

**Subject:** Studies in the News: (February 28, 2011)

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## Studies in the News for



## California Department of Mental Health

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## AGING AND MENTAL HEALTH

**Grip on Challenging Behavior: A Multi-disciplinary Care Program for Managing Behavioral Problems in Nursing Home Residents with Dementia. Study Protocol. By Sandra A. Zwijsen, VU Medical Center, Amsterdam, the Netherlands, and others. IN: BMC Health Services Research, vol. 11, no. 41 (February 21, 2011) 18 p.**

[“Behavioral problems are common in nursing home residents with dementia and they often are burdensome for both residents and nursing staff. In this study, the effectiveness and cost-effectiveness of a new care programmed for managing behavioral problems will be evaluated.

*Methods/Design:* The care programmed is based on Dutch national guidelines. It will consist of four steps: detection, analysis, treatment and evaluation. A stepped wedge design will be used. A total of 14 dementia special care units will implement the care programmed. The primary outcome is behavioral problems. Secondary outcomes will include quality of life, prescription rate of antipsychotics, and use of physical restraints and workload and job satisfaction of nursing staff. The effect of the care programmed will be estimated using multilevel linear regression analysis. An economic evaluation from a societal perspective will also be carried out.

*Discussion:* The care programmed is expected to be cost-effective and effective in decreasing behavioral problems, workload of nursing staff and in increasing quality of life of residents. *Trial registration:* The Netherlands National Trial Register (NTR). Trial number: NTR 2141.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-11-41.pdf>

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## ANTIPSYCHOTICS

**“Relapse according to Antipsychotic Treatment in Schizophrenic Patients: A Propensity-Adjusted Analysis.” By Aurelie Miller, Creativ-Ceutical France, rue du Faubourg Saint-Honoré, 75008 Paris, and others. IN: BMC Psychiatry, vol.11, no. 24 (February 10, 2011) pp. 1-24.**

[“To compare the rate of relapse as a function of antipsychotic treatment (monotherapy vs. polypharmacy) in schizophrenic patients over a 2-year period.

**Methods:** Using data from a multicenter cohort study conducted in France, we performed a propensity-adjusted analysis to examine the association between the rate of relapse over a 2- year period and antipsychotic treatment (monotherapy vs. polypharmacy).

**Results:** Our sample consisted in 183 patients; 50 patients (27.3%) had at least one period of relapse and 133 had no relapse (72.7%). Thirty-eight (37.7) percent of the patients received polypharmacy. The most severely ill patients were given polypharmacy:

the age at onset of illness was lower in the polypharmacy group ( $p=0.03$ ). Patients that received polypharmacy also presented a higher general psychopathology PANSS subscore ( $p=0.04$ ) but no statistically significant difference was found in the PANSS total score or the PANSS positive

or negative subscales. These patients were more likely to be given prescriptions for sedative drugs ( $p<0.01$ ) and antidepressant medications ( $p=0.03$ ). Relapse was found in 23.7 % of patients given monotherapy and 33.3% given polypharmacy ( $p=0.16$ ). After stratification according to quintiles of the propensity score, which eliminated all significant differences for baseline characteristics, antipsychotic polypharmacy was not statistically associated with an increase of relapse: HR=1.686 (0.812 ; 2.505).

**Conclusion:** After propensity score adjustment, antipsychotic polypharmacy is not statistically associated to an increase of relapse. Future randomised studies are needed to assess the impact of antipsychotic polypharmacy in schizophrenia.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-11-24.pdf>

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## CHILDREN AND ADOLESCENTS

**“Severe Mood Dysregulation, Irritability, and the Diagnostic Boundaries of Bipolar Disorder in Youths.”** By Ellen Leibenluft, M.D., National Institute of Mental Health. IN: *American Journal of Psychiatry*, vol. 168, no. 2 (February 2011) pp. 129-142.

