

Subject: Studies in the News: (June 1, 2011)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

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AGING

“Preferences for Depression Treatment among Elderly Home Health Care Patients.” By Patrick J. Raue and others, Weill Cornell Medical College. IN: Psychiatric Services, vol. 62, no. 5 (May 2011) pp. 532-537

[“The authors hypothesized that the depression treatment preferences of elderly home care patients would vary by their experience of depression and that preferences for active treatment would be associated with current depression and with antidepressant treatment.

Methods: The authors conducted cross-sectional secondary analyses of data from the TRIAD study (Training in the Assessment of Depression) of 256 randomly selected elderly patients newly admitted to home care. The study assessed preference for active treatments (medication or psychotherapy) and nonactive or complementary approaches (such as religious activities or doing nothing). Nondepressed patients were asked to choose as if they had serious depression. Two separate indicators of depression experience were used: a current diagnosis of major or minor depression and current or previous antidepressant treatment.

Results: Of the 256 patients, 16% (N=41) met criteria for major or minor depression. Forty-seven percent of the sample (N=121) preferred an active treatment as their first choice, and others preferred nonactive or complementary approaches. Logistic regression indicated that current antidepressant use, previous psychotherapy experience, white or Hispanic race-ethnicity (versus black), greater impairment in instrumental activities of daily living, and less personal stigma about depression were independently associated with preference for an active treatment.

Conclusions: Elderly home care patients had a variety of treatment preferences, ranging from active treatments, to religious or spiritual activities, to no treatment. Several factors were associated with a preference for active treatment, including treatment experience, physical impairment, race-ethnicity, and attitudes and beliefs. An understanding of patient preferences may help engage older depressed home care patients in treatment.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/5/532>

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“Psychological Approach to Successful Aging Predicts Future Quality of Life in Older Adults.” By Ann Bowling and Steve Illiff, University of London, London, United Kingdom. IN: *Health and Quality of Life Outcomes*, vol. 9, no. 13 (March 9, 2011) pp. 1-10

[**“Background:** Public policies aim to promote well-being, and ultimately the quality of later life. Positive perspectives of ageing are underpinned by a range of approaches to successful ageing. This study aimed to investigate whether baseline biological, psychological and social approaches to successful ageing predicted future QoL.

Methods: Postal follow-up in 2007/8 of a national random sample of 999 people aged 65 and over in 1999/2000. Of 496 valid addresses of survivors at follow-up, the follow-up response rate was 58% (287). Measures of the different concepts of successful ageing were constructed using baseline indicators. They were assessed for their ability to independently predict quality of life at follow-up.

Results: Few respondents achieved all good scores within each of the approaches to successful ageing. Each approach was associated with follow-up QoL when their scores were analysed continuously. The biomedical (health) approach failed to achieve significance when the traditional dichotomous cut-off point for successfully aged (full health), or not (less than full health), was used. In multiple regression analyses of the relative predictive ability of each approach, only the psychological approach (perceived self-efficacy and optimism) retained significance.

Conclusion: Only the psychological approach to successful ageing independently predicted QoL at follow-up. Successful ageing is not only about the maintenance of health, but about maximizing one’s psychological resources, namely self-efficacy and resilience. Increasing use of preventive care, better medical management of morbidity, and changing lifestyles in older people may have beneficial effects on health and longevity, but may not improve their QoL. Adding years to life and life to years may require two distinct and different approaches, one physical and the other psychological. Follow-up health status, number of supporters and social activities, and self-rated active ageing also significantly predicted QoL at follow-up. The longitudinal sample bias towards healthy survivors is likely to underestimate these results.”]

Full text at:

<http://www.hqlo.com/content/pdf/1477-7525-9-13.pdf>

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“Social Participation Reduces Depressive Symptoms among Older Adults: An 18-year Longitudinal Analysis in Taiwan.” By Chi Chiao, National Yang-Ming University, Taiwan, and others. IN: *BMC Public Health*, vol. 11, no. 292 (May 10, 2011) pp. 1-25.

