

**Subject:** Studies in the News: (June 10, 2009)

---



## Studies in the News for



## California Department of Mental Health

---

### Introduction to Studies in the News

Studies in the News (SITN): California Department of Mental is a service provided to the Department of Mental Health by the California State Library. This service features articles focusing on mental health issues. Prior lists can be viewed from the California State Library's Web site at [California State Library - Studies in the News](#)

.

### How to Obtain Materials Listed in SITN:

- When available on the Internet, the URL for the full-text of each item is provided.
- **California State Employees** may contact the Information Resources and Government Publications (916-654-0206; csinfo@library.ca.gov) with the SITN issue date and title of article.
- All other interested individuals should contact their local library-the items may be available there, or may be borrowed by your local library on your behalf.

## **SUBJECT HEADINGS IN THIS ISSUE**

### **CHILDREN AND ADOLESCENTS**

[Improving early childhood mental health services in California](#)

### **DEPRESSION**

[Antidepressant use among Latinos](#)

[Major depressive episodes among adults](#)

[Persistent maternal depression throughout the early years of childhood](#)

### **EMPLOYMENT**

[Prevailing barriers to competitive work](#)

### **HAPPINESS**

[Declining female happiness](#)

[What makes us happy?](#)

### **HEALTH CARE**

[Measuring trends in racial/ethnic health care disparities](#)

[Primary care providers' role in mental health](#)

### **HOMELESSNESS**

[Meeting the needs of LGBTQ homeless youth](#)

### **MENTAL HEALTH WORKFORCE**

[Mental health training for correctional officers](#)

[Restructuring California's mental health workforce](#)

### **STIGMA**

[Self-stigma and mental illness](#)

["Mad" pride](#)

[Stigma and barriers to care in soldiers postcombat](#)

### **VIOLENCE**

[Schizophrenia, substance abuse, and violent crime](#)

### **NEW CONVENTIONS**

## CHILDREN AND ADOLESCENTS

### **Recommendations for Counties on Improving and Expanding Infant/Early Childhood Mental Health Services. By Carla Denner. (Mental Health Association of California, Sacramento, California) January 2009. 16 p.**

[“Infant/ Early Childhood Mental Health, with its focus on children ages birth to five years and their families, should be a priority area of funding under the Mental Health Services Act (MHSA). An investment in infant/early childhood mental health services will not only help vulnerable children but also will save money by preventing mental health issues later in life, decreasing the need for more costly mental health, social service and criminal justice programs later in the child’s life. “Increasing services for children under the age of five would reduce the number of school age children requiring mental health services for serious disorders.” (Zero to Three, 2007)

Currently, there are a patchwork of programs that target key mental health needs for infants and toddlers. In fact, many young children in California in need of mental health treatment never receive it. This report summarizes essential elements for counties to improve mental health service delivery for their youngest children.

In brief, the recommendations of this report are as follows:

*Awareness/Promotion:* Train professionals who work with young children on social emotional development and early relationships and create a county wide public awareness campaign that educates professionals and parents on the importance of supporting social emotional development and intervening early with children and families at risk for mental health difficulties.

*Screening:* Implement a universal screening system to screen children ages birth to five years who are at risk for mental health difficulties. Develop a system for screening pregnant women and new mothers identified through physicians and family support agencies for prenatal and postpartum depression.

*Funding:* Generate funding sources for promotion, prevention and treatment. Train professionals in the use of the DC 0-3R for diagnostic and treatment planning purposes and use the crosswalk to the DSM IV in order to bill for services. Combine funding sources in order to treat children and families who do not reach the level of medical necessity.

*Treatment:* Utilize evidence based and promising practices that focus on improving the parent/child relationship and building a parental support system while enhancing parental mental health.

*Service System Development and Coordination:* Collaborate with other Early Childhood Agencies such as Early Start, Child Welfare, and Head Start to coordinate resources and incorporate mental health into all Early Childhood systems.”]

