

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



Studies in the News for



California Department of Mental Health

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ANTIPSYCHOTICS



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“Relationship of Pharmaceutical Promotion to Antidepressant Switching and Adherence: A Retrospective Cohort Study.” By Richard A. Hansen, University of North Carolina, Chapel Hill, and others. IN: Psychiatric Services, vol. 61, no. 12 (December 2010) pp. 1232-1238.

[“Patient nonadherence and early discontinuation of antidepressant treatment are common. Pharmaceutical promotion to consumers and physicians may influence this behavior. The objectives of this study were to explore whether promotional spending is related to early antidepressant switching, acute-phase adherence, and continuation phase adherence. *Methods:* A retrospective cohort study was conducted with national promotional expenditure data merged with medical and prescription claims data from a large national health plan affiliated with i3 Innovus. Included were records for continuously insured adults with major depression who received a new prescription for an antidepressant: 5,010 were in the cohort assessed for switching, 4,457 were in the cohort assessed for acute-phase adherence, and 1,772 were in the cohort assessed for continuation-phase adherence. National promotional efforts were estimated by examining inflation-adjusted spending on direct-to consumer advertising (DTCA) and physician detailing. Clinical guidelines were used to create proxies for aspects of treatment outcomes, including antidepressant switching and adherence in the acute phase and adherence in the continuation phase. Logistic regression models estimated the association between promotional variables and these outcomes. *Results:* Patients taking medications that were more highly promoted to physicians were less likely to switch medications (odds ratio [OR] =.61) and were more likely to be adherent during the acute phase of treatment (OR=1.13). DTCA had little effect on switching or antidepressant adherence. *Conclusions:* Detailing to physicians was associated with lower rates of medication switching and had a positive relationship with patient adherence during early antidepressant treatment. This finding indicates that certain aspects of promotion may have beneficial effects on antidepressant use.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/12/1232>

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CHILDREN AND ADOLESCENTS

Adverse Childhood Experiences Reported by Adults — Five States, 2009. By the Centers for Disease Control. *Morbidity and Mortality Weekly Report (MMRW)*. Vol. 59, No. 49. (U.S. Department of Health and Human Services, Washington, D.C.) December 17, 2010. 28 p.

[“Adverse childhood experiences (ACEs) include verbal, physical, or sexual abuse, as well as family dysfunction (e.g., an incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation). ACEs have been linked to a range of adverse health outcomes in adulthood, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality (1–3). Furthermore, data collected from a large sample of health maintenance organization members indicated that a history of ACEs is common among adults and ACEs are themselves interrelated (4). To examine whether a history of ACEs was common in a randomly selected population, CDC analyzed information from 26,229 adults in five states using the 2009 ACE module of the Behavioral Risk Factor Surveillance System (BRFSS). This report describes the results of that analysis, which indicated that, overall, 59.4% of respondents reported having at least one ACE, and 8.7% reported five or more ACEs. The high prevalence of ACEs underscores the need for 1) additional efforts at the state and local level to reduce and prevent child maltreatment and associated family dysfunction and 2) further development and dissemination of trauma-focused services to treat stress-related health outcomes associated with ACEs.”]

Full text at:

<http://www.cdc.gov/mmwr/pdf/wk/mm5949.pdf>

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Family Structure and Children’s Health in the United States: Findings from the National Interview Survey, 2001-2007. By D. L. Blackwell, National Center for Health Statistics. *Vital and Health Statistics, Series 10, no. 246*. (U.S. Department of Health and Human Services, Hyattsville, Maryland) December 2010. 176 p.

[“This report presents statistics from the 2001–2007 National Health Interview Survey (NHIS) on selected measures of physical health and limitations, access to or utilization of health care, and behavior or emotional well-being for children under age 18 by family structure, sex, age, race, Hispanic origin, parent’s education, family income, poverty status, home tenure status, health insurance coverage, place of residence, and region.”]

Full text at:

http://www.cdc.gov/nchs/data/series/sr_10/sr10_246.pdf

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“Use of Outcomes Information in Child Mental Health Treatment: Results From a Pilot Study.” By Bradley D. Stein, University of Pittsburg School of Medicine, and others. IN: Psychiatric Services, vol. 61, no. 12 (December 2010) pp. 1211-1216.

