

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



Studies in the News for



California Department of Mental Health

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CONTENTS

ANTIPSYCHOTICS

[Comparative Effectiveness of First and Second Generation Antipsychotics](#)

CHILDREN AND ADOLESCENTS

[Identification of social-emotional problems among young children in foster care](#)

COMMUNITY-BASED TREATMENT

[Assessing the efficacy of a community-based treatment in a developing country](#)

[Telehealth in Community Clinics](#)

ELDERLY

[Changes in Mental Well-Being in the Transition to Late Life](#)

HOMELESSNESS

[Service Use and Costs for Persons Experiencing Chronic Homelessness](#)

INTEGRATED HEALTH CARE

[Acute Services: Local Ideas to Improve Integration](#)

[Health Care Delivery: Integrated Systems Support Patient Care Strategies](#)

MINORITIES

[Addressing Depression Treatment Preferences among Low-Income Latinos](#)

POLICY ISSUES

[Medical Home 2.0: Present and Future. Issue Brief](#)

[Parity Toolkit for Addiction and Mental Health Consumers](#)

[Services under Challenge: Meeting needs of people in mental health care](#)

PUBLIC MENTAL HEALTH

[Mental Health Promotion as a New Goal in Public Mental Health Care](#)

RECOVERY

[Family Network Support and Mental Health Recovery](#)

[Recovering Mental Health in Scotland](#)

RURAL ISSUES

[Factors Influencing Rural Residents' Utilization of Urban Hospitals](#)

SUBSTANCE USE

[Influence of Family and School Factors on Early Adolescent Substance Use](#)

SUICIDE PREVENTION

[Loss, psychosis, and chronic suicidality in a Korean American immigrant](#)

[Analysis and Risk Management to Avert Depression and Suicide among Workers](#)

[Mental Health Disorders and Suicidality in a Sample of LGBT Youths](#)

VETERANS

[Transforming Mental Healthcare in the Veterans Health Administration](#)

NON PROFIT RESOURCE CENTER-GRANT WRITING

CONFERENCES, MEETINGS, SEMINARS

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

[25th Conference Annual San Diego International Conference on Child and Family Maltreatment.](#)

[Annual Meeting American College of Psychiatrists.](#)

ANTIPSYCHOTICS

Comparative Effectiveness of First and Second Generation Antipsychotics in the Pediatric and Young Adult Populations. By the Agency for Healthcare Research and Quality (AHRQ). Draft Comparative Effectiveness Review. (The Agency, Rockville, Maryland) 2010. 235 p.

[“Antipsychotic medications are widely used to treat a number of psychiatric disorders and are commonly categorized into two classes. First generation antipsychotics were initially developed in the 1950s. While they are used to treat psychotic symptoms, they are commonly associated with various side effects including extrapyramidal symptoms, dry mouth, sedation, and, in severe cases, tardive dyskinesia and neuroleptic malignant syndrome. Second generation antipsychotics emerged in the 1980s. They are generally thought to have a lower risk of motor side effects, but are associated with a higher risk of weight gain, elevated lipids and prolactin levels, and have been associated with the development of type 2 diabetes.

Use of antipsychotics for children and youth has increased over the past 20 years.¹⁻⁵ Prescribing antipsychotics to the pediatric population is controversial because there is limited high quality and longitudinal data on which to base clinical practice recommendations. In children and youth, antipsychotic medications have both approved and unapproved indications. Approved indications include treatment of childhood schizophrenia and bipolar disorders in the United States, while unapproved indications include behavioral symptoms (e.g., irritability and aggression) in younger children that are related to diagnosable conditions (e.g., pervasive developmental disorder). In general, the choice of medication in children and youth is often driven by side effect profiles that may affect normative growth and development, medication adherence and persistence, as well as other important domains such as school performance and health-related quality of life.”]

