

Subject: Studies in the News: (March 30, 2011)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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AGING AND MENTAL HEALTH

Enhancing Use of Clinical Preventive Services among Older Adults: Closing the Gap. By the Centers of Disease Control and Prevention. (The Centers, Atlanta, Georgia) 2011. 40 p.

[“This new report, *Enhancing Use of Clinical Preventive Services Among Older Adults – Closing the Gap*, calls attention to the use of potentially lifesaving preventive services by our nation’s growing population of adults aged 65 years and older. By presenting and interpreting available state and national self-reported survey data, the Report aims to raise awareness among public health and aging services professionals, policy makers, the media, and researchers of critical gaps and opportunities for increasing the use of clinical preventive services, particularly among those who are currently underserved.”]

Full text at:

http://www.cdc.gov/features/PreventiveServices/Clinical_Preventive_Services_Closing_the_Gap_Report.pdf

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Click on publication cover for current Table of Contents.

“Determining the Impact of Establishing a Psychogeriatric Outreach Team Network in Long-Term Care. By Corrine Eleanor Fischer, St. Michael’s Hospital, Toronto, Canada, and others. IN: Psychiatric Services, vol.62, no. 3 (March 2011) pp.299-302.

[“The primary objective of this study was to describe a model for specialized psychogeriatric consultation to long-term care homes in a large metropolitan Canadian city and to provide an overview of the diagnostic and demographic data of patients referred for assessment. *Methods:* Forty long-term care homes and 13 geriatric mental

health outreach teams were surveyed and provided feedback on the model. A retrospective chart review (N= 88) was also conducted to confirm the survey results and to provide an overview of the types of patients being seen. *Results:* Team data indicated that 96% of the homes they served (N=81) were using their services, that all referrals were appropriate, and that their recommendations were implemented in over 50% of cases. Referred patients tended to be older (41% age 85 or older); were referred mainly for agitation, aggression, or depressed mood (over 90%); and mainly had a mood or cognitive disorder (over 90%). *Conclusions:* These preliminary data suggest that the implementation of specialized psychogeriatric consultation to long term care may be beneficial, but future studies are required to clarify its usefulness.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/3/299>

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ANTIPSYCHOTICS

“Chemical Restraint in Routine Clinical Practice: A Report from a General Hospital Psychiatric Ward in Greece.” By Nikolaos Bilanakis, Department of Psychiatry, General Hospital of Arta, Arta, Greece, and others. IN: *Annals of General Psychiatry*, vol. 10, no. 4 (2011) pp. 1-3.

[“There is a dearth of studies regarding chemical restraint in routine clinical psychiatric practice. There may be wide variations between different settings and countries. *Methods:* A retrospective study on chemical restraint was performed in the 11-bed psychiatric ward of the General Hospital of Arta, in northwestern Greece. All admissions over a 2-year-period (from March 2008 to March 2010) were examined. *Results:* Chemical restraint was applied in 33 cases (10.5% of total admissions). From a total of 82 injections, 22 involved a benzodiazepine and/or levomepromazine, whereas 60 injections involved an antipsychotic agent, almost exclusively haloperidol (96.7% of cases), usually in combination with a benzodiazepine (61.7% of cases). In 36.4% of cases the patient was further subjected to restraint or seclusion. *Conclusions:* In our unit, clinicians prefer the combined antipsychotic/benzodiazepine regimen for the management of patients’ acute agitation and violent behaviour. Conventional antipsychotics are administered almost exclusively and in a significant proportion of cases further coercive measures are applied. Studies on the practice of chemical restraint should be regularly performed in clinical settings.”]

Full text at:

<http://www.annals-general-psychiatry.com/content/pdf/1744-859X-10-4.pdf>

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CHILDREN AND ADOLESCENTS

What Works for Acting-Out (Externalizing Behavior): Lessons from Experimental Evaluations and Social Interventions. By Mary Terzian and others, Child Trends. Child Trends Fact Sheet. Publication #2011-08. (The Trends, Washington, D.C.) March 2011. 10 p.

[“Preventing and reducing acting-out or externalizing behaviors is a goal often targeted by out-of-school time programs for children and youth. The term *externalizing* refers to disruptive, harmful, or problem behaviors that are directed to persons and/or things. Examples include aggressive behaviors such as getting into fights and bullying; hyperactive and impulsive behaviors; and delinquent behaviors such as physical assault, theft, and vandalism. Children who engage in these behaviors are more likely than their peers to be rejected and bullied by peers and experience academic difficulties, and, as adolescents, they are more likely than their peers to engage in sexual-risk taking and substance use. Children and youth with externalizing problems are also more likely to engage in criminal behavior and to abuse substances in adulthood. Thus, integrating effective practices for preventing and reducing externalizing behavior into existing programs and services holds the potential to prevent a host of social, academic, and behavioral problems.

