

**Subject:** Studies in the News: (September 3, 2009)

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## Studies in the News for



## California Department of Mental Health

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## CONTENTS OF THIS ISSUE

### CHILDREN AND ADOLESCENTS

[Effects of deployment on military children](#)

[Stigma/self-concept and adolescents in treatment](#)

### EMERGENCY CARE

[Integrating mental health and primary care in emergencies](#)

[Promoting mental health recovery after disasters](#)

### MEDICAL ADVERTISING

[Pharmaceutical advertising and mental illness stigma](#)

### PATTERNS

[Geographic patterns of frequent mental distress](#)

[National patterns in antidepressant medication treatment](#)

### POLICY

[Nursing home residents with mental illness](#)

[Premature death among state mental health agency consumers](#)

[Social and emotional development in early childhood](#)

[Social justice and mental health consequences of heterosexism](#)

### PRIMARY CARE

[Integrating mental health and pediatric primary care](#)

### SCHOOLS

[\[Special Issue of \*School Mental Health\*\] Intervention and participant engagement](#)

### SUICIDE PREVENTION

[Mental disorders and suicidal behavior](#)

### VIOLENCE

[Schizophrenia and violence](#)

### [CONFERENCES, MEETINGS AND PODCASTS](#)

## CHILDREN AND ADOLESCENTS

**“The Psychosocial Effects of Deployment on Military Children.” By Eric M. Flake and others. IN: Journal of Developmental & Behavioral Pediatrics, vol. 30, no. 4 (August 2009) pp. 271-278.**

[“*Objective:* The impact of the Global War on Terror on two million U.S. military children remains unknown. The purpose of this study was to describe the psychosocial profile of school age children during parental deployment utilizing standardized psychosocial health and stress measures, and to identify predictors of children at high risk for psychosocial morbidity during wartime deployment.

*Methods:* Army spouses with a deployed service member and a child aged 5-12 years completed a deployment packet consisting of demographic and psychosocial questions. The psychosocial health measures included the Pediatric Symptom Checklist (PSC), the Parenting Stress Index-Short Form and the Perceived Stress Scale-4.

*Results:* Overall, 32% of respondents exceeded the PSC cut off score for their child, indicating high risk for psychosocial morbidity and 42% reported high risk stress on the Parenting Stress Index-Short Form. Parenting stress significantly predicted an increase in child psychosocial morbidity (odds ratio 7.41, confidence interval 2.9-19.0,  $p < 0.01$ ). Parents utilizing military support reported less child psychosocial morbidity (odds ratio 0.32, confidence interval 0.13-0.77,  $p < 0.01$ ) and parental college education was related to a decrease in child psychosocial morbidity (odds ratio 0.33, confidence interval 0.13-0.81,  $p < 0.02$ ). The effects of military rank, child gender, child age, and race or ethnic background did not reach statistical significance.

*Conclusion:* Families in this study experiencing deployment identified one-third of military children at high risk for psychosocial morbidity. The most significant predictor of child psychosocial functioning during wartime deployment was parenting stress. Military, family and community supports help mitigate family stress during periods of deployment.”] **Please contact the California State Library for a paper or electronic copy of this article.**

**“Stigma and Self-concept among Adolescents Receiving Mental Health Treatment.” By Tally Moses. IN: American Journal of Orthopsychiatry, vol. 79, no. 2 (April 2009) pp. 261-274.**

[“Although studies indicate that adolescents diagnosed with mental disorders are stigmatized by the American public, we know very little about the extent to which stigma is experienced by these youth and its effects on their well-being. This cross-sectional study utilizes interviews with 60 adolescents treated in a wraparound program to examine: (a) the extent to which adolescents diagnosed and treated for psychiatric disorders experience mental illness stigma and cope by using secrecy, (b) the extent to which stigmatization is associated with self-concept (self-esteem, mastery, future outlook) and morale (depression), and (c) which clinical and demographic characteristics

are associated with perceived stigma. A secondary purpose was to explore the usefulness with adolescents of stigma measures created and adapted primarily from Link's adult stigma scales (Link et al., 1991, 1997). The results support both optimistic and pessimistic interpretations regarding stigma and its effects on adolescents diagnosed and treated for mental disorders. The scales developed for this study demonstrate good internal consistency and construct validity and show promise as tools for further research on stigma as experienced by youth.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

