

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



Studies in the News for



California Department of Mental Health

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BULLYING

“Early Risk Factors for Being a Bully, Victim, or Bully/Victim in Late Elementary and Early Secondary Education. The longitudinal TRAILS study.” By Danielle EMC Jansen, University of Groningen, The Netherlands, and others. IN: BMC Public Health, vol. 11, no. 440 (June 6, 2011) pp. 1-22.

“Data regarding the impact of early risk factors on later involvement in bullying are scarce. We investigated the impact of preschool behaviors, family characteristics (socioeconomic status, family breakup) and parental mental health on bullying and victimization at age 11 (T1) and age 13.5 (T2).

Methods: longitudinal data from a subsample of the TRacking Adolescents’ Individual Lives Survey (TRAILS) (T1: N=982; T2: N=977). TRAILS is a prospective study of adolescent mental health in a mixed urban and rural region of the Netherlands. At T1 parents reported on family characteristics, parental mental health and retrospectively on children’s preschool behavior at age 4-5. Schoolmates reported involvement of adolescents in bullying or victimization at T1 and T2.

Results: Children with preschool anxiety were less likely to be bully/victim at T1. Children with preschool aggressiveness were more likely to be bully (T1), bully/victim (T1 and T2) and victim (T2) and children with good preschool motor functioning were more likely to be bully (T1) and less likely to be victim (T1 and T2). Children from low socioeconomic status families were more likely to be bully, victim, or bully/victim and less likely to be uninvolved both at T1 and T2. Finally, children from intact two parent families were more likely to be uninvolved at T2.

Conclusion: Preschool behavioral, emotional and motor problems, socioeconomic status, and family breakup are related to involvement in bullying at a later age. Prevention of bullying and its consequences can be enhanced by focusing on risk groups in early life.

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-2458-11-440.pdf>

CHILDREN AND ADOLESCENTS

“Expanding School Improvement Policy to Better Address Barriers to Learning.” By H.S. Adelman and L. Taylor, UCLA School of Psychology. IN: Policy Futures in Education, vol. 9 (2011) pp. 431-436.

[“Enabling all children to succeed requires a school improvement policy that fully addresses factors that interfere with success at school. How many students are affected differs depending on whether or not a school is serving an economically disadvantaged population. However, almost every school has students who are not doing well. An estimate from the Center for Demographic Policy suggests that 40% of young people are in bad educational shape and therefore will fail to fulfill their promise. The reality for many large urban schools is that well-over 50% of their students manifest significant

behavior, learning, and emotional problems (Center for Mental Health in Schools, 2008a).

For a large proportion of these youngsters, the problems are rooted in the restricted opportunities and difficult living conditions associated with poverty. Almost every current policy discussion stresses the crisis nature of the problem in terms of future health and economic implications for individuals and for society; the consistent call is for major systemic reforms. Figure 1 graphically illustrates the problem and provides a categorization and examples of risk-producing conditions that can interfere with success at school.

The nature and scope of the problem has made this both a civil rights and public health concern. And as the true dropout figures emerge across the nation, the crisis nature of the problem will become even more apparent. Recent reports indicate that more than half a million young people drop out of high school each year, and the rate at which they drop out has remained about the same for the last 30 years (Dynarski, et al., 2008). The data confirm that in far too many school districts a majority of students do not have sufficient supports to enable them to succeed at school and will not graduate.”]

Full text at:

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

“Is this Normal? Assessing Mental Health in Young People.” By Patrick D. McCorry, University of Melbourne, Melbourne, Victoria, and Sherilyn Goldstone, Orygen Youth Health Research Center, Melbourne, Victoria. IN: Australian Family Physician, vol.40, no. 3 (March 2011) pp. 94-97.

[“Mental ill-health is a key health issue facing young Australians today. While the physical health of young people has improved in recent decades, their mental health appears to have worsened. Mental health and substance use disorders now account for over 50% of the burden of disease in the 15–25 years age group, and 75% of mental health disorders that will affect people across the lifespan will have emerged for the first time by the age of 25 years.

Objective

This article provides the general practitioner with key factors in assessing the young person with a mental illness: when to worry and what the early stages of mental illness look like; and provides guidance and tips for effective treatment.

