

Subject: Studies in the News: (April 15, 2011)



Studies in the News for



California Department of Mental Health

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AGING AND MENTAL HEALTH

The Health of Aging Lesbian, Gay, and Bisexual Adults in California. By Steven P. Wallace, UCLA Center for Health Policy Research, and others. Health Policy Research Brief. (The Center, Los Angeles, California) March 2011. 8 p.

[“Research on the health of lesbian, gay and bisexual (LGB) adults generally overlooks the chronic conditions that are the most common health concerns of older adults. This brief presents unique population-level data on aging LGB adults (ages 50-70) documenting that they have higher rates of several serious chronic physical and mental health conditions compared to similar heterosexual adults. Although access to care appears similar for aging LGB and heterosexual adults, aging LGB adults generally have higher levels of mental health services use and lesbian/bisexual women report greater delays in getting needed care. These data indicate a need for general health care and aging services to develop programs targeted to the specific needs of aging LGB adults, and for LGB-specific programs to increase attention to the chronic conditions that are common among all older adults.”]

Full text at:

<http://www.healthpolicy.ucla.edu/pubs/files/aginglgbpb.pdf>

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A Perilous Arc of Supply and Demand: How can American Meet the Multiplying Mental Health Care Needs of an Aging Population? By Nancy Hooyman and JörgenUnötzer. IN: Generations, vol. 34, no. 4 (Winter 2010/2011) pp. 36-42.

[“The number of geriatric social workers and psychiatrists is inadequate to address the current and future psychosocial and **mental** health needs of the rapidly growing and increasingly diverse older population. This article documents this shortage and some structural reasons that underlie it; including negative stereotypes and lower salaries than other specialties and the gendered nature of social work. Some promising approaches to the recruitment, retention and preparation of both geriatric psychiatrists and social workers are identified, however. Innovative collaborative care models are suggested as cross disciplinary approaches to meeting older adults' psychosocial needs.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=f5h&AN=59162141&site=ehost-live>

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ANTIPSYCHOTICS

“Efficacy of Antidepressants and Benzodiazepines in Minor Depression: Systematic Review and Meta-analysis.” By Corrado Barbui, University of Verona, Italy, and others. IN: The British Journal of Psychiatry, vol. 198 (2011) pp. 11-16

[“Depression is a common condition that has been frequently treated with psychotropics.

Aims

To review systematically the evidence of efficacy and acceptability of antidepressant and benzodiazepine treatments for patients with minor depression.

Method

A systematic review and meta-analysis of double-blind randomised controlled trials comparing antidepressants or benzodiazepines v. placebo in adults with minor depression. Data were obtained from MEDLINE, CINAHL, EMBASE, PsycInfo, Cochrane Controlled Trials Register and pharmaceutical company websites. Risk of bias was assessed for the generation of the allocation sequence, allocation concealment, masking, incomplete outcome data, and sponsorship bias.

Results

Six studies met inclusion criteria. Three studies compared paroxetine with placebo; fluoxetine, amitriptyline and isocarboxazid were studied in one study each. No studies compared benzodiazepines with placebo. In terms of failures to respond to treatment (6 studies, 234 patients treated with antidepressants and 234 with placebo) no significant difference between antidepressants and placebo was found (relative risk (RR) 0.94, 95% CI 0.81–1.08). In terms of acceptability, data extracted from two studies (93 patients treated with antidepressants and 93 with placebo) showed no statistically significant difference between antidepressants and placebo (RR = 1.06, 95% CI 0.65–1.73). There was no statistically significant between-study heterogeneity for any of the reported analyses.

Conclusions

There is evidence showing there is unlikely to be a clinically important advantage for antidepressants over placebo in individuals with minor depression. For benzodiazepines, no evidence is available, and thus it is not possible to determine their potential therapeutic role in this condition.”]

Full text at:

<http://bjp.rcpsych.org/cgi/reprint/198/1/11>

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CHILDREN AND ADOLESCENTS

“Behavioral Symptoms of Attention/Deficit Hyperactivity Disorder in Preterm and Term Children Born Small and Appropriate for Gestational Age: A Longitudinal

Study.” By Kati Heinonen, University of Helsinki, Finland, and others. IN: BMC Pediatrics, vol. 10, no. 91 (2010) pp. 1-8.