Full text at:

<http://www.mhac.org/pdf/infant%20ec%20mh%20paper%20full%20document1.pdf>

[\[Back to Top\]](#)

## DEPRESSION

**“Antidepressant Use in a Nationally Representative Sample of Community-dwelling U.S. Latinos with and without Depressive and Anxiety Disorders.”** By H.M. Gonzalez, Institute of Gerontology, Wayne State University, and others. (The University, Detroit, Michigan) IN: *Depression and Anxiety*. Epublished ahead of print (March 20, 2009)

[“*Background:* Antidepressant drugs are among the most widely prescribed drugs in the United States; however, little is known about their use among major ethnic minority groups. *Method:* Collaborative Psychiatric Epidemiology Surveys (CPES) data were analyzed to calculate nationally representative estimates of Latino and non-Latino White adults antidepressant use. *Setting:* The 48 coterminous United States was the setting. *Participants:* Household residents aged 18 years and older (N=9,250). *Main outcome:* Past year antidepressant use. *Results:* Compared to non-Latino Whites, few Latinos, primarily Mexican Americans, with 12-month depressive and/or anxiety disorders reported past year antidepressant use. Mexican Americans (OR=0.48; 95% CI=0.30-0.77) had significantly lower odds of use compared to non-Latino Whites, which were largely unaffected by factors associated with access to care. Over half of antidepressant use was by respondents not meeting 12-month criteria for depressive or anxiety disorders. Lifetime depressive and anxiety disorders explained another 21% of past year antidepressant use, leaving another 31% of drug use unexplained. *Discussion:* We found a disparity in antidepressant use for Mexican Americans compared to non-Latino Whites that was not accounted for by differences in need and factors associated with access to care. About one third of antidepressant use was by respondents not meeting criteria for depressive or anxiety disorders. Our findings underscore the importance of disaggregating Latino ethnic groups. Additional work is needed to understand the medical and economic value of antidepressant use beyond their primary clinical targets.”]

**This journal is available for loan or hard copy and may be requested from the California State Library.** [\[Back to Top\]](#)

**The NSDUH Report: Major Depressive Episode and Treatment among Adults. By the Office of Applied Studies, Substance Abuse and Mental Health Services Administration. (The Administration, Rockville, Maryland) May 14, 2009. 4 p.**

[“An estimated 16.5 million people aged 18 years or older experienced at least one major depressive episode (MDE) in the past year and 64.5 percent of them received treatment, according to a new report released today by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Among the findings:

- The rate of past year MDE was lower among persons aged 50 or older (5.8 percent) than among those aged 18 to 25 (8.9 percent) or 26 to 49 (8.5 percent). Overall the rate of past year MDE was 7.5 percent for adults aged 18 or older.
- The rate of MDE was higher for adults who perceived their overall health to be fair or poor (14.2 percent) than for those who described their health as excellent (4.3 percent).
- Among those with past year MDE who received treatment for depression in the past year, 68.8 percent saw or talked to a medical doctor or other health professional about depression and used prescription medication for depression.
- A quarter (24 percent) of those with MDE who received treatment for depression saw or talked to a medical doctor or other health professional but did not use a prescription medication.”]

Full text at: <http://www.oas.samhsa.gov/2k9/149/MDEamongAdults.pdf>

[\[Back to Top\]](#)

**“Persistence of Maternal Depressive Symptoms throughout the Early Years of Childhood.” By Sarah McCue Horwitz, Stanford University School of Medicine, and others. IN: Journal of Women’s Health, vol. 18, no. 5 (May 2009) pp. 637-645.**

[“This longitudinal follow-up of a birth cohort provides rarely available data on maternal depressive symptoms over a 4-year period during early childhood,’ state the authors of this article. Earlier work has established that both severity and chronicity of maternal depressive symptoms are important predictors of child outcomes. The article presents findings from a study to examine the prevalence of elevated maternal depressive symptoms and the relationship of variables suggested by earlier longitudinal studies to elevated symptoms throughout early childhood.