Discussion

Mental ill-health in young people is all too often accepted as a ‘normal’ feature of adolescence. However, the short and long term consequences of mental illness include impaired social functioning, poor educational achievement, substance abuse, self harm, suicide and violence. Distinguishing between what represents transitory and normative changes in behaviour and disturbances that may represent the early signs of the onset of a potentially serious mental illness is difficult, particularly in young people, where emotional disturbance and distress is such a common experience. The primary goal of initial assessment is not to make a definitive diagnosis but rather to assess risk and the

need for clinical care. The GP has an important role to play in longitudinal assessment and ongoing review, and facilitating access to treatment and mobilising support networks.”]

Full text at:

<http://www.racgp.org.au/afp/201103/201103mcgorry.pdf>

“School-wide Positive Behavior Support and Students with Emotional/Behavioral Disorders: Implications for Prevention, Identification, and Intervention.” By Timothy Lewis, University of Missouri, and others. IN: Exceptionality, vol. 18, no. 2 (April-June 2010) pp. 82-93.

[“Special education continues to document the poor within and post-school outcomes among children and youth with Emotional/Behavioral Disorders (EBD). While the poor outcomes are due to a myriad of causes, three issues routinely emerge as problematic in the field. First, the need for early intervention and prevention has been well documented, and yet educators continue to struggle with building effective prevention systems. Second, a clear disconnect exists between the current federal definition of “seriously emotionally disturbed” and the educational focus and intent of the law leading to inconsistencies and under-identification of students and the adoption of a pathology model versus a strength-based educational model. Finally, the field continues to struggle with the implementation and sustained use of evidence-based practices within and across schools and school districts. The purpose of this article is to discuss how School-Wide Positive Behavior Support can assist in addressing the issues related to the prevention, educational identification and effective intervention implementation through its systemic logic, data-based decision making, and capacity building within and across schools. Research to date is reviewed with respect to addressing EBD challenges in school and implications for future research and practice are discussed.” **NOTE: If you cannot access this article, please request an electronic copy from the California State Library.**]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=49233058&site=ehost-live>

COLLABORATIVE CARE

A National Agenda for Research in Collaborative Care: Papers from the Collaborative Care Research Network Research Development Conference. By the Agency for Healthcare Research Quality. (The Agency, Rockville, Maryland) June 2011. 46 p.

[“The ongoing crisis in health care continues to be driven by the twin concerns of cost and quality. Recent healthcare policy changes promote significant system reorganization (e.g., patient centered medical homes and accountable care organizations) aimed at increasing coordination and comprehensiveness of care as a way to both contain cost and

increase quality. Improvements in the coordination between mental health and primary care offer a prominent example of an area of healthcare reorganization that can contribute to both better quality and lower costs. The phenomena and practice of mental health and primary care have been linked inextricably, and a body of research highlights the benefits of integrating mental health into primary care and addresses mental health and physical health simultaneously. However, despite significant positive outcome data on integration, most research on mental health in primary care has been disease specific, using targeted interventions not always indicative of standard clinical practice. Systematic reviews on integrating mental health and primary care have concluded that despite the benefits of integration or the benefits of increased attention to mental health problems in primary care, more research is needed to understand the effects of specific strategies, levels of integration, care processes, or financial models on outcomes. Taking into account these gaps in evidence along with what is already known, this paper reports a research agenda for mental health in primary care created at the Collaborative Care Research Network Research Development Conference in Denver. This manuscript will propose two sets of research questions for the field of integrated mental health and primary care.”]

Full text at:

<http://www.ahrq.gov/research/collaborativecare/collabcare.pdf>

COMMUNITY HEALTH CARE SYSTEMS

“A cross-sectional study of patients with and without substance use disorders in Community Mental Health Centres.” By Linda E. Wusthoff, University of Oslo, Oslo, Norway, and others. IN: BMC Psychiatry, vol. 11, no. 93 (2011) pp. 1-9.

[“Epidemiological studies have consistently established high comorbidity between psychiatric disorders and substance use disorders (SUD). This comorbidity is even more prominent when psychiatric populations are studied. Previous studies have focused on inpatient populations dominated by psychotic disorders, whereas this paper presents findings on patients in Community Mental Health Centres (CMHCs) where affective and anxiety disorders are most prominent. The purpose of this study is to compare patients in CMHCs with and without SUD in regard to differences in socio-demographic characteristics, level of morbidity, prevalence of different diagnostic categories, health services provided and the level of improvement in psychiatric symptoms.

