

Subject: Studies in the News: (April 27, 2011)



Studies in the News for



California Department of Mental Health

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ACCOUNTABLE CARE

High Performance Accountable Care: Building on Success and Learning from Experience. By Stuart Guterman and others, The Commonwealth Fund. (The Fund, New York, New York) April 2011. 58 p.

[“A key provision of the Affordable Care Act is the establishment of the Medicare Shared Savings Program, which provides incentives for improved quality and efficiency to a new category of provider—the accountable care organization (ACO). The program, slated to begin in January 2012, rewards groups of providers who agree to collaborate to offer more accountable, effective, and efficient care with a share of the savings they achieve. While the prospect of participating in this initiative has generated a groundswell of interest and activity among providers, many issues need to be addressed about the methods that will be used to determine how that accountability is to be achieved, assessed, and rewarded. This report provides recommendations for ensuring the successful implementation and spread of ACOs to achieve the goals of a high performance health system.”]

Full text at:

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Apr/1494_Guterman_high_performance_accountable_care_v3.pdf

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BULLYING

Embedding Bullying Interventions into a Comprehensive System of Student and Learning Supports. Addressing Barriers to Learning. By the UCLA Center for Mental Health in Schools, Program and Policy Analysis. (The Center, Los Angeles, California) Spring 2011. 19 p.

[“Nobody denies school bullying is a major problem, but considerable controversy exists over the best way to address the problem. The following discussion presents (a) a brief analysis and synthesis of the current state of the art, (b) underscores the need to avoid another piecemeal set of policy and practice initiatives, and (c) stresses that the growing emphasis on school bullying provides an opportunity to accelerate development of a comprehensive, multifaceted, and cohesive system of student and learning supports.”]

Full text at:

<http://smhp.psych.ucla.edu/pdfdocs/Newsletter/spring11.pdf>

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CHILDREN AND ADOLESCENTS

Clinical Report-the Impact of Social Media on Children, Adolescents, and Families. By Gwenn Schurgin O’Keefe and others, the Council on Communications and Media Executive Committee. IN: Pediatrics, vol. 10, no. 1542 (2011) pp. 800-804.

[“Using social media Web sites is among the most common activity of today’s children and adolescents. Any Web site that allows social interaction is considered a social media site, including social networking sites such as Facebook, MySpace, and Twitter; gaming sites and virtual worlds such as Club Penguin, Second Life, and the Sims; video sites such as YouTube; and blogs. Such sites offer today’s youth a portal for entertainment and communication and have grown exponentially in recent years. For this reason, it is important that parents become aware of the nature of social media sites, given that not all of them are healthy environments for children and adolescents. Pediatricians are in a unique position to help families understand these sites and to encourage healthy use and urge parents to monitor for potential problems with cyberbullying, “Facebook depression,” sexting, and exposure to inappropriate content.”]

Full text at:

<http://pediatrics.aappublications.org/cgi/reprint/peds.2011-0054v1>

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Delivery of Well Child Care: A Look inside the Door. By Chuck Norlin, University of Utah Health Sciences Center, and others. IN: Academic Pediatrics, vol. 11, no. 1 (January-February 2011) pp. 18-26.

[“OBJECTIVE: To describe the delivery of well-child care and its components; to compare that delivery with recommendations in Bright Futures; and to compare delivery of well-child care for children with special health care needs with that for children without special needs.

METHODS: Over a 10-week period, 2 medical students observed and documented characteristics of well-child care visits by general pediatricians and midlevel pediatric providers. Parents completed a demographic questionnaire and a screener for children with special health care needs.