[“This study examined parents and clinicians’ use in treatment sessions of routinely collected information on child functioning for children receiving ambulatory mental health treatment. *Methods:* Information was obtained from 1,215 Child Outcomes Surveys completed at ten provider organizations. The Child Outcomes Survey is a collaboratively developed brief strength-based measure of child functioning and therapeutic relationship. This study examined parent-clinician discussion of information obtained in the survey from the previous session. Chi square tests were used to examine the association between sociodemographic and clinical covariates and parent-clinician discussion of information. *Results:* In the measure that assessed the extent to which parents discussed the information about their child’s functioning in the prior session with their clinician, 61% of parents reported high levels of discussion, 25% of parents reported moderate levels of discussion, and 14% reported low levels of discussion. Parents of boys, Latino children, and children of “other” races were significantly more likely to report high levels of discussion than other parents. Levels of discussion about the results of the previous Child Outcomes Survey were positively and significantly associated with successful child functioning and therapeutic relationship with clinicians. *Conclusions:* The findings of high rates of use of outcomes data routinely gathered with a very brief measure are encouraging given prior reports of challenges in using such information in treatment sessions. The successful treatment of children and families requires an ongoing and effective partnership between parents and clinicians, and the results suggest how important routine conversations about the progress of children in treatment can be. Further research is needed to understand the impact of gathering and using such data on the process and outcomes of mental health treatment for children and families.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/12/1211>

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CRIMINAL JUSTICE

“Analyzing Offense Patterns as a Function of Mental Illness to Test the Criminalization Hypothesis.” By Jillian Peterson, University of California, Irvine, and others. IN: Psychiatric Services, vol. 61, no. 12 (December 2010) pp. 1217-1222.

[“Programs for offenders with mental illness seem to be based on a hypothesis that untreated symptoms are the main source of criminal behavior and that linkage with psychiatric services is the solution. This study tested this criminalization hypothesis, which implies that these individuals have unique patterns of offending. *Methods:* Participants were 220 parolees; 111 had a serious mental illness, and 109 did not. Interview data and records were used to reliably classify offenders into one of five groups, based on their lifetime pattern of offending: psychotic, disadvantaged, reactive,

instrumental, or gang- or drug-related affiliation. The distributions of those with and without serious mental illness were compared. *Results:* A small but important minority of offenders with a mental illness (7%, N=8) fit the criminalization hypothesis, in that their criminal behavior was a direct result of psychosis (5%, N=6) or comprised minor “survival” crimes related to poverty (2%, N=2). However, the reactive group contained virtually all offenders with a mental illness (90%, N=100) and the vast majority of offenders without a mental illness (68%, N=74), suggesting that criminal behavior for both groups chiefly was driven by hostility, disinhibition, and emotional reactivity. For most offenders with a mental illness in the reactive group, crime was also driven by substance dependence. *Conclusions:* Offenders with serious mental illness manifested heterogeneous patterns of offending that may stem from a variety of sources. Although psychiatric service linkage may reduce recidivism for a visible minority, treatment that targets impulsivity and other common criminogenic needs may be needed to prevent recidivism for the larger group.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/12/1217>

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INTEGRATED HEALTH CARE

Health Care Delivery: Features of Integrated Systems Support Patient Care Strategies and Access to Care, but Systems Face Challenges. By the U.S. Government Accountability Office (GAO). GAO-11-49. (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>

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INTERVENTIONS

“Development of an intervention program to increase effective behaviors by patients and clinicians in psychiatric services: Intervention Mapping study.” By Bauke Koekkoek, Pro Persona Centre for Education and Science, Wolfheze, and others. IN: BMC Health Services Research, vol. 10, no. 293 (2010) pp. 1-11.

[“Health clinicians perceive certain patients as ‘difficult’ across all settings, including mental health care. In this area, patients with non-psychotic disorders that become long-term care users may be perceived as obstructing their own recovery or seeking secondary gain. This negative perception of patients results in ineffective responses and low-quality care by health clinicians. Using the concept of illness behavior, this paper describes the development, implementation, and planned evaluation of a structured intervention aimed at prevention and management of ineffective behaviors by long-term non-psychotic patients and their treating clinicians.