[“It remains unclear whether it is more detrimental to be born too early or too small in relation to symptoms of attention deficit/hyperactivity disorder (ADHD). Thus, we tested whether preterm birth and small body size at birth adjusted for gestational age are independently associated with symptoms of ADHD in children.

Methods: A longitudinal regional birth cohort study comprising 1535 live-born infants between 03/15/1985 and 03/14/1986 admitted to the neonatal wards and 658 randomly recruited non-admitted infants, in Finland. The present study sample comprised 828 children followed up to 56 months. The association between birth status and parent-rated ADHD symptoms of the child was analysed with multiple linear and logistic regression analyses.

Results: Neither prematurity (birth < 37 weeks of gestation) nor lower gestational age was associated with ADHD symptoms. However, small for gestational age (SGA < -2 standard deviations [SD] below the mean for weight at birth) status and lower birth weight SD score were significantly, and independently of gestational age, associated with higher ADHD symptoms. Those born SGA, relative to those born AGA, were also 3.60-times more likely to have ADHD symptoms scores above the clinical cut-off. The associations were not confounded by factors implicated as risks for pregnancy and/or ADHD.

Conclusions: Intrauterine growth restriction, reflected in SGA status and lower birth weight, rather than prematurity or lower gestational age per se, may increase risk for symptoms of ADHD in young children.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2431-10-91.pdf>

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Improving the Lives of Young Children: Meeting Parents’ Health and Mental Health Needs through Medicaid and CHIP so Children can Thrive. By Olivia Golden and Karina Fortuny, the Urban Institute. Brief 4. (The Institute, Washington, D.C.) March 2011. 21 p.

[“Many young children have developmental or behavioral problems that could be addressed or even prevented with the right early response but that are not identified or treated before entering kindergarten, compromising children’s ability to perform up to their potential in school and leading to more costly health and special education interventions later. Because the quality of parenting is so critical to young children’s development, parental or family difficulties— including maternal depression and other parental mental health and medical problems—can endanger children’s development. In these situations, treating parents may be crucial to getting children’s development back on track. Yet, for many reasons, parents often do not receive needed medical or mental health care or other supportive services.

This brief discusses state Medicaid and CHIP choices that can enhance delivery to parents and families of the medical, mental health, and related services needed to support young children's development. A range of physical and mental health problems affects parenting (for example, parents' chronic pain and general health), but the evidence for the role of two-generational services is greatest for parental mental health problems. Among these problems, research attention has focused especially on maternal depression, which is widespread among low income mothers, particularly damaging to young children's development if left untreated, yet very treatable (NRC and IOM 2009). Therefore, after initially identifying possible two-generational issues a state could consider, we focus largely on barriers and solutions to helping parents receive treatment for depression.”]

Full text at:

<http://www.urban.org/uploadedpdf/412315-Meeting-Parents-Health.pdf>

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“Maximizing the Impact of State Early Childhood Home Visitation Programs.” Issue Brief. By Amanda Szekely, National Governors’ Association. (The Association, Washington, D.C.) March 8, 2011. 11 p.

[“Early childhood is a critical time for cognitive, social, and behavioral development. The experiences a child has prior to entering kindergarten affect how the brain develops and lay the foundation for success in school and life. Many states have invested in comprehensive early childhood care and education systems that offer a wide range of supports and services to families from the prenatal period through school entry. Home visiting programs are an important component of state early childhood systems. In a typical home visiting program, trained professionals provide regular, voluntary home visits to at-risk expectant and new parents and offer guidance, risk assessment, and referrals to other services offered in the community. Well-designed programs improve outcomes for children and families, ranging from decreases in child abuse and neglect, enhancements in prenatal and child health, and improvements in school readiness and school success. By reducing long-term costs in state systems, such as human services and special education, home visiting programs can yield more than \$5.00 in returns for every \$1.00 spent.”]