Full text at:

[http://www.effectivehealthcare.ahrq.gov/ehc/products/147/585/pedsAP_CER_REPORT_draft_5Oct10%20\(ST2\).pdf](http://www.effectivehealthcare.ahrq.gov/ehc/products/147/585/pedsAP_CER_REPORT_draft_5Oct10%20(ST2).pdf)

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

CHILDREN AND ADOLESCENTS



“Identification of social-emotional problems among young children in foster care.”
By Sandra H. Jee and others, University of Rochester Medical Center. IN: *Journal of Child Psychology and Psychiatry*, vol. 51, no. 12 (December 2010) pp. 1351-1358.

[“Little is known about how best to implement behavioral screening recommendations in practice, especially for children in foster care, who are at risk for having social-emotional problems. Two validated screening tools are recommended for use with young children: the Ages and Stages Questionnaire: Social Emotional (ASQ-SE) identifies emotional problems, and the Ages and Stages Questionnaire (ASQ) identifies general developmental delays in five domains, including personal-social problems. The current study examined: (1) whether systematic use of a social-emotional screening tool improves the detection rate of social-emotional problems, compared to reliance on clinical judgment; (2) the relative effectiveness of two validated instruments to screen for social-emotional problems; and (3) the patterns of social-emotional problems among children in foster care. Methods: We used retrospective chart review of children in foster care ages 6 months to 5.5 years: 192 children before and 159 after screening implementation, to measure detection rates for social-emotional problems among children. The ASQ-SE and the ASQ were used in multivariable logistic regression analyses to examine associations between children with social-emotional problems. Results: Use of the screening tool identified 24% of the children as having a social-emotional problem, while provider surveillance detected 4%. We identified significantly more children with social-emotional problems using the ASQ-SE than using the ASQ, and agreement between the instruments ranged from 56% to 75%, when data were stratified by age group. Multivariable modeling showed that preschool children were more likely to have a social-emotional problem than toddlers and infants (aOR = 3.4, 95% CI = 1.1– 10.8). Conclusions: Systematic screening using the ASQ-SE increased the detection rate for social emotional problems among young children in foster care, compared to provider surveillance and the ASQ. A specific social-emotional screening tool appears to detect children with psychosocial concerns who would not be detected with a broader developmental screening tool. Keywords: Social-emotional, children, foster care, screening.” **NOTE: Please contact the California State Library if you would like an electronic copy of this article.]**

Full text at:

<http://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.2010.02315.x/pdf>

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

COMMUNITY BASED-TREATMENT

“Assessing the efficacy of a modified assertive community-based treatment programme in a developing country.” By Ulla A. Botha, University of Stellenbosch, Tygerberg, South Africa, and others. IN: *BMC Psychiatry*, vol. 10 (September 15, 2010) pp. 1-8.

[“Background: A number of recently published randomized controlled trials conducted in developed countries have reported no advantage for assertive interventions over standard care models. One possible explanation could be that so-called “standard care” has become more comprehensive in recent years, incorporating some of the salient aspects of assertive models in its modus operandi. Our study represents the first randomized controlled trial assessing the effect of a modified assertive treatment service on readmission rates and other measures of outcome in a developing country. Methods: High frequency service users were randomized into an intervention (n = 34) and a control (n = 26) group. The control group received standard community care and the active group an assertive intervention based on a modified version of the international model of assertive community treatment. Study visits were conducted at baseline and 12 months with demographic and *illness* information collected at visit 1 and readmission rates documented at study end. Symptomatology and functioning were measured at both visits using the PANSS, CDSS, ESRs, WHO-QOL and SOFAS. Results: At 12 month follow-up subjects receiving the assertive intervention had significantly lower total PANSS (p = 0.02) as well as positive (p < 0.01) and general psychopathology (p = 0.01) subscales’ scores. The mean SOFAS score was also significantly higher (p = 0.02) and the mean number of psychiatric admissions significantly lower (p < 0.01) in the intervention group. Conclusions: Our results indicate that assertive interventions in a developing setting where standard community *mental* services are often under resourced can produce significant outcomes. Furthermore, these interventions need not be as expensive and comprehensive as international, first-world models in order to reduce inpatient days, improve psychopathology and overall levels of functioning in patients with severe *mental illness*.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-10-73.pdf>

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

Telehealth in Community Clinics: Three Case Studies in Implementation. By Christine Duclos and others, JSI Research and Training Institute. (California Healthcare Foundation, Oakland, California) November 2010. 44 p.