Full text at:

http://www.childtrends.org/Files/Child_Trends-2011_03_03_RB_WWExternalizing.pdf

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What Works for Promoting and Enhancing Positive Social Skills: Lessons from Experimental Evaluations. By Tawana Bandy and Kristin A. Moore, Child Trends. Child Trends Fact Sheet. Publication #2011-07. (The Trends, Washington, D.C.) March 2011. 11 p.

[“Positive social skills are recognized as critical for healthy social development. Children with positive social skills are more likely to have high self-esteem, have positive relationships with peers,¹ and achieve in school.² Moreover, research finds that positive social skills are associated with positive later life outcomes, such as successful marriages and careers.³ On the other hand, deficits in social skills are related to aggressive behaviors, such as bullying, fighting and delinquency.⁴ Identification of intervention strategies and practices that promote social skills can help increase the likelihood of positive outcomes for children and adolescents, and reduce the occurrence of negative outcomes.

This *Fact Sheet* reviews 38 rigorously evaluated programs to identify what works to promote positive social skills among children and adolescents (such as getting along with others,

expressing empathy to others, trying to resolve conflicts, and regulating emotions and behaviors). This literature review identifies practices that work, or do not work, to promote positive social skills. Most of these interventions include multiple components (for example, parent training, workshops and classroom-based curricula). For these interventions, it is not possible to determine the *specific practices* that are responsible for producing the impacts.”]

Full text at:

http://www.childtrends.org/Files/Child_Trends_2011_03_02_RB_WWSocialSkills.pdf

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COMMUNITY BASED MENTAL HEALTH SERVICES

“Clothing the Emperor-What is now lacking in Mental Health Services?” By Rob Warriner, New Zealand Mental Health Commission. IN: International Journal of Leadership in Public Service, vol. 6, Supplement 1 (September 2010) pp. 73-83.

[“The shift of **mental health** service delivery from hospital to the **community** has proven to be, and continues to be, a complex matter. Huge gains have been achieved in a relatively short period of time. We now articulate the focus of **mental health services** as being to support people to live well in their **communities**; to promote relationships where people are active participants in their recovery, rather than passive recipients of treatment. Supporting people to overcome issues of disadvantage and social exclusion have become contemporary imperatives of **community-based mental health services**. Effective leadership is a key part of ensuring that this process continues. However, we need to consider such development and progress as 'a good start'. I get concerned when people speak of 'deinstitutionalisation' in the past tense - as if we've done that, so what next? The process of reform of **mental health services** is very much a work in progress.... What this paper will argue is that the evolution of post-institutional **mental health services** requires not just a change in policy or practice, but the development and propagation of a philosophy and range of values that will underpin such contemporary practices. This emerging framework raises an agenda that is potentially in conflict with biomedical psychiatry as the fundamental driver of **mental health** service provision and argues that leaders in the **mental health** sector are key to moving forward. A framework for putting such values in action is outlined.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=56527478&site=ehost-live>

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CRIMINAL JUSTICE

Monograph: 'Police Interventions with Persons Affected by Mental Illnesses'. By Jennifer Turner, Temple University, and others. (Rutgers University, New Brunswick, New Jersey) March 2011. 58 p.

[“Mental illnesses and substance abuse disorders constitute a global public health problem of enormous proportions. Developing and implementing cost-effective interventions to improve the lives of people with mental illnesses and comorbid substance abuse disorders remains a challenge for multiple, interfacing service systems, from public health to social welfare to law enforcement, the courts, and corrections.

This monograph illuminates one key component of these systems, policing, highlighting the role of police officers as front-line workers in the community. We examine trends in thinking and practice and common challenges surrounding policing and mental illnesses internationally. We suggest that police organizations (and their community and research partners) should not be uncritically accepting of existing intervention models without first engaging in a ‘Problem-Oriented Policing’ approach, designed so that available resources inter-lock to address the problems identified in particular geographical areas. We also examine challenges associated with implementing these steps, such as the need for police, health practitioners, and academic partners to collaborate in developing better and more integrated data collection systems to track health-related outcomes. Such extensive analysis, we argue, is fundamental to the development of tailored police interventions for persons affected by mental illnesses.”]