## EMERGENCY CARE

**“Mental Health Treatment Outcomes in a Humanitarian Emergency: a Pilot Model for the Integration of Mental Health into Primary Care in Habilla, Darfur.” By Renato Souza, Médecins Sans Frontières, Geneva, Switzerland, and others. IN: International Journal of Mental Health Systems, vol. 3, no. 17 (July 21, 2009) 16 p.**

[“*Background:* There is no description of outcomes for patients receiving treatment for mental illnesses in humanitarian emergencies. MSF has developed a model for integration of mental health into primary care in a humanitarian emergency setting based on the capacity of community health workers, clinical officers and health counselors under the supervision of a psychiatrist trainer. Our study aims to describe the characteristics of patients first attending mental health services and their outcomes on functionality after treatment.

*Methods:* A total of 114 patients received mental health care and 81 adult patients were evaluated with a simplified functionality assessment instrument at baseline, one month and 3 months after initiation of treatment.

*Results:* Most patients were diagnosed with epilepsy (47%) and psychosis (31%) and had never received treatment. In terms of follow up, 58% came for consultations at 1 month and 48% at 3 months. When comparing disability levels at baseline versus 1 month, mean disability score decreased from 9.1 (95%CI 8.1-10.2) to 7.1 (95%CI 5.9-8.2)  $p=0.0001$ . At 1 month versus 3 months, mean score further decreased to 5.8 (95%CI 4.6-7.0)  $p<0.0001$ .

*Conclusions:* The findings suggest that there is potential to integrate mental health into primary care in humanitarian emergency contexts. Patients with severe mental illness and epilepsy are in particular need of mental health care. Different strategies for integration of mental health into primary care in humanitarian emergency settings need to be compared in terms of simplicity and feasibility.”]

Full text at: <http://www.ijmhs.com/content/pdf/1752-4458-3-17.pdf>

**“Promoting Mental Health Recovery after Hurricanes Katrina and Rita: What can be done at What Cost.” By Michael Schoenbaum, NIMH Division of Services and Intervention Research and RAND Corporation, and others. IN: Archives of General Psychiatry, vol. 66, no. 8 (August 2009) pp. 906-914.**

[“Making evidence-based mental health services accessible to everyone in a disaster-stricken area would have substantial public health benefits, according to a statistical model developed by NIMH-funded researchers. Rough estimates of cost show such comprehensive care would be within the range of other accepted medical practices. However, given the considerable costs and resources required, further studies are needed to determine whether such broader efforts are advisable and, if so, to what degree. Research on survivors of Hurricanes Katrina and Rita shows that this population continues to face many persistent mental health issues. These issues may at times be worsened by lack of availability or access to proper mental health care services. To help inform future disaster plans, a group of researchers led by Kenneth B. Wells, M.D., MPH, of RAND Corporation and UCLA Semel Institute, Health Services Research Center, developed a model to estimate the costs and outcomes of providing enhanced, evidence-based mental health care in a post-disaster setting.

Starting with a population of around 11 million in the hurricane-affected areas (based on U.S. Census & Area Resources File<sup>1</sup> data), the researchers focused on medium-term mental health response, which starts around seven months post-disaster. They chose this period because fewer strategies have been developed for medium-term response, compared with the immediate post-disaster response (zero to six months), which mainly involves humanitarian efforts such as life-saving care and crisis counseling. Wells and colleagues modeled service use through 24 months post-disaster and measured outcomes up to 30 months out.

According to their model, providing comprehensive mental health care coverage would cost around \$1,133 per person—or about \$12.5 billion for the entire disaster-affected population—over the period between months seven and 24 post-disaster. Nearly half this amount would be spent in months seven through 12 due to screening and an initial surge in need. The researchers estimated that, overall, this spending would reduce the total number of episodes of mental illness associated with the disaster in the affected population by 35 percent, compared with providing no mental health treatment.

