. In the war-deployed cohort only, a specific diagnosis of PTSD was associated with an increased risk for both demotions (hazard ratio, 8.60; 95% confidence interval, 6.95 to 10.64) and punitive discharges (HR, 11.06; 95% CI, 8.06 to 15.16).

Conclusions

These results provide evidence of an association between PTSD and behavior problems in Marines deployed to war. Moreover, because misconduct can lead to disqualification for some Veterans Administration benefits, personnel with the most serious manifestations of PTSD may face additional barriers to care.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-10-88.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.

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

CONFERENCES, MEETINGS AND SEMINARS

**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>

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

Public Discussion on Confidentiality and Privacy Issues Related to Psychological Testing Data.

Sheraton Los Angeles Gateway Hotel Los Angeles – November 18, 2010

“The Substance Abuse and Mental Health Services Administration (SAMHSA), in close cooperation with the Department of Health and Human Services (DHHS) Office for Civil Rights (OCR), is conducting a study of the “Confidentiality and Privacy Issues Related to Psychological Testing Data.” This study was specifically called for in section 13424 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) (P.L. 111-5).

The Issue: HIPAA’s Privacy Rule includes special protections relating to the use and disclosure of *psychotherapy notes*; should these special protections also be applied to “*test data* that is related to direct responses, scores, items, forms, protocols, manuals or other materials that are part of a mental health evaluation?”

“SAMHSA is hosting a regional public meeting at the Sheraton Los Angeles Gateway Hotel in Los Angeles, California, on November 18, 2010. This is a chance for you to learn about this issue and express your opinions. Registration is necessary, but there is no charge for attending.”

Full text at:

<https://www.regonline.com/custImages/288249//Los%20Angeles%20Regional%20Meeting%20E-Brochure.pdf>

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.ztnticonference.org/>

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

The 25th Conference Annual San Diego International Conference on Child and Family Maltreatment.

**January 22-28 2011
Town and Country Resort and Convention Center
San Diego, California**

[“The San Diego Conference focuses on multi-disciplinary best-practice efforts to prevent, if possible, or otherwise to investigate, treat, and prosecute child and family maltreatment.

The objective of the San Diego Conference is to develop and enhance professional skills and knowledge in the prevention, recognition, assessment and treatment of all forms of maltreatment including those related to family violence as well as to enhance investigative and legal skills. Issues concerning support for families, prevention, leadership, policy making and translating the latest research into action are also addressed.”]

For more information:

http://www.sandiegoconference.org/Documents/2011conf/11SDConf_brochure-1.pdf

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

**Personality and Temperament: The Building Blocks of Behavior. Annual Meeting
American College of Psychiatrists.**

February 23-27, 2011.

Fairmont Hotel

San Francisco, California

[“The American College of Psychiatrists’ Annual Meeting offers Members a chance to exchange information and participate in high-quality continuing medical education programs in a relaxed setting. More than 50 percent of the Members attend the Annual Meeting.

The College organizes each four-day Annual Meeting around a central theme. Typically, the program format includes large general sessions and smaller breakout courses. Faculty members are leading scholars, clinicians, and researchers drawn from The College and the profession at large.”]

For more information:

<http://www.acpsych.org/meetings-and-news/annual-meeting>

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