Methods: The principles of Intervention Mapping were applied to guide the development, implementation, and planned evaluation of the intervention. Qualitative (individual and group interviews), quantitative (survey), and mixed methods (Delphi-procedure) research was used to gain a broad perspective of the problem. Empirical findings, theoretical models, and existing evidence were combined to construct a program tailored to the needs of the target groups. Results: A structured program to increase effective illness behavior in long-term non-psychotic patients and effective professional behavior in their treating clinicians was developed, consisting of three subsequent stages and four substantial components, that is described in detail. Implementation took place and evaluation of the intervention is being carried out.

Conclusions: Intervention Mapping proved to be a suitable method to develop a structured intervention for a multi-faceted problem in mental health care.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-10-293.pdf>

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“Promoting a healthy diet and physical activity in adults with intellectual disabilities living in community residences: Design and evaluation of a cluster-randomized intervention.” By Liselotte Schafer Elinder and others, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden. IN: BMC Public Health, vol. 10, no. 761 (December 13, 2010) pp. 1-26.

[“Many adults with intellectual disabilities have poor dietary habits, low physical activity and weight disturbances. This study protocol describes the design and evaluation of a health intervention aiming to improve diet and physical activity in this target group. In

Sweden, adults with intellectual disabilities often live in community residences where the staff has insufficient education regarding the special health needs of residents. No published lifestyle interventions have simultaneously targeted both residents and staff.

Methods/Design

The intervention is designed to suit the ordinary work routines of community residences. It is based on social cognitive theory and takes 12-15 months to complete. The intervention includes three components: 1) Ten health education sessions for residents in their homes; 2) the appointment of a health ambassador among the staff in each residence and formation of a network; and 3) a study circle for staff in each residence. The intervention is implemented by consultation with managers, training of health educators, and coaching of health ambassadors. Fidelity is assessed based on the participation of residents and staff in the intervention activities. The study design is a cluster-randomised trial with physical activity as primary outcome objectively assessed by pedometry. Secondary outcomes are dietary quality assessed by digital photography, measured weight, height and waist circumference, and quality of life assessed by a quality of life scale. Intermediate outcomes are changes in work routines in the residences assessed by a questionnaire to managers. Adults with mild to moderate intellectual disabilities living in community residences in Stockholm County are eligible for inclusion. Multilevel analysis is used to evaluate effects on primary and secondary outcomes. The impact of the intervention on work routines in community residences is analysed by ordinal regression analysis. Barriers and facilitators of implementation are identified in an explorative qualitative study through observations and semi-structured interviews.

Discussion

Despite several challenges it is our hope that the results from this intervention will lead to new and improved health promotion programs to the benefit of the target group.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-10-761.pdf>

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MULTIPLE CHRONIC CONDITIONS

Multiple Chronic Conditions: A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. By the U.S. Department of Health and Human Services. (The Department, Washington, D.C.) December 2010. 18 p.

[“We are pleased to present a strategic framework for the U.S. Department of Health and Human Services (HHS) to improve the health status of individuals with multiple chronic conditions. This framework contains a vision statement, goals, objectives, and discrete strategies to guide the department in coordinating its efforts internally and collaborating with stakeholders externally. The framework is designed to address the spectrum of all population groups with multiple chronic conditions.

A cornerstone of our nation’s approach to chronic diseases must be to prevent their occurrence. An enhanced focus on prevention and public health is essential to ensuring

optimum health and quality of life for all people. In addition, however, prevention is an important consideration for persons who already have one or more chronic conditions. This framework's focus is on improving the health and function of people who currently have multiple chronic conditions.