[“Relatively little empirical attention has focused on the association between social participation and depressive symptoms amongst older adults in Asian nations, where persons over the age of 65 represent a rapidly growing segment of the population. This study explores the dynamic relationship between participation in social activities and trajectories of depressive symptomatology among older Taiwanese adults surveyed over 18 years....

Results: Analyses using growth curve modeling showed that continuously participating or initiating participation in social activities later life is significantly associated with fewer depressive symptoms among older Taiwanese adults, even after controlling for the confounding effects of aging, individual demographic differences, and health status.

Conclusions: These findings suggest that maintaining or initiating social participation in later life benefits the mental health of older adults. Facilitating social activities among older adults is a promising direction for programs intended to promote mental health and successful aging among older adults in Taiwan.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-11-292.pdf>

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BULLYING

“Peer Victimization as Reported by Children, Teachers, and Parents in Relation to Children’s Health Symptoms.” By Audhild Lohre, Norwegian University of Science and Technology, Trondheim, Norway and others. **IN: BMC Public Health, vol. 11, 278 (May 6, 2011) pp. 1-28.**

[“Victims of bullying in school may experience health problems later in life. We have assessed the prevalence of children’s health symptoms according to whether peer victimization was reported by the children, by their teachers, or by their parents.

Methods

In a cross-sectional study of 419 children in grades 1-10 the frequency of peer victimization was reported by children, teachers and parents. Emotional and somatic symptoms (sadness, anxiety, stomach ache, and headache) were reported by the children. Frequencies of victimization reported by different informants were compared by the marginal homogeneity test for paired ordinal data, concordance between informants by cross-tables and Spearman’s rho, and associations of victimization with health symptoms were estimated by logistic regression.

Results

The concordance of peer victimization reported by children, teachers, and parents varied from complete agreement to complete discordance also for the highest frequency (weekly/daily) of victimization. Children’s self-reported frequency of victimization was strongly and positively associated with their reports of emotional and somatic symptoms. Frequency of victimization reported by teachers or parents showed similar but weaker associations with the children’s health symptoms.

Conclusion

The agreement between children and significant adults in reporting peer victimization was low to moderate, and the associations of reported victimization with the children's self-reported health symptoms varied substantially between informants. It may be useful to assess prospectively the effects of employing different sources of information related to peer victimization.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-11-278.pdf>

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CHILDREN AND ADOLESCENTS

2010 California Parent Survey. By Berkeley Policy Associates. (Lucille Packard Foundation, Palo Alto, California) 2010. 57 p.

[“California is home to 9.9 million children, the largest child population of any state. To policymakers, this presents both challenges and opportunities. Among them is the opportunity to set standards for the health and well-being of children, and to maintain those standards during periods of economic decline.

Over the past few years, the well-being of many children in California has been at risk due in large part to the state's protracted economic downturn. In fact, the proportion of California's children living in families with incomes below the federal poverty threshold—about \$22,000 for a family of four—rose from 17.31 percent in 2007 to 19.92 percent in 2009. Due to long-term effects of the Great Recession, child poverty is projected to remain high for at least the next several years.

In addition, the state's budget crisis has placed enormous pressure on programs that protect and promote the well-being of children and families. The condition of California's children has long-term consequences not only for the overall health of the state's population, but also for its long-term productivity and prosperity.

The Lucile Packard Foundation for Children's Health commissioned the 2010 California Parent Survey to assess the current status of the state's child population from parents' perspectives. The survey is designed to provide timely information about how children are faring, and to bring attention to, and compel action on, key issues related to the well-being of California children.”]

Full text at:

<http://www.kidsdata.org/parentpoll/parentsurvey-report.pdf>

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Children with Special Health Care Needs: A Profile of Key Issues in California. By the Child and Adolescent Health Measurement Initiative. (The Lucille Packard Foundation for Children’s Health, Palo Alto, California) November 2010. 97 p.