RESULTS: A total of 483 visits by 43 pediatricians and 9 midlevel providers with patients from 0 to 19 years of age were observed. Adjusted mean visit duration was 20.3 minutes; 38.9% of visits began with an open-ended question about parent/child concerns. A mean of 7.2 health supervision/anticipatory guidance topics were addressed per visit. Clinicians addressed a mean of 42% of Bright Futures–recommended age-specific health supervision/anticipatory guidance topics. Topics addressed less frequently than recommended included family support, parental well-being, behavior/discipline, physical activity, media screen time, risk reduction/substance use, puberty/sex, social-peer interactions, and violence. Shorter visits were associated with asking about

parent/child concerns and with addressing greater proportions of recommended health supervision/anticipatory guidance topics. Well-child care visits with children with special health care needs were 36% longer than those with children without special needs and addressed similar numbers of age-specific health supervision/anticipatory guidance topics. More time was spent with children with special health care needs addressing health supervision/anticipatory guidance topics, other conditions (usually their chronic condition), and testing, prescriptions, and referrals.

CONCLUSIONS: Utilizing direct observation of visits with pediatric clinicians, we found that solicitation of parent/child concerns occurred less frequently than recommended. Fewer than half of recommended visit-specific health supervision/anticipatory guidance topics were addressed, and there was little congruence with some Bright Futures age group-specific recommendations. Notably, both solicitation of patient/parent concerns and greater adherence to health supervision/anticipatory guidance recommendations were associated with shorter visits. Well-child care visits with children with special health care needs were longer than those with children without special needs; more time was spent addressing similar numbers of health supervision/anticipatory guidance topics as well as their chronic conditions.”]

Full text at:

<http://download.journals.elsevierhealth.com/pdfs/journals/1876-2859/PIIS1876285910003530.pdf>

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DISPARITIES

HHS Announces Plan to Reduce Health Disparities. By U. S. Department of Health and Human Services. (The Department, Washington, D.C.) April 8, 2011. 2 p.

[“The U.S. Department of Health and Human Services today launched two strategic plans aimed at reducing health disparities.

The *HHS Action Plan to Reduce Health Disparities* outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities.

HHS also released the *National Stakeholder Strategy for Achieving Health Equity*, a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities and other underserved groups reach their full health potential. The strategy, a product of the National Partnership for Action (NPA), incorporates ideas, suggestions and comments from thousands of individuals and organizations across the country. The NPA was coordinated by the HHS Office of Minority Health.

Racial and ethnic minorities still lag behind in many health outcome measures. They are less likely to get the preventive care they need to stay healthy, more likely to suffer from serious illnesses, such as diabetes or heart disease, and when they do get sick, are less likely to have access to quality health care.”]

Full text at:

<http://www.hhs.gov/news/press/2011pres/04/20110408a.html>

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DUAL DIAGNOSIS

“Dual Diagnosis Clients’ Treatment Satisfaction – A Systematic Review.” By Sabrina J. Schulte, International Studies Department, American University of Sharjah, United Arab Emirates, and others. IN: BMC Psychiatry, vol. 11, no. 64 (April 18, 2011) pp. 1-42.

[“The aim of this systematic review is to synthesize existing evidence about treatment satisfaction among clients with substance misuse and mental health co-morbidity (dual diagnoses, DD).

Methods

We examined satisfaction with treatment received, variations in satisfaction levels by type of treatment intervention and by diagnosis (i.e. DD clients vs. single diagnosis clients), and the influence of factors other than treatment type on satisfaction. Peer reviewed studies published in English since 1970 were identified by searching electronic databases using pre-defined search strings.

Results

Across the 27 studies that met inclusion criteria, high average satisfaction scores were found. In most studies, integrated DD treatment yielded greater client satisfaction than standard treatment without explicit DD focus. In standard treatment without DD focus, DD clients tended to be less satisfied than single diagnosis clients. Whilst the evidence base on client and treatment variables related to satisfaction is small, it suggested client demographics and symptom severity to be unrelated to treatment satisfaction. However, satisfaction tended to be linked to other treatment process and outcome variables. Findings are limited in that many studies had very small sample sizes, did not use validated satisfaction instruments and may not have controlled for potential confounders. A framework for further research in this important area is discussed.