“In 2007, the California Healthcare Foundation funded the “Telemedicine in Clinics” project with the goal of exploring the role that a telehealth system could play in improving access to specialty care services for patients of community health centers (CHCs). The three CHCs participating in the project-Open Door Community Health Centers (Open Door) based in Arcata, La Clinica de La Raza (La Clinica) based in Oakland, and the Southside Coalition of Community Health Centers (Southside) in South Los Angeles-represented three different settings in which to explore the challenges of planning and implementing telehealth programs to improve access to care.”

Full text at:

<http://www.chcf.org/~media/Files/PDF/T/PDF%20TelehealthClinicCaseStudies.pdf>

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

ELDERLY

“Changes in Mental Well- Being in the Transition to Late Life: Findings From MIDUS I and II.” By Mark Snowden, University of Washington School of Medicine, and others. IN: *American Journal of Public Health*, vol. 100, no. 12 (December 2010) pp. 2385-2388.

[“The number of adults aged 65 years and older is increasing rapidly, creating public health challenges. We used data from the 1995 and 2005 national surveys of Midlife in the United States (MIDUS) to compare changes in mental well-being of participants (n=1007) of 3 age cohorts (ages 45–54 years, 55–64 years, and 65–74 years in 1995). Older adults experienced a slight decline in mental well-being not seen among younger participants and not explained by demographic variables, physical ailments, mental illnesses, or chronic conditions.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/100/12/2385>

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

HOMELESSNESS



(Click on cover to access journal contents.)

“Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study.” By Stephen R. Poulin, University of Pennsylvania, and others. IN: *Psychiatric Services*, vol. 61, no. 11 (November 2010) pp. 1093-1098.

[“This study is the first to examine the distribution of service utilization and costs with a population-based sample that experienced chronic homelessness in sheltered and unsheltered locations in a large U.S. city. *Methods*: This study used shelter and street outreach records from a large U.S. city to identify 2,703 persons who met federal criteria

for chronic homelessness during a three-year period. Identifiers for these persons were matched to administrative records for psychiatric care, substance abuse treatment, and incarceration. *Results:* Twenty percent of the persons who incurred the highest costs for services accounted for 60% of the total service costs of approximately \$20 million a year (or approximately \$12 million). Most of the costs for this quintile were for psychiatric care and jail stays. Eighty-one percent of the persons in the highest quintile had a diagnosis of a serious mental illness, and 83% of the persons in the lowest quintile had a history of substance abuse treatment without a diagnosis of a serious mental illness. *Conclusions:* Supportive housing models for people with serious mental illness who experience chronic homelessness may be associated with substantial cost offsets, because the use of acute care services diminishes in an environment of housing stability and access to ongoing support services. However, because persons with substance use issues and no recent history of mental health treatment used relatively fewer and less costly services, cost neutrality for these persons may require less service-intensive programs and smaller subsidies.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/11/1093>

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

INTEGRATED HEALTH CARE

Acute Services: Local Ideas to Improve Integration. By Sue Mackersey and others, (New Zealand) Mental Health Commission. (The Commission, Wellington, New Zealand) November 2010. 21 p.

[“Since commencing the implementation of the *Blueprint*¹, significant changes have occurred in mental health and addiction services in New Zealand. With the *Blueprint* 80% implemented, funding for services has increased by 160% and accounts for around \$1.2 billion of Vote Health. Approximately 30% of this funding is directed to the community (non-governmental organisation [NGO]) sector and \$24 million has been allocated in recent years to a number of primary mental health initiatives.

