

**Subject:** Studies in the News: (January 15, 2010)

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## Studies in the News for



## California Department of Mental Health

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## CHILDREN AND ADOLESCENTS

**“Containing Costs and Improving Care for Children in Medicaid and CHIP.” By Genevieve M. Kenny, Urban Institute, Washington, D.C., and others. IN: Health Affairs, vol. 28, no. 6 (published online September 2009) pp.w1025-w1036.**

[“The current health reform debate is greatly concerned with “bending the curve” of cost growth and containing costs, particularly in public programs. Our research demonstrates that spending in Medicaid and the Children’s Health Insurance Program (CHIP) is highly concentrated, particularly among children with chronic health problems. Ten percent of enrollees (two-thirds of whom have a chronic condition) account for 72 percent of the spending; 30 percent of enrolled children receive little or no care. These results highlight the importance of cost containment strategies that reduce avoidable hospitalizations among children with chronic problems and policies that increase preventive care, particularly among African American children.”] **NOTE: Please contact the California State Library for a copy of this article.**

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**“If at First You Don’t Succeed...Keep Trying: Strategies to Enhance Coalition/School Partnerships to Implement School-Based Prevention Programming.” By Abigail A. Fagan, University of South Carolina, and others. IN: Australian & New Zealand Journal of Criminology, vol. 42, no. 3 (December 2009) pp. 387-405.**

[“Community-based coalitions have been advocated as a promising mechanism to reduce youth involvement in violence, delinquency, and substance use, but coalitions have not always been successful in ensuring widespread adoption of evidence-based prevention strategies. This article describes the strategies used by 12 community coalitions to collaborate with schools to select and implement school-based prevention programs; it includes the barriers to establishing coalition/school partnerships and methods for overcoming these challenges. In this 5-year research project, all communities adopted school-based prevention programs. Coalitions helped achieve this outcome by building relationships with school personnel, fostering champions within the school, creating win/win situations in which schools’ needs were addressed, and initiating school-based prevention programs as pilot efforts that were later expanded. While success was achieved in all cases, persistent messaging about the importance of youth problem behaviours was needed to overcome schools’ concerns about using academic time to teach prevention messages and replacing current practices with unfamiliar programs. Findings from this study can be used by coalitions and prevention scientists that want to partner with schools to reach a large population of students with effective prevention programming. The results are also of value to researchers and practitioners interested in fostering widespread dissemination of other types of evidence-based programs.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45390046&site=ehost-live>

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**Prop 63 Money Keeps Youths out of Jail, Homelessness. By Lora Hines, Press Enterprise, Riverside County. (December 24, 2009) 1 p.**

Riverside County has experienced a drop in arrests and school suspensions for participants in a counseling program for at-risk youths. The effort is funded by Proposition 63, a 2004 state income tax increase for high-income Californians earmarked for mental health services.

Full text at:

[http://www.pe.com/localnews/inland/stories/PE\\_News\\_Local\\_S\\_mental25.3992307.html](http://www.pe.com/localnews/inland/stories/PE_News_Local_S_mental25.3992307.html)

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**“Research Priorities for Mental Health Counseling with Youth: Implications for Counselor Preparation, Professional Development and Research.” By Elizabeth A. Mellin, Pennsylvania State University, and Terry L. Pertuit, Southeastern Louisiana University. IN: Counselor Education & Supervision, vol. 49, no. 2 (December 2009) pp. 137-155.**

[“Counselors encounter the needs of youth (3-17 years) in a variety of settings: however, outside of school counseling, the profession faces a lack of preparation, professional development, and research focused on *mental health* practice with youth. Using the Delphi method, 12 counselor educators and 15 practicing counselors were polled regarding research priorities for *mental health* counseling with youth. Research that considers how varying developmental stages and systems (e.g., families, schools, communities) affect the *mental health* of youth was identified as a priority. Implications for counselor preparation, professional development, and research are offered on the basis of these results.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47116239&site=ehost-live>

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## HEALTH CARE REFORM

**“Implementation and Enforcement of Health Care Reform-Federal versus State Government.” By Timothy S. Jost, Washington and Lee University School of Law. IN: The New England Journal of Medicine, Online Only (December 30, 2009) 3 p.**

[“Health care reform lurches forward. The House and Senate have both passed reform bills. How well reform works in practice, however, will depend on one key difference between the two bills that has received far too little attention — how their provisions will be implemented and enforced.