[“The Lucille Packard Foundation for Children’s Health is pleased to present this report on the status of California’s 1.4 million children with special health care needs. The state’s current systems of care for these children provide many valuable services, but often fall short of fulfilling the full range of needs faced by these children and their families. Problems include a broad range of issues, from a lack of family-centered and coordinated care to complicated and inefficient funding mechanisms, among other limitations. The challenge is immense, but improvements are within our reach.

Data for this report are drawn from two national surveys that provide rich, useful information about children with special health care needs. Our foundation commissioned this special analysis of California’s results from these larger surveys to provide state policymakers and child health stakeholders with an accurate picture of how the state is faring, and to compel further action on needed changes.

The report offers in-depth information about this vulnerable population of children and their families. It describes the health status of children with special needs; the impacts of their conditions; their health care service utilization; and the quality of care they receive. Each chapter also notes policy and program implications.”]

Full text at:

<http://www.lpfch.org/cshcn/fullreport.pdf>

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The Family Experience with Primary Care Physicians and Staff: A Report by the National Alliance on Mental Illness. By Darcy Gruttadaro and Dana Markey, National Alliance on Mental Illness. (The Alliance, Arlington, Virginia) May 2011. 17 p.

[“The data included in this report is based on information received by NAMI in response to a web-based survey, conducted from June 1 to July 1, 2009. NAMI received 554 survey responses. Responses to the 23 survey questions came from parents and caregivers of children and adolescents living with mental illness. Parents and caregivers answered a variety of questions related to their experiences discussing mental health concerns about their child with primary care physicians and staff. The survey took approximately 30 minutes to complete. NAMI also asked colleague mental health advocacy organizations to send the survey out through their networks.

The survey included the following sections:

- Demographics;
- Background information;
- Primary care setting;
- Initiating communication;

- Effective communication and dialogue;
- Action steps; and
- Additional recommendations and comments.”]

Full text at:

<http://www.nami.org/Template.cfm?Section=CAAC&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120671>

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“Physical and Mental Health, Cognitive Development, and Health Care Use by Housing Status of Low-income Young Children in 20 American Cities: A Prospective Cohort Study.” By Jung Min Park, University of Illinois at Urbana-Champaign, and others. IN: American Journal of Public Health, (May 5, 2011) pp. e1-e7. Published ahead of print.

[“We assessed the independent effect of homeless and doubled-up episodes on physical and mental health, cognitive development, and health care use among children. Methods. We used data from 4 waves of the Fragile Families and Child Wellbeing Study, involving a sample of 2631 low-income children in 20 large US cities who have been followed since birth. Multivariate analyses involved logistic regression using the hybrid method to include both fixed and random effects. Results. Of the sample, 9.8% experienced homelessness and an additional 23.6% had a doubled-up episode. Housing status had little significant adverse effect on child physical or mental health, cognitive development, or health care use. Conclusions. Family and environmental stressors common to many children in poverty, rather than just homeless and doubled-up episodes were associated with young children’s poor health and cognitive development and high health care use. Practitioners need to identify and respond to parental and family needs for support services in addition to housing assistance to effectively improve the health and development of young children who experience residential instability, particularly those in homeless families.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/AJPH.2010.300098v1>

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CRIMINAL JUSTICE

“The Impact of ADHD and Conduct Disorder in Childhood on Adult Delinquency: A 30 Years Follow-up Study Using Official Crime Records.” By Marianne Mordre and others, Oslo University Hospital, Norway. IN: BMC Psychiatry, vol. 11, no. 57 (April 11, 2011) pp. 1-10.