The authors found that

- Among the 82.6 percent of women without elevated depressive symptoms at the initial visit, 82.4 percent remained without symptoms over both follow-ups.
- For the 17.4 percent of women with elevated CES-D scores at the initial assessment, 37.0 percent did not have elevated symptoms at either follow-up, 35.6 percent had elevated symptoms at one of the two follow-ups, and 27.4 percent had elevated symptoms at both follow-ups.
- Women who reported elevated depressive symptoms at all three assessments were more likely to be poorly educated, have higher levels of anxiety and parent distress, and have lower levels of emotional support compared with those who reported elevated depressive symptoms at one or two assessments or who never reported elevated symptoms.

‘What is clear from these findings is the consistency in reports of depressive symptoms,’ state the authors, adding that ‘the results argue for a systematic approach to identifying and managing women with young children who experience symptoms of depression.’”]

**This journal is available for loan or hard copy and may be requested from the California State Library**

[\[Back to Top\]](#)

## EMPLOYMENT

**Employment Programming: Addressing Prevailing Barriers to Competitive Work. By Mark Salzer, University of Pennsylvania and Richard Baron, Rutgers University. (Center for Behavioral Health Services Criminal Justice Research, New Brunswick, New Jersey) March 2009. 4 p.**

[“Employment prospects are grim for people with psychiatric disabilities returning to community life from jail or prison. On the one hand, there are very few employment programs, either pre- or post-release, to help this dually disadvantaged group into the competitive labor market. On the other hand, the programs that do offer assistance with finding jobs report only modest outcomes. The unavailability and ineffectiveness of work-oriented programs is particularly discouraging because stable jobs have been demonstrated to increase emotional stability and decrease reliance on criminal activity for income. There is compelling evidence that people who work are less likely either to return to psychiatric institutions or to be reincarcerated.

Building long-term connections to work remains problematic for those with psychiatric histories released from jails or prisons. Neither the mental health system nor the criminal justice system has established employment as a clear priority, funded successful job training programs on a widespread basis, or sponsored the kind of research that can build a more comprehensive understanding of the varied contextual barriers that limit employment opportunities. New programmatic approaches are needed to ensure that people with psychiatric disabilities emerging from jails and prisons can turn to effective programs that help them return to competitive work.”]

Full text at: [http://www.cbhs-cjr.rutgers.edu/pdfs/March\\_PIB\\_2009.pdf](http://www.cbhs-cjr.rutgers.edu/pdfs/March_PIB_2009.pdf)

[\[Back to Top\]](#)

## HAPPINESS

**The Paradox of Declining Female Happiness. By Betsey Stevenson and Justin Wolfers, Wharton School, University of Pennsylvania. (The University, Philadelphia, Pennsylvania) March 28, 2009. 45 p.**

[“By many objective measures the lives of women in the United States have improved over the past 35 years, yet we show that measures of subjective well-being indicate that women’s happiness has declined both absolutely and relative to men. The paradox of women’s declining relative wellbeing is found across various datasets, measures of subjective well-being, and is pervasive across demographic groups and industrialized countries. Relative declines in female happiness have eroded a gender gap in happiness in which women in the 1970s typically reported higher subjective well-being than did men. These declines have continued and a new gender gap is emerging—one with higher subjective well-being for men.”]

Full text at:

<http://bpp.wharton.upenn.edu/betseys/papers/Paradox%20of%20declining%20female%20happiness.pdf>

[\[Back to Top\]](#)

**“What makes us Happy?” By Joshua Wolf Shenk, Washington College. IN: The Atlantic (June 2009) 20 p.**

[“Is there a formula—some mix of love, work, and psychological adaptation—for a good life? For 72 years, researchers at Harvard have been examining this question, following 268 men who entered college in the late 1930s through war, career, marriage and divorce, parenthood and grandparenthood, and old age. Here, for the first time, a journalist gains access to the archive of one of the most comprehensive longitudinal studies in history. Its contents, as much literature as science, offer profound insight into the human condition—and into the brilliant, complex mind of the study’s longtime director, George Vaillant.”]