Methods: As part of the evaluation of the National Plan for Mental Health, all patients seen in eight CMHCs during a 4-week period in 2007 were studied (n = 2154). The CMHCs were located in rural and urban areas of Norway. The patients were diagnosed according to the ICD-10 diagnoses and assessed with the Health of the Nation Outcome Scales, the Alcohol Use Scale and the Drug Use Scale.

Results: Patients with SUD in CMHCs are more frequently male, single and living alone, have more severe morbidity, less anxiety and mood disorders, less outpatient treatment and less improvement in regard to recovery from psychological symptoms compared to patients with no SUD.

Conclusion: CMHCs need to implement systematic screening and diagnostic procedures in order to detect the special needs of these patients and improve their treatment.”]

Full text at:

<http://www.biomedcentral.com/content/pdf/1471-244X-11-93.pdf>

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

HOMELESS AND MENTALLY ILL

“Off the Beaten Path: Conducting Ethical Pragmatic Trials with Marginalized Populations.” By Diego S. Silva, University of Toronto, and others. IN: Ethics and Human Research, vol. 33, no. 3 (May –June 2011) pp. 6-11.

[“In October 2009, the Mental Health Commission of Canada (MHCC) began recruiting participants for its At Home/Chez Soi (AHCS) project. The AHCS project is designed as a pragmatic trial intended “to provide policy relevant evidence [i.e., effectiveness data] about what services and system interventions best achieve housing stability and improved health and well-being for those who are homeless and mentally ill.”¹ Explanatory trials (e.g., traditional randomized control trials of a drug) test the efficacy or benefits of a treatment or intervention under ideal conditions with narrowly defined participants (i.e., Can the intervention work?), while pragmatic trials test the effectiveness or benefits of a treatment or intervention under routine clinical or health care delivery conditions with a broader pool of subjects (i.e., Does the intervention work?).² Given the importance of conducting ethically defensible research and abiding by the standards of mental health research ethics, the authors of this paper wrote an internal report about some research ethics challenges that might occur while conducting the AHCS project, paying particular attention to the sensitivity of working with persons who are homeless and mentally ill.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=60962375&site=ehost-live>



“Racial and Ethnic Service Use Disparities Among Homeless Adults with Severe Mental Illnesses Receiving ACT.” By Marcela Horvitz-Lennon, RAND Corporation, and others. IN: Psychiatric Services, vol. 62, no. 6 (June 2011) pp. 598-604.

[“Case management–based interventions aimed at improving quality of care have the potential to narrow racial and ethnic disparities among people with chronic illnesses. The aim of this study was to assess the equity effects of assertive community treatment (ACT), an evidence-based case management intervention, among homeless adults with severe mental illness. *Methods:* This study used baseline, three-, and 12-month data for 6,829 black, Latino, and white adults who received ACT services through the ACCESS study (Access to Community Care and Effective Services and Support). Zero-inflated Poisson random regression models were used to estimate the adjusted probability of use of outpatient psychiatric services and, among service users, the intensity of use. Odds ratios and rate ratios (RRs) were computed to assess disparities at baseline and over time. *Results:* No disparities were found in probability of use at baseline or over time. Compared with white users, baseline intensity of use was lower for black users (RR=.89; 95% confidence interval [CI] =.83–.96) and Latino users (RR=.65; CI=.52–.81]). Intensity did not change over time for whites, but it did for black and Latino users. Intensity increased for blacks between baseline and three months (RR=1.11, CI=1.06–1.17]) and baseline and 12 months (RR=1.17, CI=1.11–1.22]). Intensity of use dropped for Latinos between baseline and three months (RR=.83, CI=.70–.98). *Conclusions:* Receipt of ACT was associated with a reduction in service use disparities for blacks but not for Latinos. Findings suggest that ACT’s equity effects differ depending on race-ethnicity.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/62/6/598>

POLICY



“Use of Electronic Technologies to Promote Community and Personal Health for Individuals Unconnected to Health Care Systems.” By John F. Crilly, University of Rochester Medical Center, and others. IN: American Journal of Public Health, vol. 101, no. 7 (July 2011) pp. 1163-1167.