Conclusions

High satisfaction levels with current treatment provision, especially among those in integrated treatment, should enhance therapeutic optimism among practitioners dealing with DD clients.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244x-11-64.pdf>

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INTEGRATED HEALTH SERVICES

“Effectiveness of Service Linkages in Primary Mental Health Care: A Narrative Review Part 1” By Jeffrey D. Fuller, Flinders University, Adelaide, Australia, and others. IN: BMC Health Services Research, vol. 11, no. 72 (April 11, 2011) pp. 1-37.

[“With the move to community care and increased involvement of generalist health care providers in mental health, the need for health service partnerships has been emphasized in mental health policy. Within existing health system structures the active strategies that facilitate effective partnership linkages are not clear. The objective of this study was to examine the evidence from peer reviewed literature regarding the effectiveness of service linkages in primary mental health care.

Methods

A narrative and thematic review of English language papers published between 1998 and 2009. Studies of analytic, descriptive and qualitative designs from Australia, New Zealand, UK, Europe, USA and Canada were included. Data were extracted to examine what service linkages have been used in studies of collaboration in primary mental health care. Findings from the randomised trials were tabulated to show the proportion that demonstrated clinical, service delivery and economic benefits.

Results

A review of 119 studies found ten linkage types. Most studies used a combination of linkage types and so the 42 RCTs were grouped into four broad linkage categories for meaningful descriptive analysis of outcomes....

Conclusion

There is strong evidence to support collaborative primary mental health care for people with depression when linkages involve “direct collaborative activity”, plus “agreed guidelines” and “communication systems”.]

Full text at:

<http://www.biomedcentral.com/content/pdf/1472-6963-11-72.pdf>

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INTERVENTION

Implementing Response to Intervention in Context. By the Center for Mental Health in Schools at UCLA. A Center Practice Brief. (The Center, Los Angeles, California) April 2011. 29 p.

[“Response to Intervention (RTI) initiatives wisely underscore the unacceptability of waiting for students to fail. However, as with so many other efforts intended to ensure all students have an equal opportunity to succeed at school, this budding movement often is pursued as just another piecemeal effort. Fragmentary endeavors cannot address the complex realities confronting teachers and student support staff. Concern about supporting the RTI movement led the U.S. Department of Education to fund a technical assistance center, the *National Center on Response to Intervention*, involving the American Institutes for Research and researchers from Vanderbilt University and the University of Kansas (<http://www.rti4success.org/>). Clearly the RTI center increasingly will shape how response to intervention is implemented. So we begin by noting the ways in which that center defines and frames response to intervention, and we highlight some concerns about the lack of emphasis on context.

The RTI center stresses that “the purpose of RTI is to provide all students with the best opportunities to succeed in school, identify students with learning or behavioral problems, and ensure that they receive appropriate instruction and related supports.”

This purpose is translated into a definition that states “response to intervention integrates assessment and intervention within a multi-level prevention system to maximize student achievement and to reduce behavior problems. With RTI, schools identify students at risk for poor learning outcomes, monitor student progress, provide evidence-based interventions and adjust the intensity and nature of those interventions depending on a student’s responsiveness, and identify students with learning disabilities or other disabilities.”

Full text at:

<http://smhp.psych.ucla.edu/pdfdocs/implementingrti.pdf>

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POLICY

Impact of Economic Crises on Mental Health. By the World Health Organization, Regional Office for Europe. (The Organization, Copenhagen, Denmark) 2011. 34 p.

[“It is well known that mental health problems are related to deprivation, poverty, inequality and other social and economic determinants of health. Economic crises are therefore times of high risk to the mental well-being of the population and of the people affected and their families. The economic crisis that started in 2007 has continued to pose major challenges in the WHO European Region. It has led to significant declines in economic activity, a rise in unemployment, depressed housing markets and an increasing number of people living in poverty. The rise in national debt is forcing governments to implement severe cuts in public spending. Significant risks remain in the world economy, and many countries are facing an era of austerity in health and welfare services.