The essential frameworks of the House and Senate bills are quite similar: both include health insurance and underwriting reforms, insurance exchanges, and subsidies to make insurance affordable, individual mandates, and penalties for large employers who fail to insure their employees. Yet their approaches to oversight and enforcement, and in particular to the respective roles of the federal and state governments, differ substantially. As we look back a decade from now, whether we see the vast majority of Americans benefiting from ready access to uniformly fair and affordable health insurance or a national patchwork, with some states ensuring access to affordable health insurance for most residents while other states leave many uncovered, will depend largely on whether the final legislation is closer to the House or the Senate approach.”]

Full text at:

<http://content.nejm.org/cgi/reprint/NEJMp0911636.pdf?ssource=hcrc>

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## MENTAL HEALTH CRISES

**Practice Guidelines: Core Elements for Responding to Mental Health Crises. By Robert Bernstein, Bazelon Center for Mental Health Law. (Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Rockville, Maryland) 2009. 25 p.**

[“Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization.

- Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises. The statistics below paint a sobering picture of how crises affect the lives of people who have mental or emotional disabilities: From one third to one half of homeless people have severe psychiatric disorders.
- Approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness. The likelihood of mental illness among people confined in state prisons and local jails is three to four times higher than in the general population and, compared with other inmates; it is *at least twice as likely* that these individuals will be injured during their incarceration.
- About 6 percent of all hospital emergency department visits reflect mental health emergencies. Due to a lack of available alternatives, 79 percent of hospital

- emergency departments report having to “board” psychiatric patients who are in crisis and in need of inpatient care, sometimes for *eight hours or longer*.
- Almost one in 10 individuals discharged from a state psychiatric hospital will be readmitted within 30 days; more than one in five will be readmitted within 180 days.
  - About 90 percent of adult inpatients in state psychiatric hospitals report histories of trauma. About three quarters of youth in the juvenile justice system report mental health problems and one in five has a serious mental disorder.
  - Mothers with serious mental illnesses are *more than four times as likely* as other mothers to lose custody of their children. People with serious mental illnesses die, on average, *25 years earlier* than the general population.

These statistics are incomplete; they reflect just a sampling of scenarios that, while commonplace, constitute significant life crises for individuals with serious mental illnesses.”]

Full text at:

<http://download.ncadi.samhsa.gov/ken/pdf/SMA09-4427.pdf>

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**“Researching Mental Health Needs of Hard-to-Reach Groups: Managing Multiple Sources of Evidence.” By Christopher Dowrick, University of Liverpool, and others. IN: BMC Health Services Research, vol. 9, no. 226 (December 2009) pp. 1-10.**

[“Common mental health problems impose substantial challenges to patients, carers, and health care systems. A range of interventions have demonstrable efficacy in improving the lives of people experiencing such problems. However many people are disadvantaged, either because they are unable to access primary care, or because access does not lead to adequate help. New methods are needed to understand the problems of access and generate solutions. In this paper we describe our methodological approach to managing multiple and diverse sources of evidence, within a research programme to increase equity of access to high quality mental health services in primary care.

#### **Methods**

We began with a scoping review to identify the range and extent of relevant published material, and establish key concepts related to access. We then devised a strategy to collect - in parallel - evidence from six separate sources: a systematic review of published quantitative data on access-related studies; a meta-synthesis of published qualitative data on patient perspectives; dialogues with local stakeholders; a review of grey literature from statutory and voluntary service providers; secondary analysis of patient transcripts from previous qualitative studies; and primary data from interviews with service users and carers.

We synthesised the findings from these diverse sources, made judgments on key emerging issues in relation to needs and services, and proposed a range of potential interventions. These proposals were debated and refined using iterative electronic and focus group consultation procedures involving international experts, local stakeholders and service users.

