

Violence and  
Mental Illness:  
Public Policy Implications in the  
Wake of the  
Virginia Tech Tragedy

NASMHPD Winter 2007 Commissioners Meeting

James S. Reinhard, M.D.

Commissioner, DMHMRSAS

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# Mental Illness and Risk for Violence

## ■ The Research

- McArthur Violence Risk Assessment Study
- Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods
  - Steadman, Mulvey, Monahan, Robbins, Appelbaum, Grisso, Roth, Silver
    - Archives of General Psychiatry, May 1998

# Study Design

- 1,136 patient discharged from hospitals at 3 sites
- Monitored violent behavior every 10 weeks for one year after discharge
- Relied on:
  - Self-Reports
  - Collateral informants
  - Police and Hospital Records
- Compared to 519 people in Community

# Violence in Patients vs. Community

	Substance Abuse	No Substance Abuse
Discharged Patients (after 1 <sup>st</sup> 10 week interview)	22.0%	4.7%
Community Sample (Reported past 10 weeks)	11.1%	3.3%

# Targets of Violence

	Committed by Discharged Patient	Committed by Community Sample
Family	54.5 %	48.1 %
Friends/ Acquaintance	34.9 %	29.6 %
Stranger	10.7 %	22.2 %

# Summary

## Steadman et al. “McArthur” Study

- No significant difference in violence by patients not using substances compared to others living in the same neighborhoods not using substances
- Substance Abuse significantly raises the rate of violence in both patients and the community
- Higher portion of patients use substances than those in the community
- Violence in both patient and community was most frequently targeted to family members and friends and most often took place at home.

# Mental Illness and Risk of Violence

## ■ The Research

### ■ A National Study of Violent Behavior in Persons with Schizophrenia

■ Swanson, et al

■ Archives of General Psychiatry, May, 2006

# Study Design

- 1410 individuals with Schizophrenia were clinically assessed and interviewed about violent behavior in the past 6 months
- Data comes from patients enrolled in the 56 sites as part of the NIMH Clinical Antipsychotic Intervention Effectiveness (CATIE) project

# Study Design

- Minor violence
  - Simple assault
  - Without injury or weapon use
- Serious violence
  - Assault using a lethal weapon
  - Resulting in injury
  - Threat with a lethal weapon in hand
  - Sexual assault

# Prevalence of Violence in Schizophrenia (6 months)

Individuals with Schizophrenia committing no violence	1140 (80.9 %)
Individuals with Schizophrenia reporting minor violence	219 (15.5 %)
Individuals with Schizophrenia reporting Serious violence	51 (3.6 %)

# Summary of (CATIE) Violence in Schizophrenia Study

- 6 month prevalence of violence was 19.1% with 3.6% reporting serious violent behavior
- “Positive” psychotic symptoms were associated with risk of minor and serious violence
- “Negative” psychotic symptoms lowered the risk of serious violence.
- Minor violence was associated with co-occurring substance abuse.
- Serious violence was associated with psychotic and depressive symptoms, childhood conduct problems, and victimization

# National Crime Victimization Survey 1993-1999 (DOJ)

- Annual rate of nonfatal, job-related violent crime
  - 12.9/1000 - workers in all occupations
  - 16.2/1000 - physician
  - 21.9/1000 - nurses
  - 68.2/1000 - psychiatrists and MH professionals
  - 69.0/1000 - mental health custodial workers



The NEW ENGLAND  
JOURNAL of MEDICINE

## Violence and Mental Illness — How Strong is the Link?

*Richard A. Friedman, M.D.*

November 16, 2006

“Mental illness ...contributes very little to the overall rate of violence in the general population; the attributable risk has been estimated to be 3 to 5% - much lower than that associated with substance abuse.”

“In order to protect civil liberties, most states mandate treatment only if there is unambiguous evidence of an immediate danger to others...”