Reducing either the level of service coverage or available treatments would reduce both costs and benefits. Though formal cost-effectiveness analysis was beyond the study’s scope, according to the researchers, the estimated gains from preventing psychiatric episodes would be within the cost range of generally accepted medical practices, comparable to the cost benefits of screening people for high blood pressure.

The researchers noted that some questions remain on the exact definition of evidence-based care and how it applies to disaster response. Also, though the model was designed to apply to many contexts, estimates for other disasters may require different assumptions and have different results.

The researchers intend the model to serve as a starting point for policy discussions to improve services for people with persistent mental illness following the Gulf storms, and to plan coordinated strategies for future disasters.

Current research shows that the demand and clinical need for mental health services exceeds availability for many parts of the country, even in the absence of a disaster situation. Wells and colleagues suggest that effective and efficient disaster plans may need to include establishing a national ‘reserve’ of mental health care providers trained in evidence-based treatments, and linked to a logistical infrastructure for service delivery, including in-person and tele-health options. Policies on licensure, which are governed at

the state level, may need to be revised to allow providers from outside a disaster area to provide care. Communities may also want to consider ways to develop local resources through re-training or redeployment of professional and non-professional social service providers.” NIMH Science Update (August 11, 2009)] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

## **MEDICAL ADVERTISING**

**Medicalization, Direct-to-consumer Advertising, and Mental Illness Stigma. By Andrew R. Payton, University of North Carolina-Chapel Hill, and Peggy A. Thoits, Indiana University. Paper was presented at the American Sociological Association, San Francisco on August 10, 2009 (March 25, 2009) 22 p.**

[“In late 1997 the Food and Drug Administration issued new guidelines that allowed pharmaceutical companies to air prescription drug ads on television. These guidelines have played an important role in promoting the pharmaceutical industry as one of the major ‘engines’ of medicalization (Conrad 2005). One arena in which there has been a dramatic increase in direct-to-consumer advertising of pharmaceuticals (DTCA) is the marketing of psychotherapeutic drugs, especially for depression, but also more recently for anxiety and bipolar disorder. Because medicalization is thought to reduce blame and stigma attached to deviant conditions such as mental illness, the rise of DTCA for depression drugs may be altering public conceptions of mental illness in general and depression specifically. We examine this possibility by assessing changes in attitudes toward persons with mental illness (schizophrenia and major depression) from 1996 to 2006, one year before and nearly ten years after the FDA's new guidelines, taking advantage of the Mental Health Modules in the General Social Survey in these years. Contrary to expectations, medicalization and exposure to DTCA did not change the stigma associated with mental illness in the public's attitudes. We speculate that stereotyped portrayals of persons with mental illness in the media may outweigh the messages conveyed in direct to consumer advertising about depression and its treatability.”] **NOTE: The California State Library has an electronic copy of this presentation. Please contact the library for a copy.**

## **PATTERNS**

**“Geographic Patterns of Frequent Mental Distress: U.S. Adults, 1993-2001 and 2003-2006.” By David G. Moriarty, Center for Disease Control, and others. IN: American Journal of Preventive Medicine, vol. 36, no. 6 (June 2009) pp. 497-505.**

[“*Background:* Mental illnesses and other mental health problems often lead to prolonged, disabling, and costly mental distress. Yet little is known about the geographic *Methods:* Since 1993, the CDC has tracked self-perceived mental distress through the Behavioral Risk Factor Surveillance System (BRFSS). In 2007 and 2008, analysis was performed on BRFSS data reported by 2.4 million adults from 1993–2001 and 2003–2006 to map and describe the prevalence of frequent mental distress (FMD)—defined as having  $\geq 14$  mentally unhealthy days during the previous 30 days—for all states and for counties with at least 30 respondents.

*Results:* The adult prevalence of FMD for the combined periods was 9.4% overall, ranging from 6.6% in Hawaii to 14.4% in Kentucky. From 1993–2001 to 2003–2006, the mean prevalence of FMD increased by at least 1 percentage point in 27 states and by more than 4 percentage points in Mississippi, Oklahoma, and West Virginia. Most states showed internal geographic variations in FMD prevalence. The Appalachian and the Mississippi Valley regions had high and increasing FMD prevalence, and the upper Midwest had low and decreasing FMD prevalence.