Despite the expenditure, acute mental health and addiction services remain under pressure. There are a number of reasons that have been identified as contributing to this situation, including a lack of integration between primary, secondary and NGO services. More integrated services are seen as desirable because they make better use of resources; reduce the potential for incidents occurring during transitions between services and present better options for service users.

This project was commenced to explore how some mental health and addiction services in New Zealand have responded to the challenge of developing better integrated care and to share the information about their successes with other services.”]

Full report at

<http://www.mhc.govt.nz/sites/mhc.govt.nz/files/publications/2010/Acute%20Service%20Project%20FINAL.pdf>

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

Health Care Delivery: Features of Integrated Systems Support Patient Care Strategies and Access to Care, but Systems Face Challenges. By United States Government Accountability Office (GAO). Report to Congressional Committees. (The Office, Washington, D.C.) November 2010. 33 p.

[“Health care delivery in the United States often lacks coordination and communication across providers and settings. This fragmentation can lead to poor quality of care, medical errors, and higher costs. Providers have formed integrated delivery systems (IDS) to improve efficiency, quality, and access. The Health Care Safety Net Act of 2008 directed GAO to report on IDSs that serve underserved populations—those that are uninsured or medically underserved (i.e., facing economic, geographic, cultural, or linguistic barriers to care, including Medicaid enrollees and rural populations). In October 2009, GAO provided an oral briefing. In this follow-on report, GAO describes (1) organizational features IDSs use to support strategies to improve care; (2) approaches IDSs use to facilitate access for underserved populations; and (3) challenges IDSs encounter in providing care, including to underserved populations.

GAO selected a judgmental sample of 15 private and public IDSs that are clinically integrated across primary, specialty, and acute care; they vary in their degree of integration, specific organizational features, and payer mix (e.g., extent to which they serve Medicare and Medicaid beneficiaries and the uninsured). GAO interviewed chief medical officers or other system officials at all 15 IDSs and conducted site visits at 4 IDSs, interviewing system executives and clinical staff.”]

Full text at:

<http://www.gao.gov/new.items/d1149.pdf>

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

MINORITIES

“Effectiveness of Collaborative Care in Addressing Depression Treatment Preferences Among Low-Income Latinos.” By Megan Dwight-Johnson, RAND Corporation, and others. IN: *Psychiatric Services*, vol. 61, no. 11 (November 2010) pp. 1112-1118.

[“This study assessed treatment preferences among low-income Latino patients in public-sector primary care clinics and examined whether a collaborative care intervention that included patient education and allowed patients to choose between medication, therapy, and both would increase the likelihood that patients received preferred treatment. *Methods:* A total of 339 Latino patients with probable depressive disorders were recruited; participants completed a baseline conjoint analysis preference survey and were randomly assigned to receive the intervention or enhanced usual care. At 16 weeks, a patient survey assessed depression treatment received during the study period. Logistic regression models were constructed to estimate treatment preferences, examine patient characteristics associated with treatment preferences, and examine patient characteristics

associated with a match between stated preference and actual treatment received. *Results:* The conjoint analysis preference survey showed that patients preferred counseling or counseling plus medication over antidepressant medication alone and those they preferred treatment in primary care over specialty mental health care, but they showed no significant preference for individual versus group treatment. Patients also indicated that individual education sessions, telephone sessions, transportation assistance, and family involvement were barrier reduction strategies that would enhance their likelihood of accepting treatment. Compared with patients assigned to usual care, those in the intervention group were 21 times as likely to receive preferred treatment. Among all participants, women, unemployed persons, those who spoke English, and those referred by providers were more likely to receive preferred treatment. *Conclusions:* Collaborative care interventions that include psychotherapy can increase the likelihood that Latino patients receive preferred care; however, special efforts may be needed to address preferences of working persons, men, and Spanish speaking patients.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/11/1112>

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

POLICY

Medical Home 2.0: Present and Future. Issue Brief. By the Deloitte Center for Health Solutions. (The Center, Washington, D.C.) 2010. 16 p.