[“In recent years, increasing numbers of children have been diagnosed with bipolar disorder. In some cases, children with unstable mood clearly meet current diagnostic criteria for bipolar disorder, and in others, the diagnosis is unclear. Severe mood dysregulation is a syndrome defined to capture the symptomatology of children whose diagnostic status with respect to bipolar disorder is uncertain, that is, those who have severe, nonepisodic irritability and the hyperarousal symptoms characteristic of mania but who lack the well-demarcated periods of elevated or irritable mood characteristic of bipolar disorder. Levels of impairment are comparable between youths with bipolar disorder and those with severe mood dysregulation. An emerging literature compares children with severe mood dysregulation and those with bipolar disorder in longitudinal course, family history, and pathophysiology. Longitudinal data in both clinical and community samples indicate that nonepisodic irritability in youths is common and is associated with an elevated risk for anxiety and unipolar depressive disorders, but not bipolar disorder, in adulthood. Data also suggest that youths with severe mood dysregulation have lower familial rates of bipolar disorder than do those with bipolar disorder. While youths in both patient groups have deficits in face emotion labeling and experience more frustration than do normally developing children, the brain mechanisms mediating these pathophysiologic abnormalities appear to differ between the two patient groups. No specific treatment for severe mood dysregulation currently exists, but verification of its identity as a syndrome distinct from bipolar disorder by further research should include treatment trials.”]

Full text at:

<http://ajp.psychiatryonline.org/cgi/reprint/168/2/129>

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**“Youth Mental Health First Aid: A Description of the Program and an Initial Evaluation.”** By Claire M. Kelly, University of Melbourne, Australia, and others. IN: *International Journal of Mental Health Systems*, vol. 5, no. 4 (January 2011) pp. 1-9.

[“Adolescence is the peak age of onset for mental illness, with half of all people who will ever have a mental illness experiencing their first episode prior to 18 years of age. Early onset of mental illness is a significant predictor for future episodes. However, adolescents and young adults are less likely than the population as a whole to either seek or receive treatment for a mental illness. The knowledge and attitudes of the adults in an adolescent’s life may affect whether or not help is sought, and how quickly. In 2007, the Youth Mental Health First Aid Program was launched in Australia with the aim to teach adults, who work with or care for adolescents, the skills needed to recognise the early signs of mental illness, identify potential mental health-related crises, and assist adolescents to get the help they need as early as possible. This paper provides a description of the program, some initial evaluation and an outline of future directions. Methods: The program was evaluated in two ways. The first was an uncontrolled trial with 246 adult members of the Australian public, who completed questionnaires immediately before attending the 14 hour course, one month later and six months later. Outcome measures were: recognition of schizophrenia or depression; intention to offer and confidence in offering assistance; stigmatising attitudes; knowledge about adolescent mental health problems and also about the Mental Health First Aid action plan. The second method of evaluation was to track the uptake of the program, including the number of instructors trained across Australia to deliver the course, the number of courses they delivered, and the uptake of the YMHFA Program in other countries. Results: The uncontrolled trial found improvements in: recognition of schizophrenia; confidence in offering help; stigmatising attitudes; knowledge about adolescent mental health problems and application of the Mental Health First Aid action plan. Most results were maintained at follow-up. Over the first 3 years of this program, a total of 318 instructors were trained to deliver the course and these instructors have delivered courses to 10,686 people across all states and territories in Australia. The program has also spread to Canada, Singapore and England, and will spread to Hong Kong, Sweden and China in the near future. Conclusions: Initial evaluation suggests that the Youth Mental Health First Aid course improves participants’ knowledge, attitudes and helping behaviour. The program has spread successfully both nationally and internationally.”]