Full text at: <http://www.theatlantic.com/doc/200906/happiness>

[\[Back to Top\]](#)

## HEALTH CARE

**“Measuring Trends in Racial/Ethnic Health Care Disparities.” By Benjamin Le Cook, Harvard Medical School, and others. IN: Medical Care Research and Review, vol. 66, no. 1 (February 2009) pp. 23-48.**

[“Monitoring disparities over time is complicated by the varying disparity definitions applied in the literature. This study used data from the 1996-2005 Medical Expenditure Panel Survey (MEPS) to compare trends in disparities by three definitions of racial/ethnic disparities and to assess the influence of changes in socioeconomic status (SES) among racial/ethnic minorities on disparity trends. This study prefers the Institute of Medicine’s (IOM) definition, which adjusts for health status but allows for mediation of racial/ethnic disparities through SES factors. Black–White disparities in having an office-based or outpatient visit and medical expenditure were roughly constant and Hispanic–White disparities increased for office-based or outpatient visits and for medical expenditure between 1996-1997 and 2004-2005. Estimates based on the independent effect of race/ethnicity were the most conservative accounting of disparities and disparity trends, underlining the importance of the role of SES mediation in the study of trends in disparities.”]

Full text at:

<http://www.multiculturalmentalhealth.org/downloads/MeasuringTrendsInRacialEthnicHealthcareDisparities.pdf>

[\[Back to Top\]](#)

**Primary Care Providers' Role in Mental Health. By the Bazelon Center for Mental Health Law. A Healthcare Reform Issue Brief. (The Center, Washington, DC) November 2008. 4 p.**

[“Primary care providers are the backbone of our healthcare delivery system. As part of their overall focus on a person’s health and wellness, they are playing an increasingly important role in identifying and treating mental disorders. Primary care services are also critically important for individuals with severe mental illnesses, whose physical health needs are often overlooked and who often have routine contact only with mental health providers.

The World Health Organization has called integrating mental health services into primary care the most viable way of closing the treatment gap for untreated mental illnesses, characterizing primary care for mental health as affordable and an investment that can bring important benefits. WHO also states that integration is most successful when mental health is incorporated in health policy and legislative frameworks accompanied by adequate resources.

One way to support primary care providers in delivering this holistic healthcare is to integrate mental health services with physical healthcare in the same location. There is considerable evidence that this is highly effective.<sup>2</sup> Where primary care and mental health providers are not co-located, coordination is more difficult but no less important.”]

Full text at: <http://www.bazelon.org/issues/healthreform/issuepapers/PrimaryCare.pdf>

[\[Back to Top\]](#)

## **HOMELESSNESS**

**A National Approach to Meeting the Needs of LGBTQ Homeless Youth. By Rich Hooks Wayman and LaKeshia Pope, National Alliance to End Homelessness. (The Alliance, Washington, DC) April 2009. 2 p.**

[“Various incidence studies of homeless youth in the United States estimate that over 2 million youth experience one night of homelessness each year, with over 100,000 sleeping long-term on the streets. Multiple research studies indicate that a conservative estimate finds 1 in 5 homeless youth self-identify as Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning LGBTQ, twice as prevalent as for LGBTQ youth in the general population. LGBTQ youth experience an alarmingly high rate of homelessness when compared to heterosexual youth. Even more troubling is the fact that homeless LGBTQ youth experience higher rates of physical assaults, sexual exploitation, and mental health deterioration than their heterosexual homeless peers.

Unaccompanied homeless youth are defined as youth ages 12 to 24 with no familial support or permanent residency. Homeless LGBTQ youth typically sleep in shelters, public spaces, abandoned buildings, cars, or outside, or remain doubled-up with friends in temporary, highly unstable housing arrangements. Some will be solicited and exploited by adults and exchange sex for a place to stay....

Ending homelessness for LGBTQ youth will require collaborative efforts to: 1) broaden community awareness of the prevalence and causes of homelessness for LGBTQ youth; 2) engage LGBTQ adults and allies in building local advocacy networks to expand

services, shelter, and housing for LGBTQ homeless youth; 3) secure increased public investment from local, state, and federal government in services, shelter, and housing for homeless LGBTQ youth; and 4) Improve the cultural competency of local services, shelter, and housing to meet the needs of LGBTQ homeless youth.”]