The intention for this framework is to catalyze change within the context of how chronic illnesses are addressed in the United States—from an approach focused on individual chronic diseases to one that uses a multiple chronic conditions approach. It is this culture change, or paradigm shift, and the subsequent implementation of these strategies that will provide a foundation for realizing the vision of *optimum health and quality of life for individuals with multiple chronic conditions.*”]

Full text at:

http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

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RECOVERY

"Recovery From Mental Health Problems: Scratching The Surface Without Ethnography." By David Pilgrim, University of Central Lancashire. IN: **Journal of Social Work Practice**, vol. 23, no. 4 (December 2009) pp. 475-487.

["This article examines a central plank of **mental** health policy ('**recovery**') in societies which have attempted to reverse the long-term warehousing of those with a diagnosis of **mental** disorder (de-institutionalisation). The emergence of the concept is traced in relation to the shift from an institutional to a more dispersed and community-based form of service organisation. Different usages of the term '**recovery**', each with distinct implications for practice are considered on the part of three main interest groups (traditional bio-medical psychiatrists; social psychiatrists emphasising social skills training; and dissenting service users). These different usages suggest that '**recovery**' is a polyvalent concept that creates an uneasy consensus point to define the management philosophies of local services enacting **mental** health policy. Also **mental** health work is about more than the group of patients mainly considered in relation to **recovery** (those with 'severe and enduring **mental** health problems'). Practice-near research strategies are now required to investigate the varied practical scenarios these contradictions generate and ethnographic research is therefore indicated. Without multiple ethnographies, we will be left with competing rhetoric about **recovery** and its meaning or meanings may be rendered worthless."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45484061&site=ehost-live>

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“The Process of Recovery of People with Mental Illness: The Perspectives of Patients, Family Members and Care Providers: Part I. By Sylvie Nosiseux, University of Montreal Medical Center, and others. IN: BMC Health Services Research, vol. 10, no. 161 (2010) pp. 1-15

“It is a qualitative design study that examines points of divergence and convergence in the perspectives on recovery of 36 participants or 12 triads. Each triad comprising a patient, a family member/friend, a care provider and documents the procedural, analytic of triangulating perspectives as a means of understanding the recovery process which is illustrated by four case studies. Variations are considered as they relate to individual characteristics, type of participant (patient, family, member/friend and care provider), and mental illness. This paper which is part of a larger study and is based on a qualitative research design documents the process of recovery of people with mental illness: Developing a Model of Recovery in Mental Health: A middle range theory. Methods: Data were collected in field notes through semi-structured interviews based on three interview guides (one for patients, one for family members/friends, and one for caregivers). Cross analysis and triangulation methods were used to analyse the areas of convergence and divergence on the recovery process of all triads.

Results: In general, with the 36 participants united in 12 triads, two themes emerge from the cross-analysis process or triangulation of data sources (12 triads analysis in 12 cases studies). Two themes emerge from the analysis process of the content of 36 interviews with participants: (1) *Revealing dynamic context*, situating patients in their dynamic context; and (2) *Relationship issues in a recovery process*, furthering our understanding of such issues. We provide four case studies examples (among 12 cases studies) to illustrate the variations in the way recovery is perceived, interpreted and expressed in relation to the different contexts of interaction. Conclusion: The perspectives of the three participants (patients, family members/friends and care providers) suggest that recovery depends on constructing meaning around mental illness experiences and that the process is based on each person's dynamic context (e.g., social network, relationship), life experiences and other social determinants (e.g., symptoms, environment). The findings of this study add to existing knowledge about the determinants of the recovery of persons suffering with a mental illness and significant other utilizing public mental health services in Montreal, Canada.”]

Full text at:

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

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SUBSTANCE ABUSE

“How can we begin to measure recovery?” By Karen Dodge, University of Miami Miller School of Medicine, and others. IN: Substance Abuse Treatment, Prevention and Policy, vol. 5, no. 31 (December 7, 2010) pp. 1-23.

[“There is a lack of consensus in the addiction treatment literature regarding the definition of substance abuse “recovery”. *Methods*: This study utilized a review of the literature together with a participatory research design to construct a conceptual model of recovery from the perspectives of addiction treatment professionals, those recovering from addictions, and researchers. *Results*: A multidimensional, comprehensive hypothetical model consisting of seven conceptual domains (physical, biomarker, psychological, psychiatric, chemical dependency, family/social, and spiritual) is presented. Each domain is operationally defined by identifying reliable and valid instruments that may be used to measure the domain. It is proposed that the conceptual model be tested using confirmatory factor analysis. *Conclusions*: If empirically supported, this conceptual model would validate the hypothesized multidimensional nature of recovery and provide a potential means for assessing recovery in future treatment outcome studies.”]