[“Few longitudinal studies have explored lifetime criminality in adults with a childhood history of severe mental disorders. In the present study, we wanted to explore the association between adult delinquency and several different childhood diagnoses in an in-patient population. Of special interest was the impact of disturbance of activity and attention (ADHD) and mixed disorder of conduct and emotions on later delinquency, as these disorders have been variously associated with delinquent development. Methods: Former Norwegian child psychiatric in-patients (n = 541) were followed up 19-41 years after hospitalization by record linkage to the National Register of Criminality. On the basis of the hospital records, the patients were re-diagnosed according to ICD-10. The association between diagnoses and other baseline factors and later delinquency were investigated using univariate and multivariate Cox regression analyses. Results: At follow-up, 24% of the participants had been convicted of criminal activity. In the multivariate Cox regression analysis, conduct disorder (RR = 2.0, 95%CI = 1.2-3.4) and hyperkinetic conduct disorder (RR = 2.7, 95% CI = 1.6-4.4) significantly increased the risk of future criminal behaviour. Pervasive developmental disorder (RR = 0.4, 95%CI = 0.2-0.9) and mental retardation (RR = 0.4, 95%CI = 0.3-0.8) reduced the risk for a criminal act. Male gender (RR = 3.6, 95%CI = 2.1-6.1) and chronic family difficulties (RR = 1.3, 95% CI = 1.1-1.5) both predicted future criminality. Conclusions: Conduct disorder in childhood was highly associated with later delinquency both alone or in combination with hyperactivity, but less associated when combined with an emotional disorder. ADHD in childhood was no more associated with later delinquency than the rest of the disorders in the study population. Our finding strengthens the assumption that there is no direct association between ADHD and criminality.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-57.pdf>

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DEPRESSION

“Should Global Burden of Disease Estimates Include Depression as a Risk Factor? for Coronary Heart Disease?” By Fiona J. Charlson, Queensland Centre for Mental Health Research, Australia, and others. IN: BMC Medicine, vol. 9, no. 47 (May 3, 2011) pp. 1-12.

[“The 2010 Global Burden of Disease Study estimates the premature mortality and disability of all major diseases and injuries. In addition it aims to quantify the risk that diseases and other factors play in the aetiology of disease and injuries. Mental disorders and coronary heart disease are both significant public health issues due to their high

prevalence and considerable contribution to global disease burden. For the first time the Global Burden of Disease Study will aim to assess mental disorders as risk factors for coronary heart disease. We show here that current evidence satisfies established criteria for considering depression as an independent risk factor in development of coronary heart disease. A dose response relationship appears to exist and plausible biological pathways have been proposed. However, a number of challenges exist when conducting a rigorous assessment of the literature including heterogeneity issues, definition and measurement of depression and coronary heart disease, publication bias and residual confounding. Therefore, despite some limitations in the available data, it is now appropriate to consider major depression as a risk factor for coronary heart disease in the new Global Burden of Disease Study.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1741-7015-9-47.pdf>

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DSM-V DEVELOPMENT

DSM-5: The Future of Psychiatric Diagnosis-American Psychiatric Association.

DSM-V Development site.

[“Publication of the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) in May 2013 will mark one the most anticipated events in the mental health field. As part of the development process, the preliminary draft revisions to the current diagnostic criteria for psychiatric diagnoses are now available for public review. We thank you for your interest in DSM-5 and hope that you use this opportunity not only to learn more about the proposed changes in DSM-5, but also about its history, its impact, and its developers. Please continue to check this site for updates to criteria and for more information about the development process.”]

Website for review:

<http://www.dsm5.org/Pages/Default.aspx>

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DUAL DIAGNOSIS

Developing Service User Focused Outcomes in Dual Diagnosis: A Practical Tool. By Caroline Hawkings and others, National Mental Health Development Unit. (The Unit, London, United Kingdom) May 2011. 52 p.

[“Substance misuse and mental illness both exert a heavy impact on people’s lives. They can affect physical health, social status, relationships, self-image...in fact most aspects of a person’s life can be affected. For people who experience both mental ill health and addiction, the problem more than doubles. Both issues become entwined and impact on one another and the rest of our lives can fall to pieces as a result.

This document reflects many of these difficulties. Spurned by the mental health community for substance misuse and derided by the drug and alcohol teams for being chaotic, all too often the support we receive does not bridge the gap between fields, and rejection by services perpetuates low self-esteem.”]