Full text at:

<http://www.ijmhs.com/content/pdf/1752-4458-5-4.pdf>

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**Understanding School Violence: Fact Sheet. By Centers for Disease Control and Prevention. (The Centers, Atlanta, Georgia) 2010. 8 p.**

[“In the United States (U.S.), an estimated 55.5 million students are enrolled in pre-kindergarten through 12th grade.<sup>1</sup> Another 15 million students attend colleges and universities across the country.<sup>2</sup> While U.S. schools remain relatively safe, any amount of violence is unacceptable. Parents, teachers, and administrators expect schools to be safe havens of learning. Acts of violence disrupt the learning process and have a negative effect on students, the school itself, and the broader community. School violence is a subset of youth violence, a broader public health problem. Youth violence refers to harmful behaviors that may start early and continue into young adulthood. It includes a variety of behaviors such as bullying, slapping, punching, and weapon use. Victims can suffer serious injury, significant social and emotional damage, or even death. The young person can be a victim, an offender, or a witness to the violence—or a combination of these. Detailed information about youth violence is available online at [www.cdc.gov/violenceprevention](http://www.cdc.gov/violenceprevention). “]

Full text at:

[http://www.cdc.gov/violenceprevention/pdf/SchoolViolence\\_FactSheet-a.pdf](http://www.cdc.gov/violenceprevention/pdf/SchoolViolence_FactSheet-a.pdf)

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## **COLLEGE STUDENTS AND MENTAL HEALTH**

**Incoming College Students Rate Emotional Health at Record Low, Annual Survey Finds. By Alana Klein, UCLA. IN: NEWSROOM, Office of Media Relations, Los Angeles, CA. (January 26, 2011) pp. 1-3**

[“First-year college students' self-ratings of their emotional health dropped to record low levels in 2010, according to the CIRP Freshman Survey, UCLA's annual survey of the nation's entering students at four-year colleges and universities. The survey, part of the Cooperative Institutional Research Program (CIRP), is administered nationally by the [Higher Education Research Institute \(HERI\)](#) at [UCLA's Graduate School of Education & Information Studies](#).

Only 51.9 percent of students reported that their emotional health was in the "highest 10 percent" or "above average," a drop of 3.4 percentage points from 2009 and a significant decline from the 63.6 percent who placed themselves in those categories when self-ratings of emotional health were first measured in 1985.

Female students were far less likely to report high.”]

Full text at:

<http://heri.ucla.edu/PDFs/press/2010CIRPpressrelease.pdf>

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## **COMMUNITY MENTAL HEALTH SERVICES**

**“Three Models of Community Mental Health Services in Low-Income Countries.”**  
**By Alex Cohen, London School of Hygiene and Tropical Medicine, London, and**  
**others. IN: International Journal of Mental Health Systems, vol. 5, no. 3 (January**  
**25, 2011) pp. 1-10.**

[“To compare and contrast three models of community mental health services in low-income settings. Data Sources/Study Setting: Primary and secondary data collected before, during, and after site visits to mental health programs in Nigeria, the Philippines, and India. Study Design: Qualitative case study methodology. Data Collection: Data were collected through interviews and observations during site visits to the programs, as well as from reviews of documentary evidence.

Principal Findings: A set of narrative topics and program indicators were used to compare and contrast three community mental health programs in low-income countries. This allowed us to identify a diversity of service delivery models, common challenges, and the strengths and weaknesses of each program. More definitive evaluations will require the establishment of data collection methods and information systems that provide data about the clinical and social outcomes of clients, as well as their use of services.

Conclusions: Community mental health programs in low-income countries face a number of challenges. Using a case study methodology developed for this purpose, it is possible to compare programs and begin to assess the effectiveness of diverse service delivery models.”]

Full text at:

<http://www.ijmhs.com/content/pdf/1752-4458-5-3.pdf>

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## **EARLY INTERVENTION**

**Children’s Mental Health Prevention and Early Intervention: Schools on the Front Lines Utilizing Positive Behavior Support. By National Council for Community Behavioral Healthcare. (The Council, Washington, D.C.) January 2011. 8 p.**

[“Classroom teachers are usually the first to notice when a child is exhibiting potentially serious behavioral health issues, and accordingly, schools have the potential to be on the front lines of identifying and treating children’s behavioral problems. However, only a few schools have established systematic approaches to take this knowledge and connect the child and family to resources which could alleviate the problems before they become severe and threaten the child’s success in school.