Full text at: <http://www.endhomelessness.org/content/article/detail/2240>

[\[Back to Top\]](#)

## MENTAL HEALTH WORKFORCE

**“Impact of a Mental Health Training Course for Correctional Officers on a Special Housing Unit.” By George F. Parker, Indiana University School of Medicine. IN: Psychiatric Services, vol. 60, no. 5 (May 2009) pp. 640-645.**

[“*OBJECTIVE:* This study determined the impact of a ten-hour mental health training program developed by the Indiana chapter of the National Alliance on Mental Illness (NAMI-Indiana) for correctional officers on a prison special housing ("supermax") unit. *METHODS:* The training was delivered to all of the correctional officers on the unit in five weekly sessions and was repeated 15 months later for new unit staff. The number of incidents reported by unit staff in standard monthly reports, consisting of use of force by the officers and battery by bodily waste on the officers by the offenders, was compared for the nine months before and after both training sessions. *RESULTS:* Attendance at the initial training ranged from 48 to 57 officers per session, and on the basis of Likert ratings, training was well received by the officers. The total number of incidents, the use of force by the officers, and battery by bodily waste all declined significantly after the first mental health training, and the total number of incidents and battery by bodily waste declined significantly after the second training. *CONCLUSIONS:* The provision of ten hours of mental health training to correctional officers was associated with a significant decline in use of force and battery by bodily waste.”]

Full text at: <http://ps.psychiatryonline.org/cgi/reprint/60/5/640>

[\[Back to Top\]](#)

**Restructuring California’s Mental Health Workforce: Interviews with Key Stakeholders. By Vincent Lok and others, UCSF Center for the Health Professions. (The Center, San Francisco) March 2009. 9 p.**

[“The mental health workforce is challenged to provide needed mental health services to a growing and increasingly diverse population in California. Severe shortages of some categories of providers, maldistribution of the existing workforce, and limitations in scope of practice and financing, further strain an already fragile delivery system. The infusion of new funding in the form of the MHSA, along with changes in consumer demand, call for greater transition to models of care emphasizing wellness and recovery. The workforce needs further preparation to deliver services under these models. Educators must address the current misalignment between education and training and the

new models of care. Interviewees had several general recommendations to address the challenges in the mental health workforce. These included more funding for training, more loan forgiveness for students, revised curricula and field training for professional programs, and more training programs to prepare consumers for the workforce. Solutions to offset the state's provider shortage must be considered at the cultural, historical, institutional, political, regulatory, and socioeconomic levels. Our assessment found that MHSA programs have unprecedented opportunities to improve access to mental health care. Measurement criteria for follow-up reassessment must be developed to determine whether the state is successful in creating a more robust workforce that is diverse and prepared to utilize the recovery model of care.”]

Full text at: [http://www.futurehealth.ucsf.edu/pdf\\_files/MH\\_Stakeholders\\_final.pdf](http://www.futurehealth.ucsf.edu/pdf_files/MH_Stakeholders_final.pdf)

[\[Back to Top\]](#)

## STIGMA

**Fighting Shadows: Self-stigma and Mental Illness. By Debbie Peterson and others, Mental Health Foundation of New Zealand. (The Foundation, Eden Terrace, Auckland, New Zealand) 2008 (Updated April 27, 2009) 46 p.**

[“*Summary:* Self-stigma (often called internalized stigma) is an issue that most people with experience of mental illness would recognize, either seeing it in themselves or in other people. It is generally believed that self-stigma arises from internalizing the negative messages and behavior that people with experience of mental illness receive from other people. The concept of self-stigma is fundamentally linked to the concept of discrimination. This research explores the concept of self-stigma and mental illness, and offers strategies to combat it. *Results:* A new definition of stigma and discrimination arose from the findings. A model of stigma and discrimination was also developed from this definition which helps to explain the phenomenon while also offering ‘circuit breakers’ to help people combat it. *Conclusions:* Key recommendations from the research include: 1) recognizing the contribution of mental illness and foster leadership among people with experience of mental illness; 2) celebrating and accepting difference; 3) affirming human rights; 4) encourage disclosure; 5) encourage recovery-oriented practices; 6) encourage empowerment; 7) support peer-support services; and 8) challenge attitudes and behavior.”]