Full text at:

<http://www.nmhdu.org.uk/silo/files/listening-to-service-users.pdf>

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HEALTH LITERACY

“Health Literacy and Health Communication.” By Hirono Ishikawa and Takahiro Kiuchi, University of Tokyo, Japan. IN: Biopsychosocial Medicine, vol. 4, no. 18 (November 2, 2010) pp. 1-5.

[“Health communication consists of interpersonal or mass communication activities focused on improving the health of individuals and populations. Skills in understanding and applying information about health issues are critical to this process and may have a substantial impact on health behaviors and health outcomes. These skills have recently been conceptualized in terms of health literacy (HL). This article introduces current concepts and measurements of HL, and discusses the role of HL in health communication, as well as future research directions in this domain. Studies of HL have increased dramatically during the past few years, but a gap between the conceptual definition of HL and its application remains. None of the existing instruments appears to completely measure the concept of HL. In particular, studies on communication/interaction and HL remain limited. Furthermore, HL should be considered not only in terms of the characteristics of individuals, but also in terms of the interactional processes between individuals and their health and social environments. Improved HL may enhance the ability and motivation of individuals to find solutions to both personal and public health problems, and these skills could be used to address various health problems throughout life. The process underpinning HL involves empowerment, one of the major goals of health communication.”]

Full text at:

<http://www.bpsmedicine.com/content/pdf/1751-0759-4-18.pdf>

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MIGRANTS AND MENTAL HEALTH

“Health Selection among Migrants from Mexico to the U.S.: Childhood Predictors of Adult Physical and Mental Health.” By Joshua Breslau, University of California, Davis, School of Medicine, and others. IN: Public Health Reports, vol. 126, no. 3 (May/June 2011) pp. 361-370.

[“Objectives. We tested whether positive selection on childhood predictors of adult mental and physical health contributed to health advantages of Mexican born immigrants to the United States relative to U.S.-born Mexican Americans.

Methods. We combined data from surveys conducted during 2000–2003 in Mexico and the U.S. with the same structured interview. We examined retrospective reports of childhood (i.e., 16 years of age) predictors of adult health—education, height, childhood physical illness, childhood mental health, early substance use, and childhood adversities—as predictors of migration from Mexico to the U.S. at 16 years of age. We estimated overall selection by comparing migrants to all non-migrants. We also examined selection at the family (members of families of migrants vs. members of families without a migrant) and individual (migrants vs. non-migrants within families of migrants) levels.

Results. Distinguishing between family and individual selection revealed evidence of positive health selection that is obscured in the overall selection model. In particular, respondents in families with migrants were more likely to have 12 years of education (odds ratio [OR] 5 1.60) and be in the tallest height quartile (OR51.72) than respondents in families without migrants. At both the family and individual levels, migrants are disadvantaged on mental health profiles, including a higher prevalence of conduct problems, phobic fears, and early substance use.

Conclusions. Positive health selection may contribute to physical health advantages among Mexican immigrants in the U.S. relative to their U.S.-born descendants. Mental health advantages likely reflect a lower prevalence of psychiatric disorders in Mexico, rather than protective factors that distinguish migrants.” **NOTE: For a copy of this article, please contact the California State Library.]**

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POLICY

The Crucial Role of Counties in the Health of Californians: An Overview. By Deborah Reidy Kelch, Kelch Associates. (The California Healthcare Foundation, Oakland, California) March 2011. 39 p.

[“California’s 58 counties are core providers of an array of local health services, including medical care for low-income, underserved, and uninsured populations, public and environmental health services, and behavioral health and substance use treatment services. County health programs rely on a historical, complex, and shifting patchwork of federal, state, and local funds. The revenues available to counties, and the expectations of county health programs, are dramatically affected year to year by the economic and fiscal challenges, and the policy and political landscape, at all levels of government....