A successful program can be built around the well established concept of Positive Behavior Support (PBS) which is a framework for collaboration between schools and mental health agencies that addresses behavioral problems both from an educational and mental health perspective and leads to successful results in terms of increased school

success as measured by grade performance, graduation rates and attendance and reduced need for special education, child welfare, and juvenile justice interventions.  
PBS provides a comprehensive array of supports tailored to the needs of all students. }

Full text at:

<http://www.thenationalcouncil.org/galleries/policy-file/PBIS%20Issue%20Brief.pdf>

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**Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government. By Marshall Graham, Early Intervention Review Team. (Her Majesty's Government, London, England) January 2011. 179 p.**

[“In this first report I use the term Early Intervention to refer to the general approaches, and the specific policies and programmes, which help to give children aged 0–3 the social and emotional bedrock they need to reach their full potential; and to those which help older children become the good parents of tomorrow.

The rationale is simple: many of the costly and damaging social problems in society are created because we are not giving children the right type of support in their earliest years, when they should achieve their most rapid development. If we do not provide that help early enough, then it is often too late.”]

Full text at:

<http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf>

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**Early Years Interventions to Address Health Inequalities in London: The Economic Case. By GLA Economics. (Greater London Authority, City Hall, London, United Kingdom) January 2011. 121 p.**

[“This report provides evidence for and analysis of the case for investment in early years interventions to address health inequalities in London. The evidence clearly shows that well designed and implemented early years programmes can have significant benefits in terms of life-long health, educational attainment, social, emotional and economic wellbeing and reduced involvement in crime that far outweigh their costs.

This paper sets out the findings from a significant review of high quality evidence on early years interventions to identify 'what works' and 'what doesn't', provide international and national comparisons and translate data and potential savings into a UK and London context. It has been developed for, among others, service planners and commissioners in children's services, health, schools and other agencies....

Children raised in disadvantaged environments are, on average, less likely to succeed in school, in their future economic and social life and are much less likely to grow into healthy adults. The case for early years investment is even greater in London as the child

population (aged 0 to 4) is projected to increase by 11.6 per cent between 2008 and 2033, more than any other English region.”]

Full text at:

<http://www.london.gov.uk/sites/default/files/Early%20Years%20report%20OPT.pdf>

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## HEALTH INFORMATION

**Health Topics: 80% of Internet Users Look for Health Information Online. By Susannah Fox, Pew Research Center. (California Healthcare Foundation, Oakland, California) February 1, 2011. 33 p.**

[“Health information remains one of the most important subjects that internet users research online. The Pew Internet Project and California HealthCare Foundation have added eight new topics to our national survey measuring internet users’ interest in health information:

29% of internet users look online for information about food safety or recalls.

24% of internet users look online for information about drug safety or recalls.

19% of internet users look online for information about pregnancy and childbirth.

17% of internet users look online for information about memory loss, dementia, or Alzheimer’s.

16% of internet users look online for information about medical test results.

14% of internet users look online for information about how to manage chronic pain.

12% of internet users look online for information about long-term care for an elderly or disabled person.

7% of internet users look online for information about end-of-life decisions.”]

Full text at:

[http://www.pewinternet.org/~media/Files/Reports/2011/PIP\\_HealthTopics.pdf](http://www.pewinternet.org/~media/Files/Reports/2011/PIP_HealthTopics.pdf)

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## HEALTH SERVICES INTEGRATION

**Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform.** By James C. Robinson and Emma L. Dolan, University of California at Berkeley. (Integrated Healthcare Association, Oakland, California) 2010. 32 p.

[“Accountable Care Organizations (ACOs) that bring together providers and reward them for controlling costs and improving quality are a major platform for delivery system reform enshrined in the *Patient Protection and Affordable Care Act*. California has 285 physician organizations with many of the characteristics described in the national debate, and its experiences with these organizations over the past thirty years, both positive and negative, offer insight into the challenges that Federal policymakers will face with ACO implementation. This paper outlines five overarching aspects of California physician organizations—their organizational structures, payment methods, relationships with health plans, how they promote consumer choice, and the public policy and regulatory constraints they face—and offers ten key lessons for the national ACO debate.”]