The focus on social and economic determinants of the forthcoming new European health policy, Health 2020, will acknowledge these new life circumstances. It will stress that health objectives are influenced by a range of social objectives that require action across many sectors. This notion is especially important in times of economic crisis, because policy actions in sectors other than health can amend some of the health effects of the crisis. Targeted investment in public services that are crucial for many people’s well-being can ameliorate the social and economic determinants of health and the associated health disparities. The integrated response across policies must include accessible health services, with a focus on primary care response.”]

Full text at:

http://www.euro.who.int/__data/assets/pdf_file/0008/134999/e94837.pdf

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RECOVERY AND RESILIENCE

Recovery and Resilience: African, African Caribbean, and South Asian Women's Narratives of Recovering from Mental Distress. By Jayasree Kalathil and others, Mental Health Foundation. (The Foundation, London, United Kingdom) 2011. 88 p.

[“Recovery and Resilience: African, African-Caribbean and South Asian women's narratives of recovering from mental distress is the report of a research project exploring the concept and settings of recovery from mental and emotional distress. The project sought to collect positive stories of recovery and resilience and highlight what helped women from these communities in their healing process.”]

Full text at:

http://mentalhealth.org.uk/content/assets/PDF/publications/recovery_and_resilience.pdf

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STIGMA

“Internalizing Stigma Associated with Mental Illness: Findings from a General Population Survey in Jamaica.” By Roger Carl Gibson and others, University of West Indies, Kingston, Jamaica. IN: *Revista Panamericana de Salud Pública*, vol. 27, no. 2 (February 2010) pp. 26-33.

[“Objectives. The culture of stigma associated with mental illness is particularly intense when persons who are normally victims of that stigmatization (mentally ill persons and their family members) themselves act negatively toward others whom they associate with mental illness. We attempt to determine the extent of this internalization and assimilation of stigmatizing attitudes, cognitions, and behaviors in persons who are at risk for such stigmatization in Jamaica.

Methods. Data from a 2006 national survey on mental health were analyzed. Demographic variables, the presence or absence of mental illness in respondents and in their family members, and responses pertaining to behaviors and attitudes toward mentally ill persons were examined. Subsamples (respondents with mental illness, respondents with a family member with mental illness, respondents with neither) were compared using the chi-square test.

Results. Respondents with family members with mental illness were less likely to demonstrate a number of different manifestations of stigmatization than others ($P = 0.009-0.019$). Respondents with mental illness showed no difference in the demonstration of a number of different manifestations of stigmatization from other respondents ($P = 0.069-0.515$).

Conclusions. The small number of mentally ill respondents resulted in low statistical power for demonstrating differences between that subgroup and other respondents. The significantly more positive attitudes and behavior of respondents with family members with mental illness suggest that some benefit may be gained by creating more opportunities for the general public to interact with persons with mental illness.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=51642534&site=ehost-live>

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“The Power of a Label: Mental Illness Diagnoses, Ascribed Humanity, and Social Rejection.” By Andres G. Martinez and others, University of California, Berkeley. IN: *Journal of Social & Clinical Psychology*, vol. 30, no. 1 (January 2011) pp. 1-23.

[“Although the stigma of mental illness has been widely documented, the specific processes through which psychiatric labels evoke prejudice and discrimination are not well understood. We examined how ascribing humanity to an individual labeled with mental illness may influence perceptions of dangerousness and motivations for social rejection. Study 1 revealed that a general mental illness label (compared to a general physical illness label) led to reductions in ascribed humanity, which predicted increased perceptions of dangerousness. In Study 2, participants formed impressions about an individual bearing a specific mental illness label (or a specific physical illness label) while normative behavioral information and full remission status were held constant. Under these conditions, the target labeled with mental illness evoked greater ascribed humanity. Further analyses revealed a unique effect for the target bearing the mental illness label: ascribing humanity to the target predicted reductions in perceived dangerousness, which in turn influenced social rejection. A similar mediational path was not found for the target bearing the physical illness label. We discuss the implications of ascribing humanity to people labeled mentally ill for stereotyping and stigma reduction.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=57829924&site=ehost-live>

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SUICIDE PREVENTION

New Consortium Established to Study Suicide Prevention. By U.S. Medicine, the Voice of Federal Medicine. (The Voice, Washington, D.C.) 2011. 2 p.