## Conclusions

Our methods break new ground by generating and synthesising multiple sources of evidence, connecting scientific understanding with the perspectives of users, in order to develop innovative ways to meet the mental health needs of under-served groups.”]

Full text at:

<http://www.biomedcentral.com/1472-6963/9/226>

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## MENTAL HEALTH PARITY

**“Implementation of Mental Health Parity: Lessons from California.” By Margo L. Rosenbach, Mathematica Policy Research, and others. IN: Psychiatric Services, vol. 60, no. 12 (November-December 2009) pp. 1589-1594.**

[“This article reports the experiences of health plans, providers, and consumers with California’s mental health parity law and discusses implications for implementation of the 2008 federal parity law. *Methods:* This study used a multimodal data collection approach to assess the first five years of California’s parity implementation (from 2000 to 2005). Telephone interviews were conducted with 68 state-level stakeholders, and in-person interviews were conducted with 77 community-based stakeholders. Six focus groups included 52 providers, and six included 32 consumers. A semi structured interview protocol was used. Interview notes and transcripts were coded to facilitate analysis.

*Results:* Health plans eliminated differential benefit limits and cost-sharing requirements for certain mental disorders to comply with the law, and they used managed care to control costs. In response to concerns about access to and quality of care, the state expanded oversight of health plans, issuing access-to-care regulations and conducting focused studies. California’s parity law applied to a limited list of psychiatric diagnoses. Health plan executives said they spent considerable resources clarifying which diagnoses were covered at parity levels and concluded that the limited diagnosis list was unnecessary with managed care. Providers indicated that the diagnosis list had unintended consequences, including incentives to assign a more severe diagnosis that would be covered at parity levels, rather than a less severe diagnosis that would not be covered at such levels. The lack of consumer knowledge about parity was widely acknowledged, and consumers in the focus groups requested additional information about parity.

*Conclusions:* Experiences in California suggest that implementation of the 2008 federal parity law should include monitoring health plan performance related to access and quality, in addition to monitoring coverage and costs; examining the breadth of diagnoses covered by health plans; and mounting a campaign to educate consumers about their insurance benefits.”]

Full text at:

**Successful Employer Implementation of the Federal Mental Health Parity and Addiction Equity Act. By Mark Attridge, Attridge Consulting. Vol. 1, No. 3. (Partnership for Workplace Mental Health, Arlington, Virginia) December 2009. 30 p.**

[“Our third issue of *Research Works*, the Partnership’s research briefs series, is designed to help employers with the implementation of the new mental health and substance use disorder parity law. The parity law’s passage requires material changes to most health plan benefit design. Concern has been expressed about the potential for increased costs resulting from the new requirements. However, research indicates that these changes should not result in material cost increases and that any increases will be more than offset by net gains from reductions in overall health and disability costs and improved worker productivity - especially if benefits and services are well designed.

The brief highlights case examples from companies such as Weingarten Realty Investors, Houston Chronicle, JPMorgan Chase and DuPont.”]

Full text at:

<http://www.workplacementalhealth.org/pdf/RWParityFinal.pdf>

## MINORITIES

**“Generational Status and Family Cohesion Effects on the Receipt of Mental Health Services among Asian Americans: Findings from the National Latino and Asian American Study.” By Van M. Ta, University of Hawai’i at Manoa, and others. IN: *American Journal of Public Health*, vol. 100, no. 1 (January 2010) pp. 115-121.**

[“*Objectives.* We investigated the relative strengths of generational status and family cohesion effects on current use of mental health services (past 12 months) among Asian Americans.

*Methods.* We conducted a secondary data analysis with data from the National Latino and Asian American Study, 2002 to 2003, restricted to Asian American respondents (n = 2087). The study's outcome was current use (past 12 months) of any mental health services. Respondents included Chinese, Filipino, Vietnamese, and other Asian Americans.

*Results.* Multivariate analyses suggest no significant interaction exists between second- versus first-generation Asian Americans and family cohesion. The impact of generational status on mental health service use was significant for third- or later-generation Asian

Americans (versus first-generation Asian Americans) and varied with family cohesion score.