Full text download at:

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1781909

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HOMELESSNESS

“Predictors of Drop-in Center Attendance among Substance-Abusing Homeless Adolescents.” By Denitza Bantchevska and others, Ohio State University, Columbus. IN: *Social Work Research*, Vol. 35, no. 1 (March 2011) pp. 58-63.

[“Homeless youths comprise a vulnerable and disenfranchised group. They experience social exclusion and inadequate access to health and social services and are at risk of sexual assault and other trauma. Because of the vulnerability of homeless youths, engaging them into réintégration services is a priority. Although surveys have provided important information regarding demographic characteristics and problem behaviors among homeless youths, no study that we are aware of has delineated predictors of drop-in center use among these youths. Such information can inform service providers about what youths are likely to be receptive to drop-in center assistance and what youths might need modified services to increase service engagement. ‘]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=f5h&AN=59267621&site=ehost-live>

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“Rethinking Research on Forming Typologies of Homelessness.” By William McCallister, Columbia University, and others. IN: American Journal of Public Health, vol. 101, no. 4 (April 2011) pp.596-601.

[“In homelessness research and policymaking, it seems to be axiomatic that single adults experience 3 temporally based types of homelessness: chronic, episodic, and transitional. We discuss problems with the theorization of this typology and with the research design, data analysis, and time-aggregated conceptualization and measurement of temporality in the empirical work supporting the typology. To address the latter, we suggest a time-patterned approach to temporality and report a 10-group typology that differs significantly from the more familiar 3-group typology. We argue that which approach is used—and how typologies are developed more generally—should be based on theory and the uses to which typologies are put rather than on claims to being more true.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/101/4/596>

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MINORITIES AND HEALTH

Agency for Healthcare Research and Quality (AHRQ) Research and other Activities Relevant for American Indians and Alaskan Natives: Program Brief. By the Agency for Healthcare Research and Quality. (The Agency, Rockville, Maryland) 2011. 16 p.

[“American Indian and Alaska Native (AI/AN) people continue to have disproportionately higher rates of illness and higher mortality rates when compared with other Americans. AI/ANs die at higher rates than other Americans from tuberculosis (500 percent higher), alcoholism (550 percent higher), diabetes (200 percent higher), unintentional injuries (150 percent higher), homicide (100 percent higher), and suicide (70 percent higher). This group is also burdened with high infant mortality rates and high rates of obesity and diabetes among children.”]

Full text at:

<http://www.ahrq.gov/research/amindbrf.pdf>

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POLICY

“The development of the Quality Indicator for Rehabilitative Care (QuIRC): a measure of best practice for facilities for people with longer term mental health problems.” By Helen Killaspy, UCL Medical School, London, UK, and others. **IN: BMC Psychiatry, vol. 11, no. 35 (March 1, 2011) pp.**

[“Despite the progress over recent decades in developing community mental health services internationally, many people still receive treatment and care in institutional settings. Those most likely to reside longest in these facilities have the most complex mental health problems and are at most risk of potential abuses of care and exploitation. This study aimed to develop an international, standardised toolkit to assess the quality of care in longer term hospital and community based mental health units, including the degree to which human rights, social inclusion and autonomy are promoted.

Method

The domains of care included in the toolkit were identified from a systematic literature review, international expert Delphi exercise, and review of care standards in ten European countries. The draft toolkit comprised 154 questions for unit managers. Inter-rater reliability was tested in 202 units across ten countries at different stages of deinstitutionalisation and development of community mental health services. Exploratory factor analysis was used to corroborate the allocation of items to domains. Feedback from those using the toolkit was collected about its usefulness and ease of completion.

Results

The toolkit had excellent inter-rater reliability and few items with narrow spread of response. Unit managers found the content highly relevant and were able to complete it in around 90 minutes. Minimal refinement was required and the final version comprised 145 questions assessing seven domains of care.

Conclusions

Triangulation of qualitative and quantitative evidence directed the development of a robust and comprehensive international quality assessment toolkit for units in highly variable socioeconomic and political contexts.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-35.pdf>

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Experts Chart Direction of Health Care in California and Nation. By David Gorn, California Healthline Sacramento Bureau. IN: California Healthline (March 10, 2011) pp. 1-3

[“We are facing big changes in health care -- no matter what happens with efforts to repeal the national health care reform law.