Full text at:

[http://www.iha.org/pdfs\\_documents/home/ACO\\_whitepaper\\_final.pdf](http://www.iha.org/pdfs_documents/home/ACO_whitepaper_final.pdf)

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**"Using a Multi-Level Approach to Implement a Primary Care Mental Health (PCMH) Program."** By JoAnn Kirchner and others, South Central Mental Health Research, Education, and Clinical Center, North Little Rock, AK. IN: *Families, Systems and Health*, vol. 28, no. 2 (June 2010) pp. 161-174

["Successfully spreading **innovation** across large **health** care systems is a complex process requiring participation of stakeholders from a broad spectrum of professional backgrounds, skill sets, and organizational levels. We describe a process for engaging and activating stakeholders across individual, team, organization, and system levels to implement primary care-**mental health** integrated care programs in one regional Veterans Affairs **health** care network. Key stakeholders and researchers collaborated to propose and implement the program. Preliminary findings indicate that the program may reduce referrals to specialty **mental health**. Successfully spreading **innovation** across large **health** care systems is a complex process requiring participation of stakeholders from a broad spectrum of professional backgrounds, skill sets, and organizational levels. We describe a process for engaging and activating stakeholders across individual, team, organization, and system levels to implement primary care-**mental health** integrated care programs in one regional Veterans Affairs **health** care network. Key stakeholders and researchers collaborated to propose and implement the program. Preliminary findings indicate that the program may reduce referrals to specialty **mental health** care."]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2010-15711-008&site=ehost-live>

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## HOMELESSNESS

**“Does Active Substance Abuse at Housing Entry Impair Outcomes in Supported Housing for Chronically Homeless Persons?”** By Ellen Lockhard Edens, New England Mental Illness Research, Education and Clinical Center and the National Center for Homelessness among Veterans, and others. IN: *Psychiatric Services*, vol. 62, no. 2 (February 2011) pp. 171-178.

[“Recent clinical and policy trends have favored low-demand housing (provision of housing not contingent on alcohol and drug abstinence) in assisting chronically homeless people. This study compared housing, clinical, and service use outcomes of participants with high levels of substance use at time of housing entry and those who reported no substance use. *Methods:* Participants in the outcome evaluation of the 11-site Collaborative Initiative on Chronic Homelessness (N=756), who were housed within 12 months of program entry and received an assessment at time of housing and at least one follow-up (N=694, 92%), were classified as either high-frequency substance users (>15 days of using alcohol or >15 days of using marijuana or any other illicit drugs in the past 30 days; N=120, 16%) or abstainers (no days of use; N=290, 38%) on entry into supported community housing. An intermediate group reporting from one to 15 days of use (N=284, 38%) was excluded from the analysis. Mixed-model multivariate regression adjusted outcome findings for baseline group differences. *Results:* During a 24-month follow-up, the number of days housed increased dramatically for both groups, with no significant differences. High-frequency substance users maintained higher, though declining, rates of substance use throughout follow-up compared with abstainers. High-frequency users continued to have more frequent or more severe psychiatric symptoms than the abstainers. Total health costs declined for both groups over time. *Conclusions:* Active-use substance users were successfully housed on the basis of a low-demand model. Compared with abstainers, users maintained the higher rates of substance use and poorer mental health outcomes that were observed at housing entry but without relative worsening.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/2/171>

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## PREVENTIVE STRATEGIES

**“Lesson from Canada’s Universal Care: Socially Disadvantaged Patients Use More Health Services, Still Have Poorer Health.”** By David A. Alter and others, Toronto Rehabilitation Services. IN: *Health Affairs*, vol. 30, no. 2 (February 2011) pp. 274-283.