*Conclusions:* Geographic areas were identified with consistently high and consistently low FMD prevalence, as well as areas in which FMD prevalence changed substantially. Further evaluation of the causes and implications of these patterns is warranted. Surveillance of mental distress may be useful in identifying unmet mental health needs and disparities and in guiding health-related policies and interventions.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

**“National Patterns in Antidepressant Medication Treatment.” By Mark Olfson, Columbia University, and Steven C. Marcus, University of Pennsylvania. IN: Archives of General Psychiatry, vol. 66, no. 8 (August 2009) pp. 848-856.**

[“A marked and broad expansion in antidepressant treatment occurred among Americans older than 6 years between 1996 and 2005, although treatment rates remain low among racial and ethnic minorities. Treatment for mental health conditions is becoming more common in the United States, according to background information in the article.

“Several factors may have contributed to this trend, including a broadening in concepts of need for mental health treatment, campaigns to promote mental health care and growing public acceptance of mental health treatments,” the authors write. “In parallel with growth in mental health service usage, psychotropic medications have become increasingly prominent in treatment.” Antidepressants are now the most commonly prescribed class of medications in the United States....

Beyond the general expansion of mental health treatment, several factors may have contributed to the overall increase in prescriptions, they note. First, major depression may have become more common. Several new antidepressants were approved by the U.S. Food and Drug Administration to treat depression and anxiety disorders during the study period. In addition, clinical guidelines were published that supported the use of these medications for a variety of conditions.” Medical News Today (August 4, 2009)] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

## POLICY

**“How Many Nursing Home Residents Live with a Mental Illness?” By Ann D. Bagchi and others, Mathematica Policy Research. IN: Psychiatric Services, vol. 60, no. 7 (July 2009) pp. 958-964.**

[“*Objective:* A number of data sets can be used to estimate the size of the nursing home population that has mental illness; however, estimates vary because of differences in methods of data collection. This study sought to compare estimates from three nationally

representative data sets of the number of nursing home residents who have a mental illness, determine which data set provides the best national-level estimate, and identify the types of policy and monitoring questions that can best be answered with each. *Methods:* The study compared estimates of the number of nursing home residents who had either a primary or any diagnosed mental illness from the National Nursing Home Survey (NNHS), the Minimum Data Set (MDS), and the Medicaid Analytic eXtract (MAX) files. *Results:* The NNHS produced the most valid national-level estimates of residents with a mental illness—nearly 102,000 with a primary diagnosis in 2004 (6.8% of residents), of which about 23,000 were under age 65 and 79,000 were aged 65 and older. However, data from the NNHS cannot be broken down to the state level; therefore, state- and facility-level estimates would have to be generated with the MDS or MAX data sets. *Conclusions:* Policy makers and program managers need to be aware of the strengths and limitations of the data they use in order to make informed decisions. Users of the NNHS, MDS, and MAX data sets should be aware of the differences in recorded diagnoses among the three, especially the relatively limited diagnoses in the MAX and imprecise diagnoses in the MDS.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

**“Premature Death among State Mental Health Agency Consumers: Assessing Progress in Addressing a Quiet Tragedy.” By Ronald W. Manderscheid, Johns Hopkins University and the Global Health Sector of SRA International. IN: International Journal of Public Health, vol. 54, Supplement 1 (June 2009) pp. S7-S8.**

[“Consumers served by the State mental health agencies die 25 years younger than the general population. As a result of this quiet tragedy, male consumers are likely to die at about age 53; female consumers, at 59. This 25 year disparity is due to two factors, chronic physical disabilities (which account for 15–20 years of the difference) and mental factors, such as suicide (which account for 5–10 years). These troubling numbers were uncovered by Craig Colton and me and reported in *Preventing Chronic Disease* in April ([http://www.cdc.gov/pcd/issues/2006/apr/05\\_0180.htm](http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm)). Compared with findings from a much earlier related study, mental health consumers’ disparity in length of life appears to be worse in 2006 than in 1986! The causes are equally disturbing. The chronic physical disabilities contributing to this disparity are the lifestyle problems suffered by many Americans: obesity, high blood pressure, diabetes, stroke, chronic heart disease, and heart attack. Collectively, these chronic health problems are known as the ‘metabolic syndrome.’ However, unlike most other Americans, public mental health consumers are much less likely to receive care for these problems. As a result, they die prematurely.... The BRFSS is exceptionally valuable in helping us to understand the specific linkages between mental illness and chronic physical diseases in State populations. This is so because it is the only survey that covers both of these disability areas. Covering both is required to address the 25 year disparity in lifespan experienced by public mental health clients. Hence, I conclude that the BRFSS modules on mental health are essential for monitoring progress in addressing this 25 year disparity. To assure that these essential modules are available in the future, provision of sufficient financial resources must be addressed by the new Administration as part of its initiative on National Health Reform.”]