[“In the Patient Protection and Affordable Care Act of 2010, the expansion of patient-centered medical home pilot programs is among delivery system reforms intended to reduce costs and improve population-based health by leveraging clinical information technologies, care teams and evidence-based medical guidelines. Conceptually, a medical home model makes sense: Improved consumer access to primary care health services and increased accountability for healthy lifestyles are foundational to a reformed health system. For primary care clinicians, the current system of volume-based incentives limits their ability to appropriately diagnose and adequately manage patient care. For consumers, lack of access to effective and clinically accurate diagnostics and therapeutics via primary care is a formula for delayed treatment, overall poor health and higher costs. The medical home model is designed to address these issues.”]

Full text at:

http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_MedicalHome2_092210.pdf

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

Parity Toolkit for Addiction and Mental Health Consumers, Providers, and Advocates: Simplifying the Appeals Process: Strategies for winning disputes with your health plan. By Parity Implementation Coalition. (The Coalition, Arlington, Virginia) September 2010. 60 p.

[“The Parity Implementation Coalition provides this toolkit as an aid for individuals in and seeking recovery from addiction and mental illness and their families, providers and advocates to help them understand their new rights and benefits under the parity law. The toolkit is designed to be a resource in how to better communicate with plans, how to ably prepare and document information should disputes arise with a health plan over coverage or reimbursement and better understand your basic appeals rights and procedures.

Clearly, every plan has its own appeals policies and procedures and each plan participant must become informed about his or her own plan’s appeals process. As health care costs have increased, public and private health plans have imposed stricter cost containment techniques on health benefits. Many plans have subjected addiction and mental health benefits, often called “behavioral health” benefits, to an even stricter form of cost containment, often in the form of higher co-pays and deductibles, shorter day and visit limits, pre-approval or “prior-authorization” for these services and other forms of “medically managing” these benefits that are more stringent than how other medical benefits are managed.”]

Full text at:

http://www.mentalhealthamerica.net/files/Parity_Toolkit_Final.pdf

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

Services under Challenge: Critical success factors in meeting high and complex needs of people in mental health care. By Dr Jacquie Kidd and Debra Lampshire of the Mental Health Foundation. (Mental Health Commission, Wellington, New Zealand) November 2010. 33 p.

[“This report provides information about mental health services in New Zealand that have successfully adjusted service provision to meet „high and complex needs” of some service users. Some people with mental health and addiction problems appear unable to have their needs met through mental health and addiction services. They continue to cycle in and out of care, and for various reasons, they prove a challenge to services. Rather than exploring the perceived failings of services, the Mental Health Advocacy Coalition (MHAC) wanted to discover what happened in services that stepped up to the challenge and changed what they did for the benefit of this group of service users. This project aimed to identify and analyse examples of such services.”]

Full text at:

<http://www.mhc.govt.nz/sites/mhc.govt.nz/files/publications/2010/Services%20under%20Challenge-FINAL.pdf>

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

PUBLIC MENTAL HEALTH



(Click on cover to access journal contents)

“Mental Health Promotion as a New Goal in Public Mental Health Care: A Randomized Controlled Trial of an Intervention Enhancing Psychological Flexibility. By Martine Fledderus, University of Twente, Enschede, The Netherlands. and others. IN: American Journal of Public Health, vol. 100, no. 12. (December 2010) pp. 2372-2378.

[“We assessed whether an intervention based on acceptance and commitment therapy (ACT) and mindfulness was successful in promoting positive mental health by enhancing psychological flexibility. Methods. Participants were 93 adults with mild to moderate psychological distress. They were randomly assigned to the group intervention (n=49) or to a waiting-list control group (n=44). Participants completed measures before and after the intervention as well as 3 months later at follow-up to assess mental health in terms of emotional, psychological, and social well-being (Mental Health Continuum–Short Form) as well as psychological flexibility (i.e., acceptance of present experiences and value-based behavior, Acceptance and Action Questionnaire- II). Results. Regression analyses showed that compared with the participants on the waiting list, participants in the ACT and mindfulness intervention had greater emotional and psychological well-being after the intervention and also greater psychological flexibility at follow-up. Mediation analyses showed that the enhancement of psychological flexibility during the intervention mediated the effects of the intervention on positive mental health. Conclusions. The intervention is effective in improving positive mental health by stimulating skills of acceptance and value-based action.]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/100/12/2372>