[“Lower socioeconomic status is commonly related to worse health. If poor access to health care were the only explanation, universal access to care should eliminate the

association. We studied 14,800 patients with access to Canada's universal health care system who were initially free of cardiac disease, tracking them for at least ten years and seven months. We found that socially disadvantaged patients used health care services more than did their counterparts with higher incomes and education. We also found that service use by people with lower incomes and less education had little impact on their poorer health outcomes, particularly mortality. Countries contemplating national health insurance cannot rely on universal health care to eliminate historical disparities in outcomes suffered by disadvantaged groups. Universal access can only reduce these disparities. Our findings suggest the need to introduce large scale preventive strategies early in patients' lives to help change unhealthy behavior." **NOTE: Please contact the State Library for a copy of this article, if you have difficulty accessing it through the attached link.]**

Full text at:

<http://content.healthaffairs.org/content/30/2/274.full.pdf+html>

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### **SUICIDE PREVENTION**

**Suicidal Thoughts and Behaviors among Adults: 2008 and 2009. By the Substance Abuse and Mental Health Services Administration. (Center for Behavioral Health Statistics, Rockville, Maryland) December 21, 2010. 5 p.**

[“Suicide continues to be a major public health problem in this country. In 2007, suicide was the 11th leading cause of death in the United States, with more than 34,000 Americans committing suicide. In addition to those Americans who commit suicide, thousands of others each year think seriously about committing suicide, make a suicide plan, or attempt to commit suicide.

The National Survey on Drug Use and Health (NSDUH) asks respondents aged 18 or older whether they had thought seriously about killing themselves in the past year. If respondents had thought seriously about killing themselves (i.e., committing suicide), they were asked whether they made plans to kill themselves (i.e., made suicide plans) and whether they had tried to kill themselves (i.e., had attempted suicide) in the past year. If respondents had reported having made a suicide attempt, they were asked whether they had received medical attention from a doctor or other health professional for their suicide attempt; if they had received medical attention, they were asked whether they had stayed in a hospital overnight or longer for their suicide attempt.”]

Full text at:

<http://www.oas.samhsa.gov/2k10/212/SuicidalThoughts.htm>

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**Towards Evidenced-based Suicide Prevention Programmes. By World Health Organization, Western Pacific Region. (The Organization, Geneva, Switzerland) 2010. 84 p.**

[“Suicide is a global challenge. It poses a serious public health problem worldwide. It has accounted for nearly 1 million deaths and an estimated 10 million attempted suicides each year. It is estimated that approximately 32% of all suicide deaths have occurred in the Western Pacific Region (Hendin *et al.* 2008, Yip 2008), which is disproportionately found in this area consisting of 37 countries and areas with a total of 1.78 billion people or about 29% of the world’s population. It is estimated that, in this Region, the suicide rate is calculated to be about 19.3 per 100,000 (De Leo, Milner and Wang 2009). Suicide rates in some countries/ areas like Japan, the Republic of Korea and Taiwan, China have had significant increases recently and remained at historically high levels. Suicide is the leading cause of death among young people in this Region and has caused significant economic losses to society. The full impact of the world’s current economic crisis has yet to be realized, but it’s certain to have an effect on mental health and suicide. It is unfortunate as well that suicide prevention resources are limited and underdeveloped, especially in developing countries, which have the largest need for resources and help.

This monograph attempts to set out the basic framework for suicide prevention strategies. It provides details in formulating and evaluating suicide prevention programmes. The public health approaches suggested offer a multilayer intervention model, which has been adopted by a number of developed countries for setting up national prevention strategies. Nevertheless, we want to stress that there is no single solution in dealing with suicide in a heterogeneous environment: one size simply doesn’t fit all. Also, all suicide prevention programmes need to be evaluated. And where we do not have the necessary evidence, we must simultaneously implement novel approaches and rigorously evaluate them. Anything less is undesirable. The importance of evaluation is even more critical in Asia, partly due to culture and limited resources.”]