*Conclusions.* Family cohesion and generational status both affect the likelihood of Asian Americans to seek mental health services. Our findings also highlight the need for primary care and other providers to consistently screen for mental health status particularly among first-generation Asian Americans. Mental health service programs should target recent immigrants and individuals lacking a strong family support system.”]

**NOTE: Please contact the California State Library for a copy of this article.**

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## PRIVATE HEALTH INSURANCE

**“Does Private Insurance Adequately Protect Families of Children with Mental Health Disorders?”** By Susan H. Busch and Colleen L. Barry, Yale School of Public Health, Yale School of Medicine. IN: *Pediatrics*, vol. 124, supplement 4 (December 2009) pp. S399-S406.

[“Although private insurance typically covers many health care costs, the challenges faced by families who care for a sick child are substantial. These challenges may be more severe for children with special health care needs (CSHCN) with mental illnesses than for other CSHCN. Our objective was to determine if families of privately insured children who need mental health care face different burdens than other families in caring for their children.

**PATIENTS AND METHODS:** We used the 2005–2006 National Survey of Children With Special Health Care Needs (NS-CSHCN) to study privately insured children aged 6 to 17 years. We compared CSHCN with mental health care needs ( $N = 4918$ ) to 3 groups: children with no special health care needs ( $n = 2346$ ); CSHCN with no mental health care needs ( $n = 1625$ ); and CSHCN with no mental health care need but a need for other specialty services ( $n = 7902$ ). The latter group was a subset of CSHCN with no mental health care need. We used weighted logistic regression and study outcomes across 4 domains: financial burden; health plan experiences; labor-market and time effects; and parent experience with services.

**RESULTS:** We found that families of children with mental health care needs face significantly greater financial barriers, have more negative health plan experiences, and are more likely to reduce their labor market participation to care for their child than other families.

**CONCLUSIONS:** Families of privately insured CSHCN who need mental health care face a higher burden than other families in caring for their children. Policies are needed to help these families obtain affordable, high-quality care for their children.”]

Full text at:

[http://pediatrics.aappublications.org/cgi/reprint/124/Supplement\\_4/S399](http://pediatrics.aappublications.org/cgi/reprint/124/Supplement_4/S399)

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## TRAUMATIC BRAIN INJURY

**"Impact of Falls on Early Mortality from Severe Brain Injury." By Linda M. Gerber, Weill Cornell Medical College, and others. IN: Journal of Trauma Management & Outcomes, vol. 3, no. 9 (July, 2009) pp. 1-8.**

["Background: The causes of severe traumatic brain injury (TBI) vary by age and other demographic characteristics. Mortality after trauma is higher for elderly than younger patients. This study is based on 2779 patients with severe TBI treated at 24 trauma centers enrolled in a New York State quality improvement program. The prospectively collected database includes information on age, sex, mechanism of injury, initial Glasgow Coma Scale score, blood pressure, papillary assessment, and CT scan findings. This multi-center study was conducted to explore the impact of falls on early mortality from severe TBI among the elderly. Results: After exclusion criteria were applied, a total of 2162 patients were eligible for analysis. Falls contributed to 21% of all severe TBI, 12% occurring from > 3 meters and 9% from < 3 meters. Two-week mortality ranged from 18% due to injuries other than falls to 31% due to falls from < 3 meters ( $p < 0.0001$ ).

Mortality after a severe TBI is much greater among older people, reaching 58% for people 65 years and older sustaining a fall from < 3 meters. Conclusion: Among those 65 and older, falls contributed to 61% of all injuries and resulted in especially high mortality among individuals experiencing low falls. Preventive efforts directed toward older people to avoid falls from < 3 meters could have a significant impact on mortality."]