“Perhaps it makes sense to reset the threshold at the presence of known clinical risk factors – psychotic thoughts, a history of violence, and significant concurrent substance abuse”



# The NEW ENGLAND JOURNAL of MEDICINE

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“It is natural for psychiatrists and other medical professionals...to deny, to some extent, the possible danger. After all, it is hard to have a therapeutic relationship with a patient we fear. Still, we need to remind ourselves that the risk of violence, though small, is real, and we must take necessary precautions.”

“The challenge for medical practitioners is to remain aware that some of their psychiatric patients do in fact pose a small risk of violence, while not losing sight of the larger perspective – that most people who are violent are not mentally ill, and most people who are mentally ill are not violent.”

# Headlines Continue:

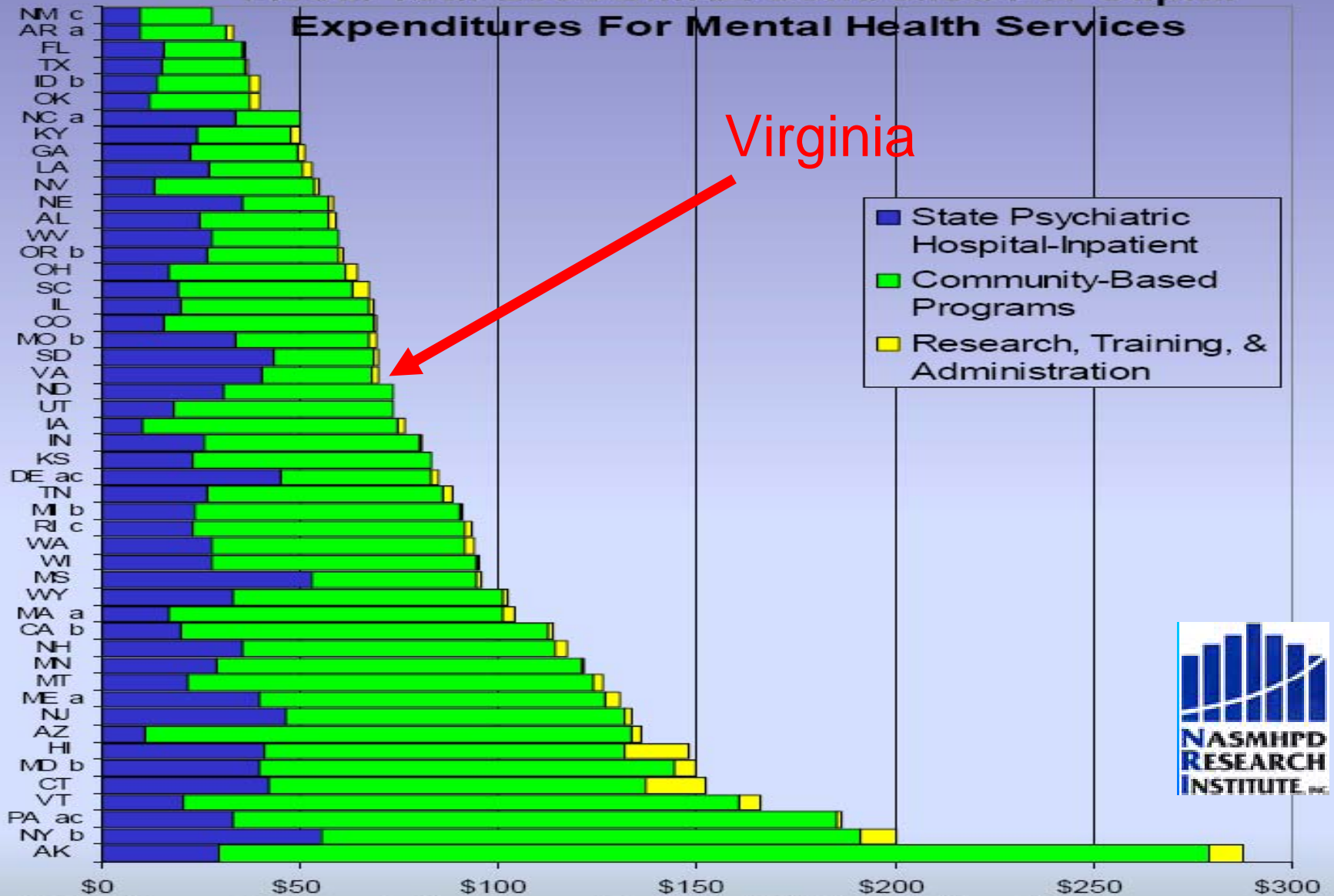
- “Gunman Kills 32 at Virginia Tech In Deadliest Shooting in U.S. History”
- “Mentally Ill Homeless Man stabs 72 year woman walking her dog in broad daylight”
- “Troubled Omaha Shooter Leaves Suicide Note”

