Mental Illness & Violence: A Complicated Picture

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Introduction

“Five killed, shooter turns gun on self.” So runs an all-too-familiar headline; a paragraph later, it is reported that the shooter had a history of mental illness, and an implicit causal connection is drawn between violence and mental illness. But is it the case that mentally ill persons are more dangerous than non-mentally ill persons? Is there a connection between mental illness and violence? And if so, what should we do about it?

Last month, the Scattergood Program for Applied Ethics in Behavioral Health Care—a research program within the Perelman School of Medicine at the University of Pennsylvania—hosted a daylong conference to examine these questions. Led by a nationally recognized group of experts, over 80 mental health care providers gathered to learn about current research on violence and mental illness and to discuss their legal and ethical obligations when treating a potentially violent patient.

The Data

While conventional wisdom now seems to support the

claim that mentally ill persons are significantly more violent than healthy individuals, the story is far more complicated. The connection between mental illness and violence is a complex one that depends on several risk factors. For the most part, mentally ill persons are non-violent and in fact are far more often the victims of violence. Cases of mentally ill persons committing public acts of mass violence are exceedingly rare.

The MacArthur Violence Risk Assessment Study provides the most comprehensive data on the connection between violence and mental illness (Monahan et al., 2001). The study included over 1,100 participants who had been hospitalized and diagnosed with disorders of personality, thought or affect or substance abuse. The researchers interviewed each patient along with persons named by the patient as collateral informants twice over a 20-week period. They were asked to describe any instances of battery, sexual assault, use of a weapon or threats made with a weapon during the post-discharge period.

Close to 20 percent of respondents reported at least one violent act during the first 20 weeks post-discharge from the hospital. Significant risk factors included a history of violence, adverse childhood experiences, substance abuse, violent thinking and objective measures of psychopathic features. These data now serve as a foundation for an actuarial model and computer-based instrument that clinicians can use to predict violence among patients prior to discharge from psychiatric

facilities (Monahan et al., 2005).

As we know from the MacArthur Study, particular psychiatric diagnoses and risk factors are predictive of future acts violence. It is therefore critical that behavioral health care providers have the tools they need to ascertain risk and intervene quickly to protect members of the public.

Options for Intervention

Interventions aimed at treating or managing potentially violent mentally ill persons exist at the nexus of behavioral health care and criminal justice. Strategies include the use of various forms of leverage to convince an individual to comply with an outpatient treatment regime, diversion courts designed to keep mentally ill persons out of jail and in treatment and compulsory hospitalization.

In the case of leverage, mentally ill persons are presented a range of options to induce them toward supervised outpatient treatment, medication compliance and/or participation in community-based services. Levers include conditional rewards such as subsidized or free housing or threats of compulsory hospitalization or prison.

Assisted outpatient therapy (AOT) has become a successful model for providing treatment and supervision to highly symptomatic patients who refuse treatment. Forty-four states have adopted AOT laws since the 1999

case of Kendra Webdale, a New York woman who was pushed to her death from a subway platform by a man with untreated schizophrenia.

Mental health courts have sprung up across the country and offer judicial mechanisms for diverting mentally ill persons away from jails and prisons and into psychiatric treatment programs. The Hon. Sheila Woods-Skipper presides over such a court in Philadelphia. Defendants who have been diagnosed with a mental illness and are competent to stand trial, if found guilty, are directed toward one of six tracks, including assertive community treatment, enhanced case management and a veterans' track in collaboration with the VA.

A Key Tension: Public Safety vs. Individual Liberty

Proponents of leverage, AOT and other forms of coercive treatment for potentially violent mentally ill persons point to the successes of Kendra's Law and other mandated treatment programs. Advocates of AOT point to recent research indicating that mandated persons—even those who lack insight into their own illnesses—are more compliant with medication and treatment plans and that AOT reduces their risk of incarceration. From a budgetary perspective, AOT, while expensive to implement, seems to help states realize significant long-term savings by reducing the need for intensive inpatient treatment and incarceration.

Some patient and consumer advocates are concerned that the use of leverage, AOT and other forms induced treatment unjustifiably infringe upon an individual's liberty because they single out mentally ill persons who are, by and large, non-violent. Those who object to coercive interventions argue that the data connecting dangerousness with mental illness are flimsy, that the predictive power of psychiatrists is shaky at best and that risk factors with similar predictive value are ignored.

Critics also point out that such programs unfairly target African American men, although it is unclear whether this bias is an artifact of the larger, disturbing trend that black men are overrepresented in U.S. prisons. Relatedly, many worry that mentally ill persons are being denied procedural due process because they are shuttled in and out of mental health and criminal courts without proper representation or advocacy.

Ultimately, the connection between mental illness and violence is far more complex than the opposing views acknowledge. In addition to marshaling public health data and research, a measured approach to addressing and preventing violence in mentally ill persons requires ethical reflection on questions of procedural justice, equity and respect.

Resources

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