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

RECOVERY

“Family Network Support and Mental Health Recovery.” By Francesca Pernice-Duca, Wayne State University. IN: Journal of Marital and Family Therapy, vol. 36, no. 1 (January 2010) pp. 13-27.

[“Family members often provide critical support to persons living with a serious *mental illness*. The focus of this study was to determine which dimensions of the family support network were most important to the *recovery* process from the perspective of the recovering person. Consumers of a community *mental* health program completed in-depth structured interviews that included separate measures of social network support and *recovery*. Consumers named an average of 2.6 family members on the social network, interacted with family on a weekly basis, and were quite satisfied with their contact. This study revealed that support and reciprocity with family members are important dimensions of a personal support network that relates to the *recovery* process.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-00687-002&site=ehost-live>

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

Recovering Mental Health in Scotland. ‘Recovery’ from Social Movement to Policy Goal. By Jennifer Smith-Merry, School of Social and Political Science, University of Edinburgh, Scotland, and others. (European Union, Luxembourg, Belgium) September 2010. 36 p.

[“This report results from a project examining the development of recovery as a policy goal for mental health in Scotland. The research is part of the European Commission funded Know and Pol project which investigates knowledge in relation to health and education policies within eight European countries. The work of the Scottish Health team throughout the project has focused on mental health policy in Scotland. Our work reported here represents the second of two case studies for ‘Orientation 2’ of the project which seeks to examine the way knowledge is used and produced within the processes of a particular policy or public action.

This report tells the story of the development of recovery in Scotland as understood by key informants involved in mental health and repeated within official documents. The story we are told leads us from the psychiatric rehabilitation movement in the 1950s, to service user organising in the 1970s and 1980s and on to the emergence of recovery into policy via the Mental Health Commission in New Zealand in the 1990s. From here the concept moved to Scotland through personal and organisational links where a group of key actors was instrumental in its move into Scottish Government policy. From within the Scottish Government the concept of recovery shifted as it was applied within key technologies such as the Scottish Recovery Indicator tool, Wellness Recovery Action Planning and Peer Support. Our story finishes with a challenge by service users who are pushing for the concept to be taken yet further still. Theoretically we position the story of recovery in Scotland as an example of a successful social movement and highlight key structural factors which facilitated its adoption within policy.”]

Full text at:

http://webcache.googleusercontent.com/search?q=cache:co6S_bndXIAJ:www.institute-of-

governance.ed.ac.uk/_data/assets/word_doc/0020/56018/Scottish_Health_O2phase2_report.doc+http://www.institute-of-governance.ed.ac.uk/_data/assets/word_doc/0020/56018/Scottish_Health_O2phase2_report.doc&cd=1&hl=en&ct=clnk

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

RURAL ISSUES

Factors Influencing Rural Residents' Utilization of Urban Hospitals. By Margaret Jean Hall and others, Division of Health Care Statistics. National Health Statistics Reports No. 31. (U.S. Department of Health & Human Services, Hyattsville, Maryland) November 18, 2010. 12 p.

[*Objective*—To examine, using nationally representative data, which patient, hospital, and county characteristics influence rural residents' urban hospitalization.

Methods—Rural residents hospitalized in urban hospitals (crossovers) are compared with those hospitalized in rural hospitals (noncrossovers). National Hospital Discharge Survey data were merged with Area Resource File and Centers for Medicare & Medicaid Services data to study rural inpatients' characteristics; hospital descriptors; and county or state socioeconomic and health service variables. Multivariate logistic regression analysis identified covariates of the likelihood of being a crossover.