This report offers an overview of the range of health services and programs that have become the responsibility of California counties, either by statute, practice, or default. It outlines: basic responsibilities currently assigned to counties in the areas of medical care services for low-income populations, public health, mental health, and substance abuse

treatment; the funding streams for these services and programs; and the variety of methods counties use to provide the services. The table in the Appendix provides a quick reference summary of the program information.

This snapshot overview is offered as background information for policy discussions about the role California counties will play in the future health of Californians.”]

Full text at:

<http://www.chcf.org/~media/Files/PDF/T/PDF%20TheCrucialRoleOfCountiesInCA.pdf>

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Developing Federally Qualified Health Centers into Community Networks to Improve State Primary Care Delivery Systems. By Mary Takach and Jason Buxbaum, National Academy for State Health Policy. (The Commonwealth Fund, New York, New York) May 2011. 47 p.

[“By fostering connections between federally qualified health centers (FQHCs) and other private primary care providers, states may be able to connect Medicaid beneficiaries with services needed to help them manage their health and reduce costly visits to hospitals. FQHCs’ mandate to provide a comprehensive scope of primary and preventive health care and support services, coupled with their access to federal funds, gives them expertise and resources that might be leveraged in collaborative relationships with states and private practices. FQHCs may find that by entering into collaborative relationships with states and private practices, they strengthen their own financial position, advance their quality goals, improve their staffing mix, enhance the continuum of care and the kinds of services available to their patients, and further their mission.”]

Full text at:

http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/May/1499_Takach_developing_FQHCs_into_community_networks_v2.pdf

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“How Intermountain Trimmed Health Care Costs through Robust Quality Improvement Efforts.” By Brent C. James, Intermountain Healthcare, and Lucy A.

Savitz, Institute for Health Care Delivery Research. IN: Health Affairs, vol. 30, no. 6 (June 2011) pp. 1-8. Web first before publication.

[“It has been estimated that full implementation of the Affordable Care Act will extend coverage to thirty-two million previously uninsured Americans. However, rapidly rising health care costs could thwart that effort. Since 1988 Intermountain Healthcare has applied to health care delivery the insights of W. Edwards Deming’s process management theory, which says that the best way to reduce costs is to improve quality. Intermountain achieved such quality-based savings through measuring, understanding, and managing variation among clinicians in providing care. Intermountain created data systems and management structures that increased accountability, drove improvement, and produced savings. For example, a new delivery protocol helped reduce rates of elective induced labor, unplanned cesarean sections, and admissions to newborn intensive care units. That one protocol saves an estimated \$50 million in Utah each year. If applied nationally, it would save about \$3.5 billion. “Organized care” along these lines may be central to the long-term success of health reform.” **NOTE: If you have difficulty accessing this report, please request an electronic copy from the California State Library.**]

Full text at:

<http://content.healthaffairs.org/content/early/2011/05/17/hlthaff.2011.0358.full.pdf+html>

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If I have a Mental Illness Will Health Reform Help Me? : For Consumers of Mental Health Services, A Review of Protections in the Affordable Care Act. By Chris Koyanagi, Bazelon Center for Mental Health Law. (The Center, Washington, D.C.) March 2011.

[“In 2010, Congress passed and the President signed the Affordable Care Act. As parts of this health reform law take effect between now and 2014, it will make major changes in health insurance and the health care system, and many parts of it can improve your access to mental health services. This fact sheet describes some of these changes.”]

Full text at:

<http://www.bazelon.org/LinkClick.aspx?fileticket=JKIsIt142F4%3d&tabid=104>

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RURAL AND REMOTE HEALTH

“Conversations on Telemental Health: Listening to Remote and Rural First Nations Communities.” By K.L. Gibson, University of New Brunswick, New Brunswick, Canada, and others. IN: Rural and Remote Health, vol. 11, no. 1656 (April 19, 2011) pp. 1-19.