# Tech Panel Recommendations

- IV-12 – The State should study what level of community outpatient service capacity will be required to meet the needs of the commonwealth and the related costs in order to adequately and appropriately respond to both involuntary court-ordered and voluntary referrals for those services. Once this information is available it is recommended that outpatient treatment services be expanded statewide

# Fiscal Year 2004 SMHA-Controlled Per Capita

## Expenditures For Mental Health Services



Virginia

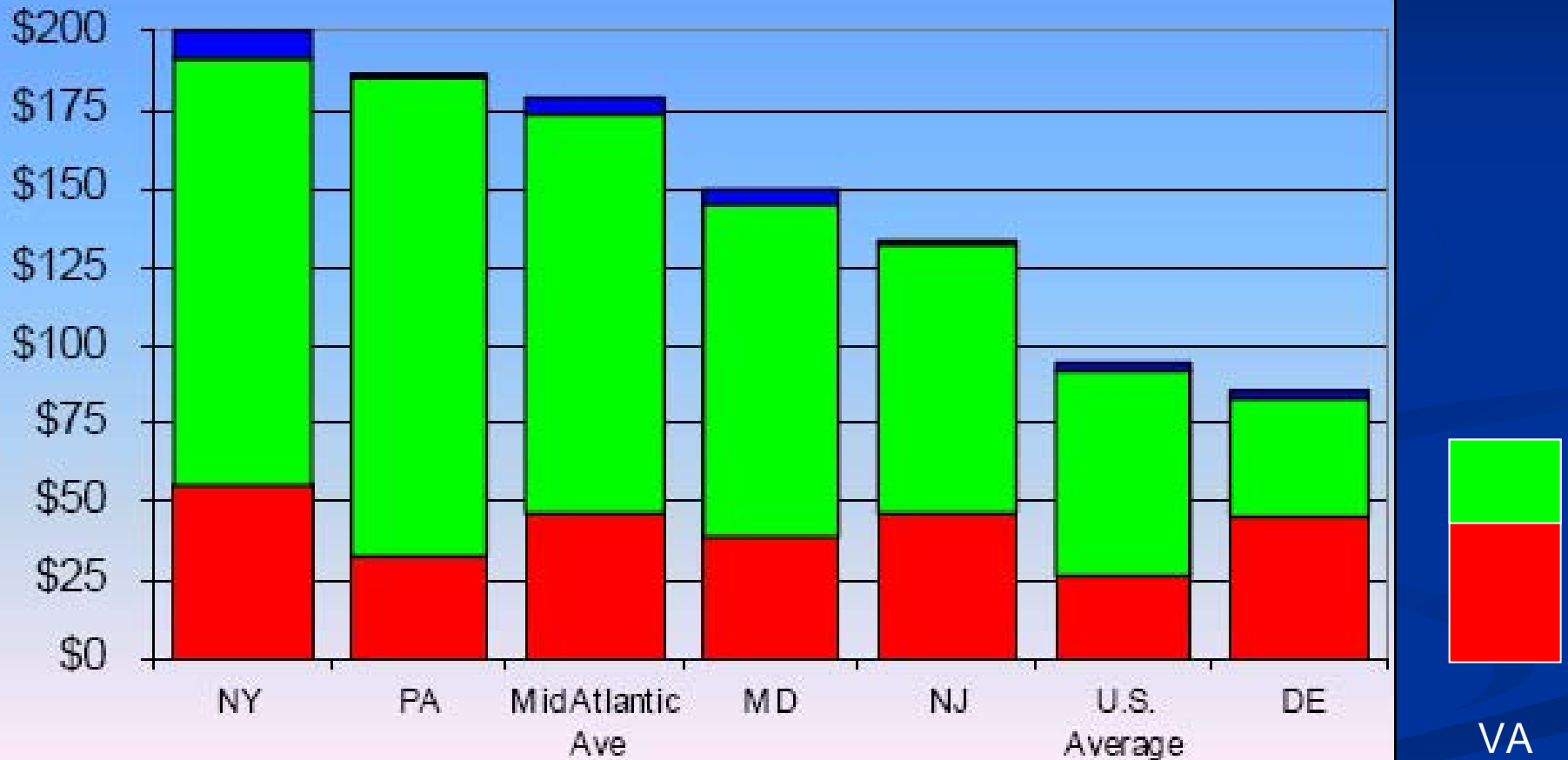
- State Psychiatric Hospital-Inpatient
- Community-Based Programs
- Research, Training, & Administration