Full Text at:

<http://www.traumamanagement.org/content/pdf/1752-2897-3-9.pdf>

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**"Intellectual Outcome from Preschool Traumatic Brain Injury: A Five-Year Prospective, Longitudinal Study." By Vicki Anderson, Murdoch Children's Research Institute, Melbourne, Australia, and others. IN: Pediatrics, vol. 124, no. 6 (Published online December 2009) pp. e1064-e1071.**

["**INTRODUCTION:** Traumatic brain injury (TBI) is a common, acquired disability that may be used as a model to understand the impact of early brain injury on brain structure and function. To date, few studies have followed very young children over time after insult.

**OBJECTIVE:** To plot recovery and outcome of intellectual ability after early TBI over the 5 years after injury, and to identify predictors of outcome including injury, sociodemographic and preinjury characteristics, and acute functional recovery.

**DESIGN:** Children aged between 2 and 7 years who were diagnosed with TBI ( $N = 54$ ) were consecutively recruited on admission to the Royal Children's Hospital, Victoria, Australia, to participate in a prospective, longitudinal study. Our study had a between-factor design that used injury severity as the independent variable. The participants were categorized into groups according to injury severity (mild, moderate, or severe), and were compared with healthy control participants ( $n = 16$ ) at the acute time point, and at 12

months, 30 months, and 5 years after injury. Intellectual measures, including verbal and nonverbal skills, attention, and processing speed, were administered.

**RESULTS:** Children with severe injuries demonstrated slower recovery and poorer cognitive outcomes up to 5 years after injury than did those who were observed for less severe injuries. Recovery trajectories were associated with injury severity over the first 30 months after injury, with the greatest deterioration in function observed for more severe injuries. From 30 months to 5 years after injury, progress was stable. Only injury severity (as determined by the Glasgow Coma Scale score) and acute cognitive performance were strong predictors of 5-year outcomes.

**CONCLUSIONS:** This study has confirmed the high risk of persisting and global deficits associated with severe brain insult in early childhood. Contrary to previous speculation about "growing into deficits," children with severe brain insults have more protracted recovery periods but do not continue to lose ground compared with their peers. By 30 months after insult, recovery seems to stabilize and children begin to make appropriate developmental gains.”] **NOTE: Please contact the California State Library for a copy of this article.**

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**“Traumatic Brain Injury.” By Jay Menaker, University of Maryland, and others. IN: Trauma Reports, vol. 10, no. 6 (Nov/Dec 2009) pp. 1-12.**

[“The article offers information on the clinical presentation and management of patients with *traumatic brain injury* (TBI). TBI is considered the leading cause of mortality in the U.S. The Centers for Disease Control and Prevention estimates that nearly 5.3 million people in the U.S. experience the long-term or life-long disabilities associated with TBI. The path physiology of TBI is explained, along with its clinical classification and diagnostic approaches.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45617289&site=ehost-live>

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## SUICIDE PREVENTION

**“Associations between Lifestyle Factors, Working Environment, Depressive Symptoms and Suicidal Ideation: A Large-Scale Study in Japan.” By Misato Takada, Mie University, Mie, Japan, and others. IN: Industrial Health, vol. 47 (2009) pp. 649-655.**

[“To improve the management of depression and the prevention of suicide, we investigated associations between lifestyle, working environment, depressive symptoms and suicidal ideation. Variables measured included job stressors, working hours, overtime work, smoking status, alcohol consumption, sleep, exercise, meals, and family factors. Original items were used to measure working on holidays, number of confidants, use of

stress reduction techniques, and suicidal ideation. A total of 4,118 employees (2,834 men, 1,284 women) in eleven cities and districts across Japan were analyzed. On stepwise multivariate logistic regression analysis, variables associated with depressive symptoms were exposure to high job stress, problem drinking, a feeling of insufficient sleep, absence of confidants, and no use of stress reduction techniques in both sexes. Further, problem drinking and absence of confidants were associated with suicidal ideation in both sexes. The prevalence of workers who had no confidants and who did not use stress reduction techniques was unexpectedly high. Given their clear association with depressive symptoms, greater attention to these factors should improve measures aimed at the prevention of suicide.”]