Full text at: <http://www.springerlink.com/content/37w145860l228782/fulltext.pdf>

**Social and Emotional Development in Early Childhood: What Every Policymaker Should Know.** By Janice L. Cooper and others, National Center for Children in Poverty. (The Center, New York, New York) August 2009. 16 p.

[“The early years of life present a unique opportunity to lay the foundation for healthy development. It is a time of great growth and of vulnerability. Research on early childhood has underscored the impact of the first five years of a child’s life on his/her emotional and social development. Negative early experiences can impair children’s mental health and effect their cognitive, behavioral, social and emotional development.”]

Full text at: [http://www.nccp.org/publications/pdf/text\\_882.pdf](http://www.nccp.org/publications/pdf/text_882.pdf)

**“Using a Social Justice Approach to Prevent the Mental Health Consequences of Heterosexism.”** By Connie R. Matthews, Slippery Rock University, and Eve M. Adams, New Mexico State University. IN: *Journal of Primary Prevention*, vol. 30, no. 1 (January 2009) pp. 11-26.

[“A growing body of research has established connections between the stigma and discrimination that the LGB population faces and negative consequences with respect to mental health. To date, prevention-specific research related to heterosexism and the LGB population is extremely limited. Albee’s (1983, 1995) social justice approach to prevention offers a framework for identifying ways in which professionals can intervene to prevent LGB people from experiencing the negative mental health consequences associated with heterosexism. This approach involves working at both the environmental level (from relatively contained local systems to larger, even national, political systems) and at the person level through social and individual empowerment. Such interventions need to be examined critically through further research. Some of the suggested activities may feel like a comfortable ‘fit’ with the work that practitioners and researchers traditionally do; other approaches, such as political involvement, may feel further outside one’s comfort zone. Perhaps it is time to stretch our comfort zones to facilitate systems-level change that can begin to reduce the incidence of stressors associated with psychological distress in LGB individuals.”]

Full text at: <http://www.springerlink.com/content/a278668537264110/fulltext.pdf>

## PRIMARY CARE

**Strategies to Support the Integration of Mental Health into Pediatric Primary Care.** By Susanna Ginsburg and Susan Foster. Issue Paper. (National Institute for Health Care Management, Washington, DC) August 2009. 40 p.

[“This paper provides an overview of research advances and policy trends that support integration of mental health into primary care and explores strategies that can be employed by primary care health professionals, with support of health plans, to achieve coordinated and integrated mental health care in the pediatric primary care setting. The issue paper was published by the National Institute for Health Care Management with support from the Maternal and Child Health Bureau. Topics include the prevalence of and risk and protective factors for children's mental health problems; the current state of mental health in pediatric primary care, including the relationships between primary care and mental health services; public and private sector financing of mental health services for children and the implications for integrative approaches; federal, organizational, and foundation initiatives supporting integrative care; and considerations and strategies for health professionals and health plans to improve the delivery of mental health care in pediatric primary care. Conclusions and selected resources on children's mental health care are provided.”]