That's the word from an impressive array of health care and economic experts who gathered at the end of February for the 20th Annual Health Care Forecast Conference at UC-Irvine.

The future, they said, is now. The health care system is changing dramatically because health care reform has built a momentum that likely will last for years, despite any legislative, economic and judicial developments aimed at stalling it.

"The Affordable Care Act will remain the law of the land until the Supreme Court rules one way or the other," according to Ted Shannon, health equity analyst for Arrowpoint Partners, an investment firm based in Denver.

"That Supreme Court ruling," Shannon said, "whatever it is isn't likely to happen until at least 2013.”]

Full text at:

<http://www.californiahealthline.org/features/2011/experts-chart-direction-of-health-care-in-california-and-nation.aspx>

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Report to Congress: National Strategy for Quality Improvement in Health Care. By the U.S. Department of Health and Human Services. (The Department, Washington, D.C.) March 2011. 25 p.

[“The Affordable Care Act seeks to increase access to high-quality, affordable health care for all Americans. To that end, the law requires the Secretary of the Department of Health and Human Services (HHS) to establish a National Strategy for Quality Improvement in Health Care (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it. This report describes the initial Strategy and plan for implementation.

The National Quality Strategy will promote quality health care in which the needs of patients, families, and communities guide the actions of all those who deliver and pay for care. It will incorporate the evidence-based results of the latest research and scientific advances in clinical medicine, public health, and health care delivery. It will foster a delivery system that works better for clinicians and provider organizations—reducing

their administrative burdens and helping them collaborate to improve care. It is guided by principles (available at www.ahrq.gov/workingforquality) that were developed with input by stakeholders across the health care system, including Federal and State agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers. Most importantly, the implementation of this Strategy will lead to a measurable improvement in outcomes of care, and in the overall health of the American people.”]

Full report at:

<http://www.healthcare.gov/center/reports/quality03212011a.html>

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POSTTRAUMATIC STRESS

“Evaluating Risk Factors and Possible Mediation Effects in Posttraumatic Depression and Posttraumatic Stress Disorder Comorbidity.” By Sidney Chiu, Fire Department of the City of New York, Bureau of Health Services, and others. IN: Public Health Reports, vol. 126 (March-April, 2011) pp. 201-209.

[“Objectives. On September 11, 2001 (9/11), attacks on the World Trade Center (WTC) killed 341 Fire Department of the City of New York (FDNY) firefighters and injured hundreds more. Previous WTC-related studies reported high rates of comorbid depression and posttraumatic stress disorder (PTSD), identifying disability retirement, alcohol use, and early arrival at the WTC site as correlates. However, those studies did not evaluate risk factors that could have mediated the observed comorbidity. We identified unique risk factors for each condition in an effort to better understand comorbidity. Methods. We screened retired WTC-exposed firefighters using self-administered questionnaires including the Center for Epidemiologic Studies Depression Scale, the Post Traumatic Stress Disorder Checklist, and the Alcohol Use Disorders Identification Test. We performed regression analyses to compare independent predictors of elevated depression and PTSD risk, and also tested a mediation hypothesis. Results. From December 2005 to July 2007, 23% and 22% of 1,915 retirees screened positive for elevated depression and PTSD risk, respectively, with comorbidity □70%. Controlling for comorbidity, we identified unique risk factors for (1) depression: problem alcohol use and (2) PTSD: early arrival at the WTC site. Conclusions. Our data support the premise that PTSD and depression are different responses to trauma with unique risk factors. The data also suggest a hypothesis that PTSD mediates the relationship between early WTC arrival and depression, while depression mediates the relationship between alcohol use and PTSD, a more complex relationship than shown in previous studies. Clinicians should consider these factors when evaluating patients for depression and PTSD.” **NOTE: If you would like a copy of this article, please request from the California State Library.**

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STIGMA

A Critical Exploration of Social Inequities in the Mental Health Recovery Literature. By Julia Weisser and others, Centre for the Study of Gender, Social Inequities and Mental Health. (The Centre, Vancouver, British Columbia) 2011. 67 p.

[“The (is) scoping review was conducted in order to assess the current state of mental health recovery literature in Canada, the US, the UK, and Australia and New Zealand. Although many definitions of ‘recovery’ exist in the literature, including those that attend to structural barriers such as racism, poverty, and homophobia, in addition to individualistic factors such as empowerment, hope, and autonomy, very few models of recovery explicitly address social and structural inequities.”]