Full text at:

<http://www.nga.org/Files/pdf/1103HOMEVISIT.PDF>

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Securing a Health Future: The Commonwealth Fund State Score-card on Child Health system Performance 2011. By Sbrina K.H. Howe and others, The Commonwealth Fund. (The Fund, New York, New York) February 2011. 92 p.

[“The *State Scorecard on Child Health System Performance, 2011*, examines states’ performance on 20 key indicators of children’s health care access, affordability of care,

prevention and treatment, the potential to lead healthy lives, and health system equity. The analysis finds wide variation in performance across states. If all states achieved benchmark performance levels, 5 million more children would be insured, 10 million more would receive at least one medical and dental preventive care visit annually, and nearly 9 million more would have a medical home. The findings demonstrate that federal and state policy actions maintained and, in some cases, expanded children’s insurance coverage during the recent recession, even as many parents lost coverage. The report also highlights the need for initiatives specifically focused on improving health system performance for children. The report includes state-by-state insurance coverage projections for children once relevant provisions of the Affordable Health Act are implemented.”]

Full text at:

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Feb/Child%20Health%20Scorecard/1468_How_securing_a_healthy_future_state_scorecard_child_hlt_sys_performance_2011_web_final_v8.pdf

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Therapies for Children with Autism Spectrum Disorders. By the Agency for Healthcare Research and Quality. Comparative Effectiveness Review No. 26. (The Agency, Rockville, Maryland) April 2011. 20 p.

[“Autism spectrum disorders (ASDs) have an estimated prevalence of 1 in 110 children in the United States.¹ Disorders within the spectrum include Autistic Disorder, Asperger Syndrome, and Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS). Individuals with ASDs have impaired social interaction, behavior, and communication, including lack of reciprocal social interaction and joint attention (i.e., the ability to use nonverbal means such as pointing to direct others’ attention to something in which the child is interested); dysfunctional or absent communication and language skills; lack of spontaneous or pretend play; intense preoccupation with particular concepts or things; and repetitive behaviors or movements.³⁻⁵ Children with ASDs may also have impaired cognitive skills and sensory perception.

Treatment for ASDs focuses on improving core deficits in social communication, as well as addressing challenging behaviors to improve functional engagement in developmentally appropriate activities. In addition to addressing core deficits, treatments are provided for difficulties associated with the disorder (anxiety, attention difficulties, sensory difficulties, etc.). Individual goals for treatment vary for different children and may include combinations of therapies.”]

Full text at:

http://www.effectivehealthcare.ahrq.gov/ehc/products/106/651/Autism_Disorder_exec-summ.pdf

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CULTURAL COMPETENCY

“Good Practice in Health Care for Migrants: Views and Experiences of Care Professionals in 16 European Countries.” By Stefan Priebe, Newham Centre for Mental Health, London, and others. IN: BMC Public Health, vol. 11, no. 187 (March 25, 2011) pp. 1-41.

[“Health services across Europe provide health care for migrant patients every day. However, little systematic research has explored the views and experiences of health care professionals in different European countries. The aim of this study was to assess the difficulties professionals experience in their service when providing such care and what they consider constitutes good practice to overcome these problems or limit their negative impact on the quality of care.

Methods

Structured interviews with open questions and case vignettes were conducted with health care professionals working in areas with high proportion of migrant populations in 16 countries. In each country, professionals in nine primary care practices, three accident and emergency hospital departments, and three community mental health services (total sample = 240) were interviewed about their views and experiences in providing care for migrant patients, i.e. from first generation immigrant populations. Answers were analysed using thematic content analysis.

Results

Eight types of problems and seven components of good practice were identified representing all statements in the interviews. The eight problems were: language barriers, difficulties in arranging care for migrants without health care coverage, social deprivation and traumatic experiences, lack of familiarity with the health care system, cultural differences, different understandings of illness and treatment, negative attitudes among staff and patients, and lack of access to medical history. The components of good practice to overcome these problems or limit their impact were: organisational flexibility with sufficient time and resources, good interpreting services, working with families and social services, cultural awareness of staff, educational programmes and information material for migrants, positive and stable relationships with staff, and clear guidelines on the care entitlements of different migrant groups....