Full text at: <http://www.tepou.co.nz/knowledge-exchange/research/view/listing/132/>

[\[Back to Top\]](#)

**“Listening to Madness: Why Some Mentally Ill Patients are Rejecting their Medication and Making the Case for Mad Pride.” By Alissa Quart. IN: Newsweek (May 18, 2009) 2 p.**

[“Welcome to Mad Pride, a budding grassroots movement, where people who have been defined as mentally ill reframe their conditions and celebrate unusual (some call them ‘spectacular’) ways of processing information and emotion.

Just as some deaf activists prefer to embrace their inability to hear rather than ‘cure’ it with cochlear implants, members of Icarus reject the notion that the things that are called mental illness are simply something to be rid of. Icarus members cast themselves as a dam in the cascade of new diagnoses like bipolar and ADHD. The group, which now has a membership of 8,000 people across the U.S., argues that mental-health conditions can be made into ‘something beautiful.’ They mean that one can transform what are often considered simply horrible diseases into an ecstatic, creative, productive or broadly ‘spiritual’ condition. As Hall puts it, he hopes Icarus will ‘push the emergence of mental diversity.’

Embracing ‘mental diversity’ is one thing, but questioning the need for medication in today's pill-popping world is controversial—and there have been instances in which those who experience mental extremes harm themselves or others. Icaristas argue that some of the severely mentally ill may avoid taking medication, because for some the drugs don't seem to help, yet produce difficult side effects. And while some side effects like cognitive impairment are surely debilitating, others are more subtle, such as the vague feeling that people are not themselves. Icaristas call themselves ‘pro-choice’ about meds—some do take their drugs, but others refuse.”]

Full text at: <http://www.newsweek.com/id/195694/page/1>

[\[Back to Top\]](#)

**“Stigma and Barriers to Care in Soldiers Postcombat.” By Kathleen M. Wright, Walter Reed Army Institute of Research, and others. IN: Psychological Services, vol. 6, no. 2 (May 2009) pp. 108-116.**

[“The present study examined the effects of leadership and unit cohesion on mental health stigma and perceived barriers to care. A sample of 680 soldiers from combat support units were surveyed 3 months after their return from combat operations in Iraq. The survey included scales on psychological symptoms and perceptions of leader behaviors and unit cohesion, as well as items assessing stigma and barriers to care. The sample was used to test the independent and interactive effects of leadership and unit cohesion on soldiers’ perceptions of stigma and barriers to care. Analyses yielded significant interaction effects between leadership and cohesion in predicting stigma and barriers to care, while controlling for the effects of mental health symptoms. Soldiers who rated their leaders more highly and who reported higher unit cohesion also reported lower scores on both stigma and perceived barriers to care. Thus, positive leadership and unit cohesion can reduce perceptions of stigma and barriers to care, even after accounting for the relationship between mental health symptoms and these outcomes.”]

**This journal is available for loan or hard copy and may be requested from the California State Library.**

[\[Back to Top\]](#)

## RELATED ANNOUNCEMENT:

### DoD Launches Program to Fight Stigma of Seeking Psychological Health Care

[“The Department of Defense today launched the Real Warriors Campaign, a multimedia public education effort designed to combat the stigma keeping some service members veterans and their families from seeking needed psychological health care.

The campaign will promote the processes of building resilience, facilitating recovery and supporting reintegration for those with psychological wounds via an interactive web site and through radio and television public service announcements.

‘You’re tough, and you go into the hospital when you receive a physical wound,’ said Dr. (Brig. Gen.) Loree K. Sutton, director, of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. ‘That doesn’t mean you’re weak in some way. So why wouldn’t you seek treatment when you’ve received a psychological wound?’