[“Ensuring health care services for populations outside the mainstream health care system is challenging for all providers. But developing the health care infrastructure to better serve such unconnected individuals is critical to their health care status, to third party payers, to overall cost savings in public health, and to reducing health disparities.

Our increasingly sophisticated electronic technologies offer promising ways to more effectively engage this difficult to reach group and increase its access to health care resources. This process requires developing not only newer technologies but also collaboration between community leaders and health care providers to bring unconnected individuals into formal health care systems. We present three strategies to reach vulnerable groups, outline benefits and challenges, and provide examples of successful programs.”]

Full text at:

<http://ajph.aphapublications.org/cgi/reprint/101/7/1163>

A Portrait of California: California Human Development Report 2011. By Sarah Burd-Sharps and Kristen Lewis, American Human Development Project of the Social Science Research Project. The Measure of America Series. (California Endowment, Santa Monica, California) 2011. 179 p.

[“We in California are accustomed to looking at indicators on unemployment, poverty, income, education, and more to gauge how we are doing as a state. What we urgently need—and what this unique and timely report provides—is a way to make sense of all these data.

A Portrait of California offers a nonpartisan, fact-based look at how ordinary people in communities across our great state are faring. It tells us who in California is thriving, and who is merely surviving—and why. The centerpiece of this work, the American Human Development Index, is a composite measure that summarizes with a single number the key ingredients of well-being and access to opportunity. The Index is based on an international methodology pioneered at the United Nations, used in 160 countries, and viewed as the global gold standard for assessing human well-being.

We in the donor consortium were attracted to the holistic human development approach that underlies this work because it offers a way to understand and address health, education, and living standards in the interconnected way that people actually experience them—rather than as separate issues requiring separate solutions. We believe that this report will thus prove tremendously useful not just to the philanthropic world but also to policy-makers, researchers, advocates, and those who deliver social services.”]

Full text at:

http://www.calendow.org/uploadedFiles/Publications/Publications_Stories/APortraitOfCA.pdf

STIGMA

“Prevalence of Internalized Stigma among Persons with Severe Mental Illness.” By Michelle L. West, John Jay College of Criminal Justice, and others. **IN: Stigma Research and Action, vol. 1, no. 1 (2011) pp. 54-59.**

[“There is evidence that internalized stigma significantly impacts the lives of people with severe mental illness. Nevertheless, there is little data on the prevalence of clinically significant internalized stigma. This study investigated the current prevalence and demographic correlates of significantly elevated levels of internalized stigma in two samples of people with severe mental illness living in the community.

Method: A total of 144 people (79.9% males, 20.1% females) participated, completing a demographic form and the Internalized Stigma of Mental Illness scale.

Results: Overall, 36% of the sample had elevated internalized stigma scores using a cutoff criterion. Participants in the middle of the age distribution had the highest scores, and there was a site difference. No other demographic variables studied were related to overall internalized stigma.

Conclusions: We conclude that internalized stigma affects a relatively high percentage of people with severe mental illness.” **NOTE: If you would like a copy of this article, please request it from the California State Library at csinfo@library.ca.gov. Please reference the Studies in the News for the Department of Mental Health, June 30, 2011 issue. Or go to <http://stigmaj.org/issue/view/1/showToc> for the complete journal: Stigma: Research and Action.**

SUICIDE PREVENTION

“A Conceptual Model of Suicide in Rural Areas.” By C.R. Stark, NHS Highland, Inverness, Scotland, and others. IN: Rural and Remote Health, vol.11, no. 1122 (June 21, 2011) pp. 1-11.

[**“Context:** Suicide is an important public health issue among rural communities although there is no single pattern of suicide in rural areas. Despite this, there are common themes in much of the research evidence on suicide in rural areas. From the published research in the area, a conceptual model of rural suicide has been developed which can be used by clinical and public health services when considering possible routes of intervention.