Conclusions

Health care professionals in different services experience similar difficulties when providing care to migrants. They also have relatively consistent views on what constitutes good practice. The degree to which these components already are part of routine practice varies. Implementing good practice requires sufficient resources and organisational flexibility, positive attitudes, training for staff and the provision of information.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-11-187.pdf>

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HOMELESSNESS

The Boston Health Care for Homeless Program: A Public Health Framework. By James J. O’Connell, Harvard University School of Public Health, and others. IN: American Journal of Public Health, vol. 100, no. 8 (August 2010) pp. 1400-1408.

[“During the past 25 years, the Boston Health Care for the Homeless Program has evolved into a service model embodying the core functions and essential services of public health. Each year the program provides integrated medical, behavioral, and oral health care, as well as preventive services, to more than 11000 homeless people. Services are delivered in clinics located in 2 teaching hospitals, 80 shelters and soup kitchens, and an innovative 104-bed medical respite unit. We explain the program's principles of care, describe the public health framework that undergirds the program, and offer lessons for the elimination of health disparities suffered by this vulnerable population.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=52335287&site=ehost-live>

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POLICY

Mental Health Community Wants in on Meaningful Use Program. By Kate Ackerman, iHealthBeat Senior Editor. IN: iHealthBeat, (March 24, 2011) pp. 1-2.

[“Last week, Sen. Sheldon Whitehouse (D-R.I.) introduced the Behavioral Health Information Technology Act of 2011 ([S 539](#)) to expand eligibility for meaningful use incentive payments to include behavioral health, mental health and substance misuse treatment professionals and facilities. <http://www.biomedcentral.com/content/pdf/1472-6963-11-66.pdf>

Under the 2009 federal economic stimulus package, hospitals and eligible professionals who demonstrate meaningful use of electronic health records can qualify for Medicare and Medicaid incentive payments. Under the current law, most mental health providers and facilities are excluded from the health IT incentive payments.”]

Full text at:

<http://www.ihealthbeat.org/features/2011/mental-health-community-wants-in-on-meaningful-use-program.aspx>

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PRIMARY CARE AND MENTAL HEALTH

“Building Effective Service Linkages in Primary Health Care: A Narrative Review Part 2.” By Jeffrey D. Fuller, Flinders University, Adelaide, Australia, and others. IN: *BMC Health Services Research*, vol. 11, no. 66 (March 25, 2011) pp. 1-28

[“Primary care services have not generally been effective in meeting mental health care needs. There is evidence that collaboration between primary care and specialist mental health services can improve clinical and organisational outcomes. It is not clear however what factors enable or hinder effective collaboration. The objective of this study was to examine the factors that enable effective collaboration between specialist mental health services and primary mental health care.

Methods

A narrative and thematic review of English language papers published between 1998 and 2009. An expert reference group helped formulate strategies for policy makers. Studies of descriptive and qualitative design from Australia, New Zealand, UK, Europe, USA and Canada were included. Data were extracted on factors reported as enablers or barriers to development of service linkages. These were tabulated by theme at clinical and organisational levels and the inter-relationship between themes was explored.

Results

A thematic analysis of 30 papers found the most frequently cited group of factors was “partnership formation”, specifically role clarity between health care workers. Other factor groups supporting clinical partnership formation were staff support, clinician attributes, clinic physical features and evaluation and feedback. At the organizational level a supportive institutional environment of leadership and change management was important. The expert reference group then proposed strategies for collaboration that would be seen as important, acceptable and feasible. Because of the variability of study types we did not exclude on quality and findings are weighted by the number of studies. Variability in local service contexts limits the generalisation of findings.

Conclusion

The findings provide a framework for health planners to develop effective service linkages in primary mental health care. Our expert reference group proposed five areas of strategy for policy makers that address organisational level support, joint clinical problem solving, local joint care guidelines, staff training and supervision and feedback.