Findings—About one-third of the rural resident hospitalizations in 2003 were in urban hospitals. Other factors constant, those requiring greater resources had higher odds of crossing over, as did younger inpatients, those transferred from other hospitals, receiving surgery, and with mental diagnoses or congenital anomalies. Males, emergency admissions, and intervertebral disk disorder inpatients had lower odds of crossing over compared with those who were not in these categories. Crossover patients' hospitals had higher Medicare case mix indices than hospitals used by noncrossovers. Rural inpatients in government hospitals, rather than proprietary or non-profit hospitals, had greater odds of crossing over, as did rural patients from counties with lower population density, fewer hospital beds, more hospitals, more commuters, and lower per capita income compared with those in other categories.

Conclusions—Rural hospitals continue to be an important source of inpatient care, but rural residents travel to urban hospitals in some specific instances.”]

Full text at:

<http://www.cdc.gov/nchs/data/nhsr/nhsr031.pdf>

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

SUBSTANCE USE

The Influence of Personal, Family, and School Factors on Early Adolescent Substance Use. By Regina Shih and others, RAND Corporation. (The Corporation, Santa Monica, California) September 2010. 3 p.

[“Teen substance use is a serious public health problem in the United States. Substance use during adolescence has been linked with violent behavior, early sexual activity, and greater odds of substance abuse in adulthood. Prior research has shown that some teens are more prone to substance use than others, especially in early adolescence. Yet we still have limited insight into the factors that may influence substance use during the middle school years, when risk of initiation is greatest, and how these factors may vary for young teens from different racial and ethnic backgrounds.

To shed more light on these issues, a team of RAND Health researchers examined alcohol, cigarette, and marijuana use among a racially and ethnically diverse group of 7th and 8th graders. The team surveyed approximately 5,500 students at 16 middle schools in Southern California in 2008.”]

Full text at:

http://www.rand.org/pubs/research_briefs/2010/RAND_RB9561.pdf

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

SUICIDE PREVENTION

“Loss, psychosis, and chronic suicidality in a Korean American immigrant man: Integration of cultural formulation model and multicultural case conceptualization.” By Munyi Shea, California State University, Los Angeles, and others. IN: *Asian American Journal of Psychology*, vol.1, no. 3 (September 2010) pp. 212-223.

[“Culture shapes the nature, experience, and expression of psychopathology and help-seeking behavior across ethnically diverse groups. Although the study of psychopathology among Asian Americans has advanced, clinicians remain in need of culturally appropriate tools for the assessment and diagnosis of severe *mental* disorders including psychotic symptoms among Asian Americans. In this article, we present a brief overview of two culturally relevant conceptual tools: a) the Cultural Formulation Model, and b) the Multicultural Case Conceptualization approach. We use a case scenario to illustrate the integration of these two approaches in providing culturally responsive clinical conceptualization, assessment and treatment of a Korean American immigrant suffering from prominent psychiatric symptoms. We intend this discussion to engender further empirical work to advance our knowledge of the manifestation and experience of severe *mental illness* including psychotic disorders among Asian Americans, and contribute to culturally competent prevention and intervention of chronic and persistent *mental illness* within this group.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=aap-1-3-212&site=ehost-live>

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

“Matrix Analysis and Risk Management to Avert Depression and Suicide among Workers.” By Takeaki Takeuchi, Teikyo University School of Medicine, Tokyo, Japan. IN: BioPsychoSocial Medicine, vol. 4, no. 15 (November 5, 2010) pp. 1-27.