Full text at: <http://nihcm.org/pdf/PediatricMH-FINAL.pdf>

## SCHOOLS

**Assessing Implementation Integrity beyond Intervention Delivery: Measuring Intervention Content and Delivery, and Participant Engagement [Special Issue.] Edited by Stephen S. Leff and Jessica A. Hoffman. School Mental Health, vol. 1, no. 3 (September 2009) pp. 103-157.**

[“Table of Contents:

[Intervention Integrity: New Paradigms and Applications](#)

[An Analysis of Teacher Investment in the Context of a Family–School Intervention for Children with ADHD](#)

[Using Participatory Action Research to Design an Intervention Integrity System in the Urban Schools](#)

[Intervention Implementation Integrity Within Conjoint Behavioral Consultation: Strategies for Working with Families](#)

[Training School-Based Practitioners to Collect Intervention Integrity Data](#)

[Assessing Integrity of Intervention Implementation: Critical Factors and Future Directions](#) “]

For a list and links to all articles:

<http://www.springerlink.com/content/h46q0u937h15/?p=f48721d7399746a3b99ea2f36140f3&pi=0>

## SUICIDE PREVENTION

**“Cross-national Analysis of the Associations among Mental Disorders and Suicidal Behavior: Findings from the WHO World Mental Health Surveys.”** By Matthew K. Nock, Harvard University, and others. IN: *PLoS Medicine*, vol. 6, no. 8, published online on August 11, 2009. 17 p.

[“*Background:* Suicide is a leading cause of death worldwide. Mental disorders are among the strongest predictors of suicide; however, little is known about which disorders are uniquely predictive of suicidal behavior, the extent to which disorders predict suicide attempts beyond their association with suicidal thoughts, and whether these associations are similar across developed and developing countries. This study was designed to test each of these questions with a focus on nonfatal suicide attempts.

*Methods and Findings:* Data on the lifetime presence and age-of-onset of Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) mental disorders and nonfatal suicidal behaviors were collected via structured face-to-face interviews with 108,664 respondents from 21 countries participating in the WHO World Mental Health Surveys. The results show that each lifetime disorder examined significantly predicts the subsequent first onset of suicide attempt (odds ratios [ORs] = 2.9–8.9). After controlling for comorbidity, these associations decreased substantially (ORs = 1.5–5.6) but remained significant in most cases. Overall, mental disorders were equally predictive in developed and developing countries, with a key difference being that the strongest predictors of suicide attempts in developed countries were mood disorders, whereas in developing countries impulse-control, substance use, and post-traumatic stress disorders were most predictive. Disaggregation of the associations between mental disorders and nonfatal suicide attempts showed that these associations are largely due to disorders predicting the onset of suicidal thoughts rather than predicting progression from thoughts to attempts. In the few instances where mental disorders predicted the transition from suicidal thoughts to attempts, the significant disorders are characterized by anxiety and poor impulse-control. The limitations of this study include the use of retrospective self-reports of lifetime occurrence and age-of-onset of mental disorders and suicidal behaviors, as well as the narrow focus on mental disorders as predictors of nonfatal suicidal behaviors, each of which must be addressed in future studies.

*Conclusions:* This study found that a wide range of mental disorders increased the odds of experiencing suicide ideation. However, after controlling for psychiatric comorbidity, only disorders characterized by anxiety and poor impulse-control predict which people with suicide ideation act on such thoughts. These findings provide a more fine-grained understanding of the associations between mental disorders and subsequent suicidal behavior than previously available and indicate that mental disorders predict suicidal behaviors similarly in both developed and developing countries. Future research is needed to delineate the mechanisms through which people come to think about suicide and subsequently progress from ideation to attempts.”]

Full text at: <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000123>

## VIOLENCE

**“Schizophrenia and Violence: Systematic Review and Meta-Analysis.”** By Seena Fazel, University of Oxford, United Kingdom, and others. IN: *PLoS Medicine*, vol. 6, no. 8, published online at August 11, 2009. 15 p.

[“*Background:* Although expert opinion has asserted that there is an increased risk of violence in individuals with schizophrenia and other psychoses, there is substantial heterogeneity between studies reporting risk of violence, and uncertainty over the causes of this heterogeneity. We undertook a systematic review of studies that report on associations between violence and schizophrenia and other psychoses. In addition, we conducted a systematic review of investigations that reported on risk of homicide in individuals with schizophrenia and other psychoses.