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-11-66.pdf>

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SEVERE MENTAL ILLNESS

“Does Monitoring Need for Care in Patients Diagnosed with Severe Mental Illness Impact on Psychiatric Service use? Comparison of Monitored Patients with Matched Controls.” IN: *BMC Psychiatry*, vol. 11, no. 45 (March 21, 2011) pp. 1-23.

[“Effectiveness of services for patients diagnosed with severe mental illness (SMI) may improve when treatment plans are needs based. A regional Cumulative Needs for Care Monitor (CNCM) introduced diagnostic and evaluative tools, allowing clinicians to

explicitly assess patients' needs and negotiate treatment with the patient. We hypothesized that this would change care consumption patterns.

Methods. Psychiatric Case Registers (PCR) register all in-patient and out-patient care in the region. We matched patients in the South-Limburg PCR, where CNCM was in place, with patients from the PCR in the North of the Netherlands (NN), where no CNCM was available. Matching was accomplished using propensity scoring including, amongst others, total care consumption and out-patient care consumption. Date of the CNCM assessment was copied to the matched controls as a hypothetical index date had the CNCM been in place in NN. The difference in care consumption after and before this date (after minus before) was analysed.

Results. Compared with the control region, out-patient care consumption in the CNCM region was significantly higher after the CNCM index date regardless of treatment status at baseline (new, new episode, persistent), whereas a decrease in in-patient care consumption could not be shown.

Conclusions. Monitoring patients may result in different patterns of care by flexibly adjusting level of out-patient care in response to early signs of clinical deterioration.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-45.pdf>

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“A Well-being Support Program for Patients with Severe Mental Illness: A Service Evaluation.” By Donna Eldridge, Social Care Partnership Trust, UK, and others. IN: *BMC Psychiatry*, vol. 11, no. 46 (March 21, 2011) pp. 1-36.

[“The risk of cardiovascular disease is increased in patients with severe mental illness (SMI) dramatically reducing life expectancy. **Method:** A real world pragmatic service evaluation of a Well-Being Support Program (WSP) was conducted. This was a four-session package delivered over a one-year period by mental health practitioners that had received additional training in providing physical health assessment and intervention. Patients’ physical health was screened and appropriate one-to-one and group intervention was offered.

Results: 212 mental health practitioners were trained in the WSP and 782 patients were enrolled on the program. The majority of our sample was overweight or obese; 66% had a Body Mass Index (BMI) >25. Lifestyle risk factors for cardiovascular disease (CVD) were common and the patients had low self esteem. The average number of formally recorded well-being sessions attended was 2.10. Just under a quarter of those patients enrolled in the program completed. The only cardiovascular risk factor that significantly altered in patients that completed the program was BMI. The qualitative feedback about the program was largely positive.

Conclusions: The need to intervene to enhance the physical health of people with SMI is beyond doubt. Maintaining patient engagement in a physical health improvement program is challenging. Regular comprehensive physical health monitoring is necessary to establish the benefit of intervention and increase life expectancy and well-being in this population.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-46.pdf>

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STIGMA

“Personal Stigma and Use of Mental Health Services among People with Depression in a General Population in Finland.” By Esa Aromaa, Vaasa Central Hospital, Finland, and others. IN: BMC Psychiatry, vol. 11, no. 52 (March 31, 2011) pp. 1-15.

[“A minority of people suffering from depression seek professional help for themselves. Stigmatizing attitudes are assumed to be one of the major barriers to help seeking but there is only limited evidence of this in large general population data sets. The aim of this study was to analyze the associations between mental health attitude statements and depression and their links to actual use of mental health services among those with depression.

Methods

We used a large cross-sectional data set from a Finnish population survey (N=5160). Attitudes were measured by scales which measured the belief that people with depression are responsible for their illness and their recovery and attitudes towards antidepressants. Desire for social distance was measured by a scale and depression with the Composite International Diagnostic Interview Short Form (CIDI-SF) instrument. Use of mental health services was measured by self-report.

Results

On the social discrimination scale, people with depression showed more social tolerance towards people with mental problems. They also carried more positive views about antidepressants. Among those with depression, users of mental health services, as compared to non-users, carried less desire for social distance to people with mental health problems and more positive views about the effects of antidepressants. More severe depression predicted more active use of services.