a = Medicaid Revenues for Community Programs are not included in SMHA-Controlled Expenditures  
 b = SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.  
 c = Children's Mental Health Expenditures are not included in SMHA-Controlled Expenditures  
 d = SMHA-Controlled Expenditures includes the "majority" of publicly supported housing provided to Adults with SMI and/or Children with SED

# South Eastern States

## MidAtlantic States



VA

 Inpatient Per Capita

 Community Per Capita

# Tech Panel Recommendations

- IV-15 The criteria for involuntary commitment in Va. Code 37.2-817 (B) should be modified in order to promote more consistent application of the standard and to allow involuntary treatment in a broader range of cases involving severe mental illness.

# Major Legislative Changes

- Commitment Criteria
  - Changing “Imminent danger”
  - “Substantial Likelihood” in “near future”
- Mandatory Outpatient Treatment code language
  - More clarity
  - More “teeth”
  - Likely similar to New York’s Kendra’s Law

Involuntary Outpatient Commitment (IOC)

is the same as

Mandatory Outpatient Treatment (MOT)

and

Assisted Outpatient Treatment (AOT)

# *Three Types of MOT*

1. *Conditional Release* – Commitment order begins with hospital care and remains in effect after discharge to outpatient (e.g., NGRI, §19.2-182.7)
2. *Alternative to Hospitalization* – Same criteria (e.g., dangerous or unable to care for self) but two dispositions - inpatient or outpatient (§ 37.2-817)
3. *Need for Treatment* (e.g., Kendra's Law) –There is a lower standard for outpatient commitment order (need for treatment to prevent deterioration) than for inpatient commitment order

# *Controversies*

- Effectiveness – Does MOT really work?
  - Belleview Study
  - Duke Study
- Availability of Services and Infrastructure in the Community to support changes

# *Kendra's Law*

## *Current Research Questions*

- Is the court order necessary?
- Would enhanced services alone be enough?
- Large fiscal obligation –
  - Are we committed?
  - If not, at what cost to the rest of the system?

# *New York's Kendra's Law*

- Enacted 1999
- State, regional, local “AOT” infrastructure to support implementation and oversight
- \$32 million (FY05-06) added for case management, other services and oversight
- \$125 million added for enhanced community services for all consumers (nearly equal to VA's state GF funds for all MH community services)

- “From a marketing perspective, it may be necessary to capitalize on the fear of violence to get the law passed”
  - D.J. Jaffe, an advertising executive with the Treatment Advocacy Center (TAC)

- We are witnessing an unprecedented wave of interest in outpatient commitment. In part, enthusiasm for outpatient commitment stems from concerns about highly publicized acts of violence by persons with mental disorders, although this is one of the weaker justifications for new laws. Provision of involuntary outpatient treatment may be an important component of a system of care for persons with ...serious mental illnesses for reasons entirely unrelated to the prevention of headline-grabbing acts of violence.

- **Paul Appelbaum**

- Thinking Carefully About Outpatient Commitment
- Psychiatric Services August 2001