*Methods and Findings:* Bibliographic databases and reference lists were searched from 1970 to February 2009 for studies that reported on risks of interpersonal violence and/or violent criminality in individuals with schizophrenia and other psychoses compared with general population samples. These data were meta-analysed and odds ratios (ORs) were pooled using random-effects models. Ten demographic and clinical variables were extracted from each study to test for any observed heterogeneity in the risk estimates. We identified 20 individual studies reporting data from 18,423 individuals with schizophrenia and other psychoses. In men, ORs for the comparison of violence in those with schizophrenia and other psychoses with those without mental disorders varied from 1 to 7 with substantial heterogeneity ( $I^2 = 86\%$ ). In women, ORs ranged from 4 to 29 with substantial heterogeneity ( $I^2 = 85\%$ ). The effect of comorbid substance abuse was marked with the random-effects ORs of 2.1 (95% confidence interval [CI] 1.7–2.7) without comorbidity, and an OR of 8.9 (95% CI 5.4–14.7) with comorbidity ( $p < 0.001$  on metaregression). Risk estimates of violence in individuals with substance abuse (but without psychosis) were similar to those in individuals with psychosis with substance abuse comorbidity, and higher than all studies with psychosis irrespective of comorbidity. Choice of outcome measure, whether the sample was diagnosed with schizophrenia or with nonschizophrenic psychoses, study location, or study period were not significantly associated with risk estimates on subgroup or metaregression analysis. Further research is necessary to establish whether longitudinal designs were associated with lower risk estimates. The risk for homicide was increased in individuals with psychosis (with and without comorbid substance abuse) compared with general population controls (random-effects OR = 19.5, 95% CI 14.7–25.8).

*Conclusions:* Schizophrenia and other psychoses are associated with violence and violent offending, particularly homicide. However, most of the excess risk appears to be mediated by substance abuse comorbidity. The risk in these patients with comorbidity is similar to that for substance abuse without psychosis. Public health strategies for violence reduction could consider focusing on the primary and secondary prevention of substance abuse.”]

Full text at:

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000120;jsessionid=50464050A91067A9BEF8A2C0054AB09D>

## CONFERENCES, MEETINGS AND WEBCASTS

**California Mental Health Policy Forum:** *Keeping our bearings, adapting our change agenda in turbulent times.*

Napa, California  
September 9-11, 2009

For more information and registration:

<http://elearning.networkofcare.org/CiMH/PackageOverview.asp?id=231486>

**AHRQ's 2009 Annual Conference:** *Research to Reform: Achieving Health System Change.*

Bethesda, Maryland  
September 13-16, 2009

For more information and registration: <http://www.ahrq.gov/about/annlconf09.htm>

**Cross-Cultural Mental Health Symposium:** *to promote ongoing dialogue between the mental health and addictions system and cross-cultural communities by exploring current issues and potential solutions/promising practices.*

October 21-22, 2009  
Vancouver, British Columbia, Canada

For more information and registration:

[http://www.ccmhs.ca/index.php?option=com\\_content&view=article&id=9&Itemid=5](http://www.ccmhs.ca/index.php?option=com_content&view=article&id=9&Itemid=5)

**14th Annual Conference on Advancing School Mental Health:** *School Mental Health: Promoting Success for All Students.* Center for School Mental Health, University of Maryland School of Medicine.

November 2-4, 2009  
Minneapolis, Minnesota

For more information:

[http://csmh.umaryland.edu/conf\\_meet/AnnualConference/index.html](http://csmh.umaryland.edu/conf_meet/AnnualConference/index.html)

For registration:

<https://ww2.eventrebels.com/er/Registration/StepRegInfo.jsp?ActivityID=4093&StepNumber=1>

**DBSA (Depression and Bipolar Support Alliance) Real Recovery Podcast Series-- Medical Research & Surviving Family History of Suicide:** *Diagnosis, Causes, and Course of Mood Disorders*

In this two-part series, Dr. Ellen Frank and Dr. Andrew Nierenberg discuss, with Sheri Jenkins Tucker and DBSA's Kevin Siembor, consumer interest in—and concerns about—medical research related to the cause and treatment of mood disorders. The questions addressed were selected from an online survey conducted by DBSA, and these podcasts are brought to you by a partnership between DBSA and the [American College of Neuropsychopharmacology \(ACNP\)](#). ACNP, founded in 1961, is the nation's premier professional society in brain, behavior, and psychopharmacology research.

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