Conclusions

Although stronger discriminative intentions can reduce the use of mental health services, this does not necessarily prevent professional service use if depression is serious and views about antidepressant medication are realistic.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-11-52.pdf>

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SUICIDE PREVENTION

“Changes in Mental Health Services and Suicide Mortality in Norway: An Ecological Study.” By Hakon A. Johannessen, Norwegian Institute of Public Health, and others. IN: BMC Health Services Research, vol. 11, no. 68 (March 28, 2011) pp. 1-27

[“Mental disorders are strongly associated with excess suicide risk, and successful treatment might prevent suicide. Since 1990, and particularly after 1998, there has been a substantial increase in mental health service resources in Norway. This study aimed to investigate whether these changes have had an impact on suicide mortality.

Methods

We used Poisson regression analyses to assess the effect of changes in five mental health services variables on suicide mortality in five Norwegian health regions during the period 1990-2006. These variables included: number of man-labour years by all personnel, number of discharges, number of outpatient consultations, number of inpatient days, and number of hospital beds. Adjustments were made for sales of alcohol, sales of antidepressants, education, and unemployment.

Results

In the period 1990-2006, we observed a total of 9480 suicides and the total suicide rate declined by 26%. None of the mental health services variables were significantly associated with female or male suicide mortality in the adjusted analyses ($p > 0.05$). Sales of antidepressants (adjusted Incidence Rate Ratio = 0.98; 95% CI = 0.97-1.00) and sales of alcohol (adjusted IRR = 1.41; 95% CI = 1.18-1.72) were significantly associated with female suicide mortality; education (adjusted IRR = 0.86; 95% CI = 0.79-0.94) and unemployment (adjusted IRR = 0.91; 95% CI = 0.85-0.97) were significantly associated with male suicide mortality.

Conclusions

The adjusted analyses in the present study indicate that increased resources in Norwegian mental health services in the period 1990-2006 were statistically unrelated to suicide mortality.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-11-68.pdf>

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Suicide Attempts and Related Factors in Patients Admitted to a General Hospital: A Ten-year Cross-sectional Study (1997-2007). By Jesus Alberdi-Sudupe, Hospital de Oza, Coruna, Spain, and others. IN: BMC Psychiatry, vol. 11, no. 51 (March 31, 2011) pp. 1-30.

[“Suicide and suicide attempts represent a severe problem for public health services. The aim of this study is to determine the socio-demographic and psychopathological variables associated with suicide attempts in the population admitted to a General Hospital.

Methods

An observational-descriptive study of patients admitted to the A Coruña University Hospital (Spain) during the period 1997-2007, assessed by the Consultation and Liaison Psychiatric Unit. We include $n=5,234$ admissions from 4,509 patients. Among these admissions, $n=361$ (6.9%) were subsequent to a suicide attempt. Admissions arising from a suicide attempt were compared with admissions occurring due to other reasons. Multivariate generalised estimating equation logistic regression models were used to examine factors associated with suicide attempts.

Results

Adjusting by age, gender, educational level, cohabitation status, being employed or unemployed, the psychiatric diagnosis at the time of the interview and the information on previous suicide attempts, we found that the variables associated with the risk of a suicide attempt were: age, psychiatric diagnosis and previous suicide attempts.

The risk of suicide attempts decreases with age (OR= 0.969). Psychiatric diagnosis was associated with a higher risk of suicide attempts, with the highest risk being found for Mood or Affective Disorders (OR=7.49), followed by Personality Disorders (OR=7.31), and Schizophrenia and Other Psychotic Disorders (OR=5.03). The strongest single predictive factor for suicide attempts was a prior history of attempts (OR=23.63).

Conclusions

Age, psychopathological diagnosis and previous suicide attempts are determinants of suicide attempts.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-11-51.pdf>

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Suicides --- United States, 1999—2007. By Alex E. Crosby and others, National Center for Injury Prevention and Control. (Centers for Disease Control and Prevention, Atlanta, Georgia). January 14, 2011. 3 p.