[“The Military Operational Medicine Research Program (MOMRP) has announced that it has established a new \$17 million Military Suicide Research Consortium (MSRC).

The Denver Veterans Affairs Medical Center and Florida State University have each been awarded \$8.5 million over three years to direct the consortium. The consortium will help develop studies to find the best ways to conduct suicide screening, prevention, and intervention in the military.

Col Carl Castro, MOMRP director, underscored the need for scientifically proven prevention and screening methods. He noted that currently none of the suicide prevention training used by the military is evidence-based. “[They are] good ideas, experts thinking that is what we need to do, but we do not have any evidence that that training actually, in fact, prevents suicides.”

A database of suicide research that is relevant to the military will be created as part of the consortium’s work. The system will be searchable and can be used to provide suicide research data to policymakers and others. “It is our fervent hope that we inform suicide prevention, not only in the military, but beyond in the civilian populations as well,” Thomas Joiner, PhD, of Florida State University, who serves as one of the co-directors of the MSRC.”]

Full text at:

<http://www.usmedicine.com/articles/new-consortium-established-to-study-suicide-prevention.html>

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Understanding Families and Suicide Risk. By John Fitzgerald and others, the Psychology Center. (The National Centre of Mental Health Research, Information and Workforce Development, Auckland, New Zealand). July 2010. 95 p.

[“The overall goal of the research reported here was to develop a better understanding of the dynamic and proximal family factors that become relevant when a young family member is at risk of suicide. Of particular interest were the experiences of families who have faced this challenge. From their perspective, we were interested in what family dynamics have the potential to mitigate suicide risk for a young person and to facilitate family resilience.

This project was completed with support from the Ministry of Health’s Suicide Prevention Research Fund. This fund was established to address two priorities: suicide intervention; and enhancing our knowledge about suicidal behaviour. Under these priorities sit a number of supplementary areas of interest including: the care of people who make non-fatal suicide attempts; the views and experiences of family/whānau and significant others bereaved or affected by suicidal behaviour; and the risk and resiliency factors for suicidal behaviour.”]

Full text at:

<http://www.tepou.co.nz/file/Research-projects/suicide/understanding-families-and-suicide-risk-report.pdf>

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TRAUMATIC BRAIN INJURY

Traumatic Brain Injury and Depression. Effective Care Program. Comparative Effectiveness Review. #25. By the Agency for Healthcare Research and Quality. (The Agency, Rockville, Maryland) April 2011. 389 p.

[“We do not know the extent to which depression contributes to long-term disability following traumatic brain injury (TBI), although depression is one of several potential psychiatric illnesses that may be common following TBI. Major depression may be triggered by physical or emotional distress, and it can deplete the mental energy and motivation needed for both recovering from the depression itself and adapting to the physical, social, and emotional consequences of trauma with brain injury. Depression may be masked by other deficits after head injury, such as cognitive changes and flat affect, which may be blamed for lack of progress in post-trauma treatment but actually reflect underlying depression. Clinicians, caregivers, and patients lack formal evidence to guide the timing of depression screening, which tools to use for screening and assessment, treatment choices, and assessment of treatment success.

Full text at:

http://www.effectivehealthcare.ahrq.gov/ehc/products/77/658/CER25_TBI_Depression_Report_04_13_2011.pdf

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VETERANS

“Mental Health and Substance Use Disorder Spending in the Department of Veteran’s Affairs, Fiscal Years 2000-2007.” By Todd H. Wagner and others, Department of Veterans Affairs, Palo Alto Healthcare System. IN: Psychiatric Services, vol. 62, no. 4 (April 2011) pp. 389-395.