Issue: A conceptual model can be defined as ‘a type of diagram which shows a set of relationships between factors that are believed to impact or lead to a target condition’. The model presented here uses the ‘Cry of pain/ Entrapment’ model of suicide risk to build a framework of factors which are associated with suicide in rural areas. Cross setting factors associated with suicide rates include gender, poverty, mental illness, substance use, biological factors including apparent genetic risk, coping skills and media coverage of suicide. There are, however, other factors that appear to have particular importance in rural areas. These include rural stressors, such as isolation and political and social exclusion; factors affecting support, including social support, cultural norms on help-seeking, stigma associated with mental illness service availability; factors affecting the decision to self-harm, including modeling and cultural views on self-harm, and issues affecting the likelihood of self-harm resulting in death, including method availability, norms on methods of self-harm and treatment availability after harm occurs. Identifying which of these areas are the greatest local priorities helps to target activity.”]

Full text at:

http://www.rrh.org.au/publishedarticles/article_print_1622.pdf

VETERANS

For Soldiers with PTSD, A Daily Struggle By National Public Radio. IN: Talk of the Nation. (June 27, 2011) pp 1-3.

[“According to the Department of Veterans Affairs, 10 to 18 percent of Iraq and Afghanistan war veterans may have post-traumatic stress disorder, or PTSD. The sleeplessness, anger, anxiety and sense of isolation that can accompany the disorder pose tremendous challenges for veterans and their families, and there's an enduring stigma around mental health care that still discourages many from seeking help.”]

Full text at:

<http://www.npr.org/2011/06/02/136895807/the-profound-daily-struggle-of-soldiers-with-ptsd>

“How to Get Mental Health Care Right for Today’s Veterans.” By Charles Marmar, NYU Lagone Medical Center. IN: The Huffington Post (April 16, 2011) pp. 1-2.

[“Observations of combat-related stress disorders appear as early as the writings of Homer in descriptions of returning Trojan war veterans. During the Civil War, PTSD was characterized as soldier’s heart, in World War I it was shell shock, in World War II it was battle fatigue and during the Vietnam War it was Vietnam Syndrome. With the 1980 inclusion of Post-traumatic Stress Disorder (PTSD) in the "American Psychiatric Association Diagnostic and Statistical Manual," PTSD has been officially designated as one of the anxiety disorders....

The lifetime risk for PTSD in the general American population has been estimated to be 7.8 percent (1). The best estimate of the rates of PTSD in combat has been derived from the National Vietnam Veterans Readjustment Study (NVVRS) (2, 3). The NVVRS found that 20 percent of those who served in the Vietnam War developed deployment-related PTSD, with those suffering from PTSD having increased rates of depression, alcohol and drug abuse, family adjustment problems and interpersonal violence....

The U.S. invaded Afghanistan on October 7, 2001 and Iraq on March 20, 2003. To date, more than 1.6 million men and women have served in Afghanistan and Iraq. Milliken and colleagues (4) conducted a longitudinal study of 88,235 soldiers returning from Iraq. Screening was conducted immediately following return from the warzone and again three to six months later. Based on combined screening, 20.3 percent of active-duty and 42.4 percent of reservists screened positive for mental health disorders....

Between April 2002 and March 2008, data was reported on 289,328 Iraq and Afghanistan veterans using VA healthcare for the first time; 36.9 percent received one or more mental health diagnoses; 21.8 percent received a diagnosis of PTSD; 17.4 percent a diagnosis of depression, 7 percent for alcohol use disorder and 3 percent for substance abuse disorder.”]

Full text at:

http://www.huffingtonpost.com/charles-r-marmar-md/veterans-ptsd_b_849766.html



Mental Health Screening and Coordination of Care for Soldiers Deployed to Iraq and Afghanistan. By Madelyn Hsiao-Rei Hicks, King's College London. IN: American Journal of Psychiatry, vol. 168 (April 2011) pp. 341-343.

[“Mental health screening of soldiers prior to deployment to a theater of war was first attempted by the U.S. Army in World War I in the hope of avoiding the high rates of psychiatric casualties observed in British and French troops, but it did not prevent extensive disability from shell shock in American World War I veterans (1). In World War II, the U.S. military carried out mass neuropsychiatric screening with the aim of identifying individuals who might be psychologically vulnerable to later psychiatric breakdown in the combat environment because of, for example, neuroses or minor personality defects (1). In World War II, as in later wars, predeployment screening to predict the development of future mental disorders was a failure for a variety of reasons, including imprecise screening methods and instruments, poor interrater reliability, high false positive rates, low thresholds for caseness that did not discern significant severity, and low predictive power.”