[“Injury from self-directed violence, which includes suicidal behavior and its consequences, is a leading cause of death and disability. In 2007, suicide was the 11th leading cause of death in the United States and the cause of 34,598 deaths. In 2000, the estimated cost of self-directed violence (fatal and nonfatal) was \$33 billion (\$32 billion in productivity losses and \$1 billion in medical costs). Suicide rates are influenced by biological, psychological, social, moral, political, and economic factors. Self-directed violence in the United States affects all racial/ethnic groups but often is misperceived to be a problem solely affecting non-Hispanic white males.

To determine differences in the prevalence of suicide by sex, race/ethnicity, age, and geographic region in the United States, CDC analyzed 1999--2007 data from the Web-based Injury Statistics Query and Reporting System --- Fatal (WISQARS Fatal) and the National Vital Statistics System (NVSS). Mortality data originate from NVSS, which collects death certificate data filed in the 50 states and the District of Columbia. Data in this report were based on suicides from any cause and include the 1999--2007 data years. The WISQARS database contains mortality data based on NVSS and population counts for all U.S. counties based on U.S. Census data. Counts and rates of death can be obtained by underlying cause of death, mechanism of injury, state, county, age, race, sex, year, injury cause of death (e.g., firearm, poisoning, or suffocation) and by manner of death (e.g., suicide, homicide, or unintentional injury)”].

Full text at:

http://www.cdc.gov/mmwr/preview/mmwrhtml/su6001a11.htm?s_cid=su6001a11_w

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VETERANS

“A Clinician’s Guide for PTSD Treatments for Returning Veterans.” By Brian Sharpless, Pennsylvania State University and Jacques P. Barber, University of Pennsylvania. IN: Professional Psychology: Research and Practice, vol. 42, no. 1 (February 2011) pp. 8-15.

[“What options are available to mental health providers helping clients with posttraumatic stress disorder (PTSD)? In this paper we review many of the current pharmacological and psychological interventions available to help prevent and treat PTSD with an emphasis on combat-related traumas and veteran populations. There is strong evidence supporting the use of several therapies including prolonged exposure (PE), eye movement desensitization and reprocessing (EMDR), and cognitive processing therapies (CPT), with PE possessing the most empirical evidence in favor of its efficacy. There have been relatively fewer studies of nonexposure based modalities (e.g., psychodynamic, interpersonal, and dialectical behavior therapy perspectives), but there is no evidence that these treatments are less effective. Pharmacotherapy is promising (especially paroxetine, sertraline, and venlafaxine), but more research comparing the relative merits of medication vs. psychotherapy and the efficacy of combined treatments is needed. Given the recent influx of combat-related traumas due to ongoing conflicts in Iraq and Afghanistan, there is clearly an urgent need to conduct more randomized clinical trials research and effectiveness studies in military and Department of Veterans Affairs PTSD samples. Finally, we provide references to a number of PTSD treatment manuals and propose several recommendations to help guide clinicians' treatment selections.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=pro-42-1-8&site=ehost-live>

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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 O’Toole and others, Providence Veterans Affairs Medical Center for Systems, Outcomes, and Quality in Chronic Disease and Rehabilitation, Providence, RI. 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 prospective 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://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=56458090&site=ehost-live>

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Engaging Veterans and Families to Enhance Service Delivery: A Tool-kit for Community-Based Organizations. By the National Center for Family on Homelessness. (The Center, Needham, Massachusetts) 2010. 52 p.

[“The return of our men and women in uniform serving in Iraq and Afghanistan will rival the scale of World War II demobilizations in some communities. Our federal government agencies and their community-based organization grantees are engaged in a commitment to end veteran homelessness within five years led by President Barack Obama and Secretary of Veterans Affairs General Eric Shinseki. These events underscore the urgent need to expand veteran services and improve their effectiveness for returning troops, many of whom have sustained physical and psychological injuries.

We can and must improve the effectiveness of informing veterans and their family members about the full range of available government and community based resources. We must also address the very real barriers that limit access and use of these vital programs and services.