Full text at:

<http://www.jstage.jst.go.jp/article/indhealth/47/6/649/pdf>

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**“Optimizing Suicide Prevention Programs and their Implementation in Europe (OSPI Europe): An Evidence-Based Multi-Level Approach. By Ulrich Hegerl, University of Leipzig, and others. IN: BMC Public Health, vol. 9, no. 428 (November 2009) pp. 1-10.**

[“Suicide and non-fatal suicidal behaviour are significant public health issues in Europe requiring effective preventive interventions. However, the evidence for effective preventive strategies is scarce. The protocol of a European research project to develop an optimized evidence based program for suicide prevention is presented.

#### **Method**

The groundwork for this research has been established by a regional community based intervention for suicide prevention that focuses on improving awareness and care for depression performed within the European Alliance Against Depression (EAAD). The EAAD intervention consists of (1) training sessions and practice support for primary care physicians,(2) public relations activities and mass media campaigns, (3) training sessions for community facilitators who serve as gatekeepers for depressed and suicidal persons in the community and treatment and (4) outreach and support for high risk and self-help groups (e.g. helplines). The intervention has been shown to be effective in reducing suicidal behaviour in an earlier study, the Nuremberg Alliance Against Depression. In the context of the current research project described in this paper (OSPI-Europe) the EAAD model is enhanced by other evidence based interventions and implemented simultaneously and in standardised way in four regions in Ireland, Portugal, Hungary and Germany.

The enhanced intervention will be evaluated using a prospective controlled design with the primary outcomes being composite suicidal acts (fatal and non-fatal), and with intermediate outcomes being the effect of training programs, changes in public attitudes, guideline-consistent media reporting. In addition an analysis of the economic costs and consequences will be undertaken, while a process evaluation will monitor implementation of the interventions within the different regions with varying organisational and healthcare contexts.

## Discussion

This multi-centre research seeks to overcome major challenges of field research in suicide prevention. It pools data from four European regions, considerably increasing the study sample, which will be close to one million. In addition, the study will gather important information concerning the potential to transfer this multilevel program to other health care systems. The results of this research will provide a basis for developing an evidence-based, efficient concept for suicide prevention for EU-member states.”]

Full text at:

<http://www.biomedcentral.com/1471-2458/9/428>

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## CONFERENCES, MEETINGS, WEBINARS

### **CALIFORNIA WORKING FAMILIES POLICY SUMMIT Special Presentation from Labor Secretary Hilda Solis and a Video Message to Working Families from First Lady Michelle Obama**

February 25, 2010  
Sacramento Convention Center  
Sacramento California

Registration available on January 15, 2010 at:

[www.ccrwf.org](http://www.ccrwf.org)

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### **REQUEST FOR PROPOSALS: 15TH ANNUAL CONFERENCE ON ADVANCING SCHOOL MENTAL HEALTH**

Proposals are now being accepted for the 15th Annual Conference on Advancing School Mental Health to be held **October 7-9, 2010** at the *Hyatt Regency Albuquerque, Albuquerque, New Mexico*. The Conference is sponsored by the Center for School Mental Health (CSMH) and the IDEA Partnership (funded by the Office of Special Education Programs (OSEP), sponsored by the National Association of State Directors of Special Education). The theme of this year’s conference is School Mental Health and Promoting Positive School Culture. The conference features twelve specialty tracks plus a specialty strand on School Mental Health for Culturally Diverse Youth and offers numerous opportunities to network and advance knowledge and skills related to school mental health practice, research, training, and policy.

The deadline for submissions is **February 6, 2010**--all proposals must be submitted online, <http://csmh.umaryland.edu>.

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**Breaking the Silence: Empowering School Counselors & and Lesbian Gay Bi-Sexual Transgender Queer/Questioning & Intersex (LGBTQI) Youth. Center for Excellence in School Counseling and Leadership**

February 5-7, 2010  
San Diego, California

For more information and registration:

<http://www.cescal.org/documents/SaveTheDateLGBTQI-2.pdf>

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**23rd Annual Children's Mental Health Research and Policy Conference**

March 7-10, 2010  
Tampa, Florida

For more information:

<http://rtckids.fmhi.usf.edu/cmhconference/>

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