Full text at:

<http://www.wpro.who.int/NR/rdonlyres/94606C00-2CAB-404D-A6CF-ECCA2CF26B63/0/TowardsEvidencebasedSPP.pdf>

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## VETERANS

**“The Stigma of Mental Health Problems and other Barriers to Care in the UK Armed Forces.” By Amy C. Iversen and others, Kings College London. IN: BMC Health Services Research, vol. 11, no. 31 (February 10, 2011) pp. 1-27.**

[“As with the general population, a proportion of military personnel with mental health problems do not seek help. As the military is a profession at high risk of occupational psychiatric injury, understanding barriers to help-seeking is a priority.

**Method:** Participants were drawn from a large UK military health study. Participants undertook a telephone interview including the Patient Health Questionnaire (PHQ); a

short measure of PTSD (Primary Care PTSD, PC-PTSD); a series of questions about service utilisation; and barriers to care. The response rate was 76% (821 participants). **Results:** The most common barriers to care reported are those relating to the anticipated public stigma associated with consulting for a mental health problem. In addition, participants reported barriers in the practicalities of consulting such as scheduling an appointment and having time off for treatment. Barriers to care did not appear to be diminished after people leave the Armed Forces. Veterans report additional barriers to care of not knowing where to find help and a concern that their employer would blame them for their problems. Those with mental health problems, such as PTSD, report significantly more barriers to care than those who do not have a diagnosis of a mental disorder.

**Conclusions:** Despite recent efforts to de-stigmatise mental disorders in the military, anticipated stigma and practical barriers to consulting stand in the way of access to care for some Service personnel. Further interventions to reduce stigma and ensuring that Service personnel have access to high quality confidential assessment and treatment remain priorities for the UK Armed Forces.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-11-31.pdf>

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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**

**4<sup>th</sup> Annual Conference: Trading Secrets-Working Together for Individuals with Dual Diagnosis Involved in the Criminal Justice System.**

**March 9<sup>th</sup>, 2011**

**8:00am-4:30pm**

**Hilton Mission Valley**

**San Diego, California**

In California, at least one in five persons with a developmental disability receiving Regional Center services also has a mental health diagnosis. Many individuals with a dual diagnosis (DD-MI) are dually or triply served by multiple service systems including the Criminal Justice System. Emerging Best Practice for persons with DD-MI indicates that cross systems collaboration is the key to providing effective services; Cross Systems collaboration reduces overlapping service costs for involved systems. Cross Systems collaboration increases a person's ability to live in their community and avoid a higher level of care. This statewide conference offers an opportunity to hear from all systems affected in providing care for this specialty population, discuss barriers and solutions, and identify key ways to improve cross system collaboration and identify resources for better services to the DD-MI criminally involved population.

For further information:

<http://www.mhsinc.org/classes/2011/03/09/4th-annual-conference-trading-secrets-working-together-individuals-dual-diagnosis>

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**Caring for Veterans with Post Deployment Health Concerns: Past, Present, and Future.**

**March 30 and 31<sup>st</sup>. 2011**

**West Coast Location-To be determined**

For further information and agenda:

<http://www.warrelatedillness.va.gov/WARRELATEDILLNESS/education/conferences/2011-mar/2011-03-30-31-conference-info.asp>

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**9<sup>th</sup> Annual UC Davis Clinical Pharmacotherapy: Practical Information for Physicians, Nurses, and Pharmacists.**

**April 8-10, 2011**

**Napa Valley Marriott**

**Napa, California**

**REGISTER EARLY AS THIS CONFERENCE WILL SELL OUT.**

For more information:

[http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/PHARM11\\_4-8-11w.pdf](http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/PHARM11_4-8-11w.pdf)

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**Aging in America: Annual Conference of the American Society on Aging.**

**April 26-30, 2011**

**San Francisco, California**

“With more than 600 workshops spanning over 50 content areas, Aging in America is the most comprehensive multidisciplinary conference on aging available anywhere. Our conference community of more than 3,000 participants includes leaders in aging services, business, government, policy, education and research, in addition to professionals representing more than 150 product and service exhibiting firms.”

For more information at:

[http://www.asaging.org/aia11/pdfs/AiA11\\_announce\\_FNL.pdf](http://www.asaging.org/aia11/pdfs/AiA11_announce_FNL.pdf)

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