To enhance support for veterans and their families, and increase the use of government and community based services, The National Center on Family Homelessness (The National Center) with funding from the Wal-Mart Foundation, created *Engaging Veterans and Families To Enhance Service Delivery: A Tool Kit for Community-Based Organizations*. This publication offers tools, resources, best practices, lessons learned, and cutting-edge research to improve the effectiveness of community based organizations’ staffing, program design, delivery, and outreach and engagement of veterans and their families and friends.”]

Full text at:

<http://www.familyhomelessness.org/media/174.pdf>

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Management Weaknesses at Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Require Attention. By the United States Accountability Office (GAO). GAO-11-219. (The Office, Washington, D.C.) February 2011. 48 p.

[“The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) was established to lead DOD’s effort to develop excellence in DOD prevention, outreach, and care for those with psychological health and traumatic brain injury conditions. GAO was asked to report on (1) challenges DCOE has faced in its development; (2) the extent to which DCOE’s strategic plan aligns with key practices used by leading public-sector organizations; and (3) the extent to which internal controls provide reasonable assurance that DCOE information on financial obligations is reliable for management decision making. GAO reviewed documentation and interviewed DCOE officials about DCOE development challenges, evaluated DCOE’s strategic plan against practices used by leading public-sector organizations, assessed the design of internal controls for recording obligations, and tested fiscal year 2009 DCOE obligations to supporting documentation to determine if the obligations were properly classified.”]

Full text at:

<http://www.gao.gov/new.items/d11219.pdf>

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VA Spends Millions Post-Traumatic Stress Disorder Research and Incorporates Research Outcomes into Guidelines and Policy for Post-Traumatic Stress Disorder Services. By the United States Government Accountability Office (GAO). GAO-11-32 (The Office, Washington, D.C.) January 2011. 47 p.

[“In addition to providing health care to veterans, the Department of Veterans Affairs (VA) funds research that focuses on health conditions veterans may experience. According to VA, experts estimate that up to 20 percent of Operation Enduring Freedom and Operation Iraqi Freedom veterans have experienced post-traumatic stress disorder (PTSD) and demand for PTSD treatment is increasing. Because of the importance of research in improving the services that veterans receive, GAO was asked to report on VA’s funding of PTSD research, and its processes for funding PTSD research proposals, reviewing and incorporating research outcomes into clinical practice guidelines (CPG)—tools that offer clinicians recommendations for clinical services but do not require clinicians to provide one service over another—and determining which PTSD services are required to be made available at VA facilities. To do this work, GAO obtained and summarized VA data on the funding of PTSD research from its medical and prosthetic research appropriation through its intramural research program. GAO also reviewed relevant VA documents, such as those for developing CPGs and those related to VA’s 2008 *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook

(Handbook), which defines certain mental health services that must be made available at VA facilities. GAO also interviewed VA officials.”]

Full text at:

<http://www.gao.gov/new.items/d1132.pdf>

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Wounded Warriors: Caregivers for Wounded Vets Wait to get Funds from VA. By Michael A. Fuoco, Pittsburg Post Gazette. (The Gazette, Pittsburg, Pennsylvania) February 20, 2011. 2 p.

[“Leslie Kammerdiener is sick. And tired. And broke. And nearly broken. The Clarion County native is suffering from the cumulative physical, emotional and financial toll of providing daily 24-hour care for her son, Army veteran Kevin Kammerdiener, since a suicide bomber nearly killed him in Afghanistan in 2008.

The divorced mother of two quit her job and moved from her native East Brady to be by his hospital bed and, upon his release, to be his primary caregiver during every step of his continuing treatment for a traumatic brain injury and burns.

Ms. Kammerdiener isn't complaining about her choice to care for her 22-year-old son herself instead of institutionalizing him in a Veterans Affairs Department facility. But like thousands of family members caring for troops wounded in Iraq and Afghanistan, she's been waiting for the VA to put in place measures mandated in a law to support caregivers that President Barack Obama signed in May.”]

Full text at:

<http://www.post-gazette.com/pg/11051/1126729-455.stm#ixzz1HX0IHVnj>

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