Full text at:

<http://ajp.psychiatryonline.org/cgi/content/full/168/4/341>

Promoting Psychological Resilience in the U.S. Military. By Lisa S. Meredith and others, RAND Corporation. (The Corporation, Santa Monica, California) 2011. 186 p.

[“The operational tempo associated with the conflicts in Iraq and Afghanistan creates a number of challenges for service members and their families. Service members have been deploying for extended periods on a repeated basis, which, combined with the other consequences of combat, may challenge their and their families’ ability to cope with the stress of deployment. While most military personnel and their families cope well under these difficult circumstances, many will also experience difficulties handling stress at some point.

There are, however, a growing number of programs and strategies provided by the military and civilian sectors to encourage and support psychological resilience to stress for service members and families. Psychological resilience is defined as the capacity to adapt successfully in the presence of risk and adversity. Previous research from the field of psychology delineating the factors that foster psychological resilience is available, but we do not know whether and how well the current military resilience programs are addressing these factors in their activities. Further, there is little known about the effectiveness of these programs on developing resilience.

To assist the Department of Defense (DoD) in understanding methodologies that could be useful in promoting resilience among service members and their families, the RAND National Defense Research Institute (RAND NDRI) conducted a focused literature review to identify factors that were supported by the literature (e.g., evidence informed) for promoting psychological resilience. The study also included a review of a subset of

resilience programs to determine the extent to which they included those evidence-informed factors. This monograph describes the context, approach, and findings from these research activities. It will be of interest to researchers and policymakers in the military community concerned with programming to promote health and prevent negative consequences of war on the nation's service members and their families.”]

Full text at:

http://www.rand.org/content/dam/rand/pubs/monographs/2011/RAND_MG996.pdf

“Virtual Reality Goes to War: A Brief Review of the Future of Military Behavioral Healthcare.” By Albert Rizzo, University of Southern California, and others. IN: Journal of Clinical Psychology in Medical Settings, vol. 18, no. 2 (2011) pp. 176-187.

[“Numerous reports indicate that the incidence of posttraumatic stress disorder (PTSD) in returning OEF/OIF military personnel is creating a significant healthcare challenge. These findings have served to motivate research on how to better develop and disseminate evidence-based treatments for PTSD. Virtual Reality delivered exposure therapy for PTSD has been previously used with reports of positive outcomes. This article details how virtual reality applications are being designed and implemented across various points in the military deployment cycle to prevent, identify and treat combat-related PTSD in OIF/OEF Service Members and Veterans. The summarized projects in these areas have been developed at the University of Southern California Institute for Creative Technologies, a U.S. Army University Affiliated Research Center, and this paper will detail efforts to use virtual reality to deliver exposure therapy, assess PTSD and cognitive function and provide stress resilience training prior to deployment.”]

Full text at:

<http://www.springerlink.com/content/03533254r5q65p86/fulltext.pdf>

WORLD REPORT ON DISABILITY

World Report on Disability. By the World Health Organization. (The Organization, Geneva, Switzerland) 2011. 349 p.

[“More than one billion people in the world live with some form of disability, of whom nearly 200 million experience considerable difficulties in functioning. In the years ahead, disability will be an even greater concern because its prevalence is on the rise. This is due to ageing populations and the higher risk of disability in older people as well as the global increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders.

Across the world, people with disabilities have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities. This is partly because people with disabilities experience barriers in

accessing services that many of us have long taken for granted, including health, education, employment, and transport as well as information. These difficulties are exacerbated in less advantaged communities.

To achieve the long-lasting, vastly better development prospects that lie at the heart of the 2015 Millennium Development Goals and beyond, we must empower people living with disabilities and remove the barriers which prevent them participating in their communities; getting a quality education, finding decent work, and having their voices heard.

As a result, the World Health Organization and the World Bank Group have jointly produced this *World Report on Disability* to provide the evidence for innovative policies and programmes that can improve the lives of people with disabilities, and facilitate implementation of the United Nations Convention on the Rights of Persons with Disabilities, which came into force in May 2008. This landmark international treaty reinforced our understanding of disability as a human rights and development priority.”]

Full text at:

http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf

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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