[“This study analyzed spending for treatment of mental health and substance use disorders in the Department of Veterans Affairs (VA) in fiscal years (FYs) 2000 through 2007. *Methods:* VA spending as reported in the VA Decision Support System was linked to patient utilization data as reported in the Patient Treatment Files, the National Patient Care Database, and the VA Fee Basis files. All care and costs from FY 2000 to FY 2007 were analyzed. *Results:* Over the study period the number of veterans treated at the VA increased from 3.7 million to over 5.1 million (an average increase of 4.9% per year), and costs increased .7% per person per year. For mental health and substance use disorder treatment, the volume of inpatient care decreased markedly, residential care increased, and spending decreased on average 2% per year (from \$668 in FY 2000 to \$578 per person in FY 2007). FY 2007 saw large increases in mental health spending, bucking the trend from FY 2000 through FY 2006. *Conclusions:* VA’s continued emphasis on outpatient and residential care was evident through 2007. This trend in spending might be unimpressive if VA were enrolling healthier Veterans, but the opposite seems to be true:

over this time period the prevalence of most chronic conditions, including depression and posttraumatic stress disorder, increased. VA spending on mental health care grew rapidly in 2007, and given current military activities, this trend is likely to increase.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/4/389>

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Panel Questions Adequacy of Mental Health Care. By Andrew Tilghman, Staff Writer, Army Times. (Gannett Corporation, Springfield, Virginia) April 7, 2011. 1 p.

[“The military’s top doctors faced heated questions on Capitol Hill about whether there are enough mental health professionals to meet the soaring demand from troubled troops. “Do you feel you have adequate mental health personnel?” asked Sen. Barbara Mikulski, D-Md., at an April 6 hearing of the Senate Appropriations Committee’s defense panel. Lt. Gen. Eric Schoomaker, the Army surgeon general, acknowledged that the military would prefer to have more, but cited an overall lack of mental health professionals nationwide as a key challenge.”]

Full text at:

<http://www.armytimes.com/news/2011/04/military-panel-questions-adequacy-of-mental-health-care-040711/>

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WELLBEING AND MENTAL HEALTH

Improving Wellbeing through Healthy Life Choices: Lessons from a West Midlands Initiative with Health Trainers and Psychological Therapy Practitioners. By Kate O’Hara, Well-being and Public Mental Health, and others. (National Mental Health Development Unit, London, United Kingdom) 2011. 25 p.

[“Physical Health and Mental Health are inter-related

- Poor physical health is a significant risk factor for poor mental health;
 - Positive mental health and well-being protects physical health and improves health outcomes and recovery rates.
 - Early intervention and treatment of mental health problems is recommended to improve health outcomes for people with physical illness
 - Early provision of advice on promoting physical health for people with mental ill health will help to increase well-being and prevent development of physical health problems.
- Health Trainer services were introduced as a new public health workforce from 2004, to work with people from disadvantaged communities, supporting them in considering their health behaviours and lifestyles and deciding about possible changes to make.”]

Full text at:

<http://www.nmhd.org.uk/silo/files/improving-wellbeing-through-healthy-life-choices.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.

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

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CONFERENCES, MEETINGS AND SEMINAR

American Mental Health Counselors Association: Annual Conference: The Power of Partnerships: Effective Pathways to Mental Health.

July 14-16, 2011

San Francisco, California

PARC 55 Wyndham Hotel

on Union Square

[“Each year, AMHCA's conference draws several hundred mental health counselors from across the United States to participate in this educational gathering. AMHCA's is the only conference devoted entirely to the mental health counseling profession, delivering high-quality education, peer connections, relaxation and exploration.”]

Full text at:

http://www.amhca.org/member/annual_conference.aspx

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Sixth Annual UC Davis Conference: Psychotic Disorders: Advanced Strategies for the Management of Psychosis: A State of the Art Conference for Experienced Clinicians.

**Thursday
September 15, 2011**

**Hilton Hotel Arden West
Sacramento, California**

For more information at:

http://www.ucdmc.ucdavis.edu/cme/conferences/pdfs/APSYC12_9-15-11w.pdf

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