Full text at:

http://www.socialinequities.ca/wordpress/wp-content/uploads/2011/02/Recovery-Scoping-Review.Final_STYLE.pdf

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SUICIDE PREVENTION

Preliminary Data for 2009: National Vital Statistics Reports. By K.D.Kochanek and others, National Center for Health Statistics. (The Center, Hyattsville, Maryland) March 16, 2011. 69 p.

[“Objectives—This report presents preliminary U.S. data on deaths, death rates, life expectancy, leading causes of death, and infant mortality for 2009 by selected characteristics such as age, sex, race, and Hispanic origin.

Methods—Data in this report are based on death records comprising more than 96 percent of the demographic and medical files for all deaths in the United States in 2009. The records are weighted to independent control counts for 2009. Comparisons are made with 2008 preliminary data.

Results—The age-adjusted death rate decreased from 758.7 deaths per 100,000 population in 2008 to 741.0 deaths per 100,000 population in 2009. From 2008 to 2009 age-adjusted death rates decreased significantly for 10 of the 15 leading causes of death: Diseases of heart, Malignant neoplasms, Chronic lower respiratory diseases, Cerebrovascular diseases, Accidents (unintentional injuries), Alzheimer’s disease, Diabetes mellitus, Influenza and pneumonia, Septicemia, and Assault (homicide). Life expectancy increased by 0.2 year from 78.0 years in 2008 to 78.2 in 2009.”]

Full text at:

http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf

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VETERANS

Mental Health Assessments for Members of the Armed Forces Deployed in Connection with a Contingency Operation. By the Office of the Assistant Secretary of Defense. (The Office, Washington, D.C.) July 2010. 11 p.

[“The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2010, Section 708, required the Department of Defense to institute a person-to-person mental health assessment for each member of the Armed Forces who is deployed in connection with a contingency operation. The definition of deployment, leadership responsibilities to ensure compliance, types of providers (other than licensed mental health professionals) who can conduct person-to-person assessments, and the instructions and exemptions for a comprehensive deployment health program, are delineated in Reference (b) and are applicable (except as superseded by Reference (a) and this guidance) to the mental health assessments outlined in this guidance.”]

Full text at:

http://www.health.mil/libraries/HA_Policies_and_Guidelines/10-005.pdf

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“Relationship Adjustment, PTSD Symptoms, and Treatment Utilization among Coupled National Guard Soldiers Deployed to Iraq.” By Laura A. Meis, Minneapolis VA Health Care system, and others. IN: Journal of Family Psychology, vol. 24, no. 5 (October 2010) pp. 560-567

[“Although combat-related posttraumatic stress disorder (PTSD) is associated with considerable impairment in relationship adjustment, research has yet to investigate how PTSD symptoms and relationship distress uniquely and jointly predict utilization of a range of **mental health services**. The present study sought to examine these issues utilizing a longitudinal sample of National Guard soldiers surveyed 2–3 months following return from deployment to Iraq and again 12 months later (N = 223). Results indicated that PTSD symptom severity, but not relationship adjustment, uniquely predicted greater odds of utilizing individual-oriented **mental health services**. A significant interaction was found indicating associations between PTSD symptoms and the odds of using services were increased when soldiers reported greater relationship adjustment. For utilization of family-oriented care, greater relationship distress was significantly correlated with greater odds of using **services**, but associations with PTSD symptoms were nonsignificant. The association between relationship distress and utilization of family-oriented **services** did not vary significantly with severity of PTSD symptoms. Results suggest supportive intimate relationships facilitate **mental health** treatment utilization for soldiers with PTSD symptoms.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=fam-24-5-560&site=ehost-live>

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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.

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CONFERENCES, MEETINGS AND SEMINAR

Flourishing: Positive Mental Health is Good Public Health

WEBINAR: Wednesday, April 13th

2:00-3:30 pm EST

****11:00am-12:30pm PST** NOTE**

“The absence of mental illness does not translate into the presence of mental health, and any condition less than being “flourishing” results in elevated ‘burden’ to self and society. The dual continua model suggests that the causes of positive mental health may be distinct processes from those now understood as causes of mental illness. Rather than intensifying the exclusive focus on mental illness, nations must adopt two complementary approaches to tackle the problem of mental illness: (1) Protection and promotion of flourishing mental health for the prevention of mental illness, while (2) improving the treatment of and recovery from mental illness.”

Registration at:

<https://www120.livemeeting.com/lrs/8002073444/Registration.aspx?PageName=g50xdf3msb8gwvtd>

9th 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

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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

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