[“Telemental health involves technologies such as videoconferencing to deliver mental health services and education, and to connect individuals and communities for healing and health. In remote and rural First Nations communities there are often challenges to obtaining mental healthcare in the community and to working with external mental health workers. Telemental health is a service approach and tool that can address some of these challenges and potentially support First Nations communities in their goal of improving mental health and wellbeing. Community members’ perspectives on the usefulness and appropriateness of telemental health can greatly influence the level of engagement with the service. It appears that no research or literature exists on First Nations community members’ perspectives on telemental health, or even on community perspectives on the broader area of technologies for mental health services. Therefore, this article explores the perspectives on telemental health of community members living in two rural and remote First Nations communities in Ontario, Canada.

Methods: This study was part of the VideoCom project, a collaborative research project exploring how remote and rural First Nations communities are using ICTs. This current exploration was conducted with the support of Keewaytinook Okimakanak (KO), our partner in Northwestern Ontario. With the full collaboration of the communities’ leadership, a team involving KO staff and VideoCom researchers visited the two communities in the spring of 2010. Using a participatory research design, we interviewed 59 community members, asking about their experiences with and thoughts on using technologies and their attitudes toward telemental health, specifically. A thematic analysis of this qualitative data and a descriptive quantitative analysis of the information revealed the diversity of attitudes among community members. Finally, based on a discussion with the community telehealth staff, a ‘ways forward’ section was proposed as a way to begin addressing certain issues that were raised by community members.

Results: This article explores the continuum of community members’ perspectives that range from interest and enthusiasm to hesitancy and concern. One participant reported personal experience with using telemental health and found the approach helpful in increasing her comfort in the therapeutic situation. In addition, concerns relating to appropriateness and safety were voiced. A variety of advantages (e.g. facilitation of disclosure, increased access to services, usefulness) and disadvantages or concerns (e.g. interference with capacity building, concerns about privacy) are reported and discussed. Following a coding procedure, a descriptive quantitative analysis demonstrated that 47% of the participants were categorized as having a positive response toward telemental health, 32% as having a negative response, and 21% as being neutral or undecided.

Conclusions: Valuing Indigenous knowledge can help us understand community members’ experiences of and concerns with telemental health and inform more successful and appropriate initiatives. With the invaluable support of the KO Telemedicine co-authors, we offer ways forward to address concerns identified by the community members. Most importantly, any ways forward for community telemental health initiatives need to be community driven and community led.”]

Full text at:

http://www.rrh.org.au/publishedarticles/article_print_1656.pdf

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SUICIDE PREVENTION

CAMS Study: Suicidal Inpatients Benefit from Clinician Empathy, Focus on Suicide Drivers. By M. Alexander Otto, **Internal Medicine News Digital Network.** IN: **Internal Medicine News, (May 10 2011) pp. 1-3.**

[“Collaborative Assessment and Management of Suicidality significantly helped depressed, hopeless, and suicidal psychiatric inpatients in a small case series at the Menninger Clinic in Houston.

It was an open study with no control group, but also the first study to show the technique – which previously has been proven to help military, college, and other outpatients – helps hospitalized people, too.

Sixteen women and five men aged 18-55 years reported significant drops in suicidality after an average of about 11 sessions of CAMS, as the technique is known, over 6 weeks. At the heart of CAMS is a strong, trusting bond – or collaboration – between patients and therapists. CAMS also tackles suicidality as a problem in itself, not merely as a symptom of a disorder, said lead investigator Thomas E. Ellis, Psy.D. "So often when you view suicidality as a symptom and you treat the disorder, you anticipate that as the person feels better, the suicide problem is eliminated. Research is not consistent with that model. We view suicidal ideation and behavior as a target," said Dr. Ellis, director of psychology at the Menninger Clinic. "We address the disorder, but at the same time, we don't assume suicidality will be eliminated just because the disorder's been treated.”]