Full text at:

<http://www.substanceabusepolicy.com/content/pdf/1747-597x-5-31.pdf>

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"Supporting good practice in the provision of services to people with comorbid mental health and alcohol and other drug problems in Australia: describing key elements of good service models. " by Monica Merkes and others, Australian Institute for Primary Care & Ageing, Faculty of Health Sciences, LaTrobe University, Melbourne, Australia. IN: BMC Health Services Research, vol.10, no. 325 (2010) pp. 1-10

[“The co-occurrence of mental illness and substance use problems (referred to as “comorbidity” in this paper) is common, and is often reported by service providers as the expectation rather than the exception. Despite this, many different treatment service models are being used in the alcohol and other drugs (AOD) and mental health (MH) sectors to treat this complex client group. While there is abundant literature in the area of comorbidity treatment, no agreed overarching framework to describe the range of service delivery models is apparent internationally or at the national level. The aims of the current research were to identify and describe elements of good practice in current service models of treatment of comorbidity in Australia. The focus of the research was on models of service delivery. The research did not aim to measure the client outcomes achieved by individual treatment services, but sought to identify elements of good practice in services. *Methods*: Australian treatment services were identified to take part in the study through a process of expert consultation. The intent was to look for similarities in the delivery models being implemented across a diverse set of services that were perceived to be providing good quality treatment for people with comorbidity problems. *Results*: A survey was designed based on a concept map of service delivery devised from a literature review. Seventeen Australian treatment services participated in the survey, which explored the context in which services operate, inputs such as organisational philosophy and service structure, policies and procedures that guide the way in which treatment is delivered by the service, practices that reflect the way treatment is provided

to clients, and client impacts. Conclusions: The treatment of people with comorbidity of mental health and substance use disorders presents complex problems that require strong but flexible service models. While the treatment services included in this study reflected the diversity of settings and approaches described in the literature, the research found that they shared a range of common characteristics. These referred to: service linkages; workforce; policies, procedures and practices; and treatment.

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-10-325.pdf>

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Talking Therapies for People with Problematic Substance Abuse: Best and promising Practice Guide for Mental Health and Addiction Services. By The National Centre of Mental Health Research, Information and Workforce Development. (The Centre, Auckland, New Zealand) November 2010. 84 p.

[“Talking therapies for people with problematic substance use is a resource developed to assist practitioners who work with people with addiction-related problems.

The treatment experience of people with addiction-related problems is influenced by a multitude of factors including their health, the quality of their relationships, the nature of their addiction, and the quality of the treatment interventions provided to them.

A common determinant of a positive treatment experience is the quality of the therapeutic relationship with the practitioners involved in the enhancement of the person’s well-being. The emphasis on engagement in Section 2 of this guide is a welcome reminder that effective engagement, including practitioner attitude and ability, is a crucial element in treatment retention.

Treatment retention is positively correlated with better treatment outcomes. Therefore, techniques that encourage people to stay engaged in the treatment process are likely to increase our effectiveness as a treatment workforce.

Treatment for addiction-related problems involves interventions that are provided in a range of settings and modalities, which may be applied differently across the various stages of the person’s treatment journey. It is essential, however, that people with addiction-related problems have access to high-quality, best practice or evidence-based treatment options, and to appropriately applied therapies.

The information provided in this guide is the latest in a series of excellent initiatives pursued and delivered by Te Pou. While it is not a definitive guide, it provides very useful background information on problematic substance use, suggestions for interventions during the various stages of treatment, and information on the range of talking therapies currently utilised by practitioners in New Zealand. It will be a useful resource for practitioners, from students through to the experienced, from both specialist and generalist fields, who encounter people with addiction-related problems.”]