[“Suicide is among the most tragic outcomes of all mental disorders, and the prevalence of suicide has risen dramatically during the last decade, particularly among workers. This paper reviews and proposes strategies to avert suicide and depression with regard to the mind body medicine equation hypothesis, metrics analysis of mental health problems from a public health and clinical medicine view. In occupational fields, the mind body medicine hypothesis has to deal with working environment, working condition, and workers’ health. These three factors chosen in this paper were based on the concept of risk control, called *San-kanri*, which has traditionally been used in Japanese companies, and the causation concepts of host, agent, and environment. Working environment and working condition were given special focus with regard to tackling suicide problems. Matrix analysis was conducted by dividing the problem of working conditions into nine cells: three prevention levels (primary, secondary, and tertiary) were proposed for each of the three factors of the mind body medicine hypothesis (working environment, working condition, and workers’ health). After using these main strategies (mind body medicine analysis and matrix analysis) to tackle suicide problems, the paper talks about the versatility of case-method teaching, “*Hiyari-Hat* activity,” routine inspections by professionals, risk assessment analysis, and mandatory health check-up focusing on sleep and depression. In the risk assessment analysis, an exact assessment model was suggested using a formula based on multiplication of the following three factors: (1) severity, (2) frequency, and (3) possibility. Mental health problems, including suicide, are rather tricky to deal with because they involve evaluation of individual cases. The mind body medicine hypothesis and matrix analysis would be appropriate tactics for suicide prevention because they would help the evaluation of this issue as a tangible problem.”]

Full text at:

<http://www.bpsmedicine.com/content/pdf/1751-0759-4-15.pdf>

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

“Mental Health Disorders, Psychological Distress, and Suicidality in a Diverse Sample of Lesbian, Gay, Bisexual, and Transgender Youths.” By Brian S. Mustanski, University of Illinois, Chicago, and others. IN: American Journal of Public Health, vol. 100, no. 12 (December 2010) pp. 2426-2432.

[“We examined associations of race/ethnicity, gender, and sexual orientation with mental disorders among lesbian, gay, bisexual, and transgender (LGBT) youths. Methods. We assessed mental disorders by administering a structured diagnostic interview to a community sample of 246 LGBT youths aged 16 to 20 years. Participants also completed the Brief Symptom Inventory 18 (BSI 18). Results. One third of participants met criteria for any mental disorder, 17% for conduct disorder, 15% for major depression, and 9% for

posttraumatic stress disorder. Anorexia and bulimia were rare. Lifetime suicide attempts were frequent (31%) but less so in the prior 12 months (7%). Few racial/ethnic and gender differences were statistically significant. Bisexually identified youths had lower prevalence of every diagnosis. The BSI 18 had high negative predictive power (90%) and low positive predictive power (25%) for major depression. Conclusions. LGBT youths had higher prevalence of mental disorder diagnoses than youths in national samples, but were similar to representative samples of urban, racial/ethnic minority youths. Suicide behaviors were similar to those among representative youth samples in the same geographic area. Questionnaires measuring psychological distress may overestimate depression prevalence among this population.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/100/12/2426>

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

VETERANS

“Transforming Mental Healthcare in the Veterans Health Administration: A Model for Measuring Performance to Improve Access, Quality, and Outcomes.” By Katherine E. Watkins, RAND Corporation, and others. IN: Journal for Healthcare Quality, vol.32, no. 6 (November, December 2010) pp. 33-43.

[“In this paper we present the conceptual framework and research design of a national evaluation of the quality of mental healthcare provided to veterans by the Veterans Health Administration, and present results on the reported availability of evidence-based practices. We used the Donabedian paradigm to design a longitudinal evaluation of the quality of mental healthcare. To evaluate the structure of care we used a combination of survey and administrative data and designed a web-based facility survey to examine the availability and characteristics of 12 evidence-based practices and other mental health services. We identified 138 unique facilities that provided mental healthcare to 783,280 veterans. With the exception of opiate substitution therapies, every evidence-based practice was reported in at least one location in each service network. We use maps to estimate the maximum number of veterans that might benefit from expanding the availability of an evidence-based practice. We demonstrate the feasibility of overcoming several major challenges typically associated with measuring the quality of healthcare systems. This framework for evaluation of mental healthcare delivery provides a model upon which other stakeholders can continue to build and expand.”]

Full text at:

<http://onlinelibrary.wiley.com/doi/10.1111/j.1945-1474.2010.00109.x/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

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>

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