Full text at:

<http://www.internalmedicineneeds.com/news/mental-health/single-article/cams-study-suicidal-inpatients-benefit-from-clinician-empathy-focus-on-suicide-drivers/df690b8673.html>

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“Increased Risk of Suicide Attempts among Black and Latino Lesbians, Gay Men, and Bisexuals.” By Shannon O’Donnell, **E’cole des Hautes Etudes, Paris, France, and others.** IN: **American Journal of Public Health, vol. 101, no. 6 (June 2011) pp. 1055-1059.**

[“Members of racial/ethnic minority groups have a lower lifetime prevalence than have Whites of mental disorders, a risk factor for suicide attempts; paradoxically, however, lesbian, gay, and bisexual (LGB) ethnic minority youths may be at increased risk for suicide attempts relative to White LGB youths. We found that the increased risk of suicide attempts among racial/ethnic minority LGB respondents in our sample relative to White respondents was not explained by excess youth onset of depression and substance abuse or by a higher susceptibility to suicide in the racial/ethnic minority LGB group.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/101/6/1055>

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VETERANS

Military Kids with Deployed Parents Experience Higher Risk of Hospitalization. By Arlene Kaplan. *Psychiatric Times*. IN: *Psychiatric Times* (May 18, 2011) pp. 1-2

[“Children of active-duty military face increased risk of psychiatric hospitalization when a parent is deployed for longer than 6 months, as suggested by new research presented during the American Psychiatric Association (APA) meeting in Hawaii.

At a press conference, lead author Jeffrey Millegan, MD, MPH, a Naval lieutenant commander and a Disaster and Preventive Psychiatry Fellow at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, said that the effects of the war efforts in Iraq and Afghanistan on families have received increasing attention. He believes the study on the relationship of parental military deployment to child psychiatric hospitalizations in the US Armed Forces that he co-authored with Charles Engel, MD, MPH, Michael Dinesen, MD, PhD, and Xian Liu, PhD, “is the first comparative population-based study on this topic.”]

Full text at:

<http://www.psychiatrictimes.com/conference-reports/apa2011/content/article/10168/1863438>

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“Treatment of Department of Veterans Affairs Primary Care Patients with Posttraumatic Stress Disorder.” By Kyle Possemato, VA Healthcare New York and Syracuse University and others. IN: *Psychological Services-Advance online publication*. (April 18 2011) pp. 1-13

[“Posttraumatic stress disorder (PTSD) is common among Veterans Affairs (VA) primary care patients and may be managed via multiple treatment pathways. Using the Behavioral Model of Health Service Use (Anderson, 1995), this retrospective study based on medical chart review examined factors associated with three types of **mental health** treatment: intervention by a 1) primary care provider (PCP), 2) primary care-**mental health** integration (PC-MHI) provider, and 3) specialty **mental health** (SMH) provider. A second goal was to describe PTSD treatment services for patients not receiving SMH by detailing the content of **mental health** treatment provided by PCPs and PC-MHI providers. Electronic medical record data for a five year time period for 133 Veterans were randomly selected for review from a population 6,637 primary care

patients with PTSD. Results indicated that the evaluated needs of participants (i.e., number of unique medical and psychiatric disorders) were associated with **Veterans** receiving more intensive services (i.e., SMH). PCPs commonly addressed patients' **mental health** concerns, but patients often declined referrals for **mental health** treatment. PC-MHI consultations most often focused on medication management and supportive psychotherapy.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=pdh&AN=ser-2011-07956-001&site=ehost-live>

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WORLD HEALTH STATISTICS 2011

World Health Statistics 2011. By the World Health Organization. (The Organization, Geneva, Switzerland) May 2011. 162 p.

[“The World Health Statistics series is WHO’s annual compilation of health-related data for its 193 Member States, and includes a summary of the progress made towards achieving the health-related Millennium Development Goals (MDGs) and associated targets.

As with previous versions, *World Health Statistics 2011* has been compiled using publications and databases produced and maintained by the technical programmes and regional offices of WHO. Indicators have been included on the basis of their relevance to global public health; the availability and quality of the data; and the reliability and comparability of the resulting estimates.”]

Full text at:

http://www.who.int/whosis/whostat/EN_WHS2011_Full.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 SEMINARS

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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