The launch is part of a larger effort by the Department of Defense to ensure service members and their families can access necessary treatment for the invisible wounds of war as well as the visible wound.”]

For more information, visit <http://www.realwarriors.net>

[\[Back to Top\]](#)

## VIOLENCE

**“Schizophrenia, Substance Abuse, and Violent Crime.” By Seena Fazel, Oxford University, England, and others. IN: Journal of the American Medical Association, vol. 301, no. 19 (May 20, 2009) pp. 2016-2023.**

[“*Context:* Persons with schizophrenia are thought to be at increased risk of committing violent crime 4 to 6 times the level of general population individuals without this disorder. However, risk estimates vary substantially across studies, and considerable uncertainty exists as to what mediates this elevated risk. Despite this uncertainty, current guidelines recommend that violence risk assessment should be conducted for all patients with schizophrenia. *Objective:* To determine the risk of violent crime among patients diagnosed as having schizophrenia and the role of substance abuse in mediating this risk. *Design, Setting, and Participants:* Longitudinal designs were used to link data from nationwide Swedish registers of hospital admissions and criminal convictions in 1973-2006. Risk of violent crime in patients after diagnosis of schizophrenia (n = 8003) was compared with that among general population controls (n = 80 025). Potential confounders (age, sex, income, and marital and immigrant status) and mediators (substance abuse comorbidity) were measured at baseline. To study familial confounding, we also investigated risk of violence among unaffected siblings (n = 8123) of patients with schizophrenia. Information on treatment was not available. *Main Outcome Measure:* Violent crime (any criminal conviction for homicide, assault, robbery, arson, any sexual offense, illegal threats, or intimidation).

*Results:* In patients with schizophrenia, 1054 (13.2%) had at least 1 violent offense compared with 4276 (5.3%) of general population controls (adjusted odds ratio [OR], 2.0; 95% confidence interval [CI], 1.8-2.2). The risk was mostly confined to patients with substance abuse comorbidity (of whom 27.6% committed an offense), yielding an increased risk of violent crime among such patients (adjusted OR, 4.4; 95% CI, 3.9-5.0), whereas the risk increase was small in schizophrenia patients without substance abuse comorbidity (8.5% of whom had at least 1 violent offense; adjusted OR, 1.2; 95% CI, 1.1-1.4;  $P < .001$  for interaction). The risk increase among those with substance abuse comorbidity was significantly less pronounced when unaffected siblings were used as controls (28.3% of those with schizophrenia had a violent offense compared with 17.9% of their unaffected siblings; adjusted OR, 1.8; 95% CI, 1.4-2.4;  $P < .001$  for interaction), suggesting significant familial (genetic or early environmental) confounding of the association between schizophrenia and violence.

*Conclusions:* Schizophrenia was associated with an increased risk of violent crime in this longitudinal study. This association was attenuated by adjustment for substance abuse, suggesting a mediating effect. The role of risk assessment, management, and treatment in individuals with comorbidity needs further examination.”]

**This journal is available for loan or hard copy and may be requested from the California State Library.**

[\[Back to Top\]](#)

## NEW CONVENTIONS

**Research Society on Alcoholism** 32<sup>nd</sup> Annual Scientific Conference.

June 20-24, 2009  
San Diego, California

For more information and registration: <http://www.rsoa.org/2009meet-indexPre.htm>

**University of Colorado 2009 Aging and Mental Health Conference:** *Integrated Health Care for Older Adults.*

June 18-21, 2009  
Colorado Springs, Colorado

For more information and registration: <http://www.uccs.edu/~geropsy/>

**National Prevention Network: 22<sup>nd</sup> Annual NPN Research Conference:** *Prevention Research, Striking Gold.* (Bringing together researchers and practitioners, as well as leaders from federal agencies supporting prevention, the conference will include presentations on underage drinking, prescription drugs, social marketing and public policy. This year focuses on ensuring culturally competent and relevant services.)

September 15-18, 2009  
Anaheim, California

For more information and registration: <http://swpc.ou.edu/npn/index.htm>

[\[Back to Top\]](#)