Full text at:

<http://www.tepou.co.nz/file/Workforce-Projects/Talking-Therapies/1000822-tp-talking-therapies-for-people-with-problematic-substance-use-web.pdf>

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SUICIDE PREVENTION

“Mental disorders seek space at the global health table.” By Wayne Kondro, Canadian Medical Association. IN: CMJ: Canadian Medical Association Journal, vol.182, no. 17 (November 23, 2010) pp. E767-E768.

[“The article reports on issues concerning mental disorder which seeks for inclusion in the global health agenda. According to the World Health Organization (WHO), mental health disorders cause about one million suicides annually worldwide. It states the efforts taken by Dr. Thomas Insel, director of the U.S. National Institute of Mental Health, to advance the progress of modern interventions for mental illnesses. It adds the scarcity of comprehensive mental health or suicide prevention programs.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=55704701&site=ehost-live>

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VETERANS



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“Applying the Chronic Care Model to Homeless Veterans: Effect of a Population Approach to Primary Care on Utilization and Clinical Outcomes.” By Thomas P. O’Toole and others, Providence Veteran Affairs Medical Center. IN: American Journal of Public Health, vol. 100, no. 12 (December 2010) pp. 2493-2499

[“We compared a population-tailored approach to primary care for homeless veterans with a usual care approach. Methods. We conducted a retrospective prolective cohort study of homeless veterans enrolled in a population-tailored primary care clinic matched to a historical sample in general internal medicine clinics. Overall, 177 patients were

enrolled: 79 in the Homeless-Oriented Primary Care Clinic and 98 in general internal medicine primary care .Results. Homeless-oriented primary care–enrolled patients had greater improvements in hypertension, diabetes, and lipid control, and primary care use was higher during the first 6 months (5.96 visits per person vs. 1.63 for general internal medicine) but stabilized to comparable rates during the second 6 months (2.01 vs. 1.31, respectively). Emergency department (ED) use was also higher (2.59 vs. 1.89 visits), although with 40% lower odds for nonacute ED visits than for the general internal medicine group (95% confidence interval=0.2, 0.8). Excluding substance abuse and mental health admissions, hospitalizations were reduced among the homeless veterans between the 2 periods (28.6% vs 10.8%; P<.01) compared with the general internal medicine group (48.2% vs 44.4%; P=.6; difference of differences, P<.01). Conclusions. Tailoring primary care to homeless veterans can decrease unnecessary ED use and medical admissions and improve chronic disease management.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/100/12/2493>

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“Self-Inflicted Deaths among Women with U.S. Military Service: A Hidden Epidemic?” By Bentson H. McFarland, Oregon Health and Science University, and others. IN: *Psychiatric Services*, vol. 61, no. 12 (December 2010) pp. 1177-1177.

[“Prospective analyses of National Health Interview Survey and National Death Index data found an adjusted risk of suicide among male veterans twice that of nonveteran males (1). That study also examined data for 11 female veterans and 246 female nonveterans who completed suicide and found that women with past military service were more likely to complete suicide (adjusted hazard ratio= 3.62, 95% confidence interval [CI] = 1.95–6.73).”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/12/1177>

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NON PROFIT RESOURCE CENTER-GRANT WRITING

[“Our mission is to enhance the resources and improve the management of nonprofit organizations, primarily within California's northern Central Valley and Sierra Nevada regions.

We invite you to visit us often to find resources that will help your nonprofit grow stronger and be more successful -- from information on training opportunities, consultation and technical assistance, to building connections with your peers.

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

More information about grant-writing at:

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

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CONFERENCES, MEETINGS AND SEMINAR

**California Working Families Policy Summit 2011
Making the system work for working families**

**January 12, 2011
Sacramento Convention Center
Sacramento, California**

[“Timed to coincide with the launch of the legislative session, the California Working Families Policy Summit convenes leaders from the Legislature, state and local government, nonprofit and for-profit organizations, and local communities. In 2011, we will focus on the state budget, health care, welfare, school services, early learning, child care, asset building, housing, food stamps, nutrition programs, and paid leave.”]

For more information:

http://www.newamerica.net/events/2010/california_working_families_policy_summit

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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

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**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>

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