Mental Illness, Violence, and Mandated Community Treatment

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Part 1: Mental Illness and Violence
NIMH Epidemiological Catchment Area (ECA) Study
Swanson et al (1990)

- 10,000 adult household residents of Baltimore, Raleigh-Durham, and Los Angeles
- Controlled for age, gender, SES, and race
- Psychiatric disorder measured with the Diagnostic Interview Schedule, administered by trained interviewers.
Violence Questions in the ECA

1. Did you ever hit or throw things at your partner?

2. Have you ever spanked or hit a child hard enough so that he/she had bruises or had to stay in bed or see a doctor?

3. Since age 18, have you been in more than one fight that came to swapping blows?

4. Have you ever used a weapon like a stick, knife, or gun in a fight since you were 18?

5. Have you ever gotten into physical fights while drinking?
## Results: Violence in Past Year

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% Violent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Disorder</td>
<td>2</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>13</td>
</tr>
<tr>
<td>Major Depression</td>
<td>12</td>
</tr>
<tr>
<td>Mania or Bi-Polar</td>
<td>11</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>26</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>35</td>
</tr>
</tbody>
</table>
**Probability of any violent behavior in 1 year by cumulative risk factor profiles: NIMH Epidemiologic Catchment Area Study (Swanson et al, 1990)**

<table>
<thead>
<tr>
<th></th>
<th>Younger age</th>
<th>Male</th>
<th>Lower SES</th>
<th>Substance abuse</th>
<th>Major mental disorder</th>
<th>History of arrest</th>
<th>History of psychiatric hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lowest risk group:</strong> 1% probability of any violence in year</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Highest risk group:</strong> 65% probability of any violence in year</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The MacArthur Violence Risk Assessment Study

Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Roth, Grisso & Banks (2001)
MacArthur Violence Risk Assessment Study

• 1,100 patients discharged from short-term psychiatric facilities in 3 states (MA, PA, and MO)
• Measured 134 possible risk factors for violence to others
• 5 month community follow-up; self-report, collateral report, arrest and hospital records
• Violence: weapon use, threat with a weapon in hand, battery resulting in injury, or sexual assault
• Comparison group: 500 people, matched for neighborhood, age, and race, randomly sampled from the community.
Violence in First 10 Weeks After Discharge - Pittsburgh

- Community: 4.6%
- Patients: 11.5%
Violence in First 10 Weeks After Discharge, by Substance Abuse Symptoms - Pittsburgh

<table>
<thead>
<tr>
<th></th>
<th>Without Substance Abuse</th>
<th>With Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community (17.5)</td>
<td>3.3%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Patients (31.5)</td>
<td>4.7%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>
### Targets of Violence

<table>
<thead>
<tr>
<th>Targets</th>
<th>% of Violent Acts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharged Patients</td>
</tr>
<tr>
<td>Family members</td>
<td>55</td>
</tr>
<tr>
<td>Friends/ Acquaintances</td>
<td>35</td>
</tr>
<tr>
<td>Strangers</td>
<td>11</td>
</tr>
</tbody>
</table>
Common Risk Factors for Violence in the MacArthur Study

- What the person “is”
- What the person “has”
- What the person “has done”
- What has been “done to” the person
Common Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “IS”

- Age: 1-yr increase in age, violence ↓ 20%
- Anger control: 1 SD increase in anger, violence ↑ 52%
- Gender: M 51% ↑ violent than W
Common Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “HAS”

• Major mental disorder, or a
• Personality disorder
Violence in First 10 Weeks by Patient Groups and Community Group

- Community-Pittsburgh: 4.6%
- Patients-Schizophrenia: 8.1%
- Patients-Bipolar: 15.5%
- Patients-Depression: 18.8%
- Patients-Personality Disorder: 22.7%
Common Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “HAS”

• Major mental disorder
• Personality disorder
• Substance abuse disorder
Violence in First 10 Weeks After Discharge, by Substance Abuse Symptoms - Pittsburgh

- Without Substance Abuse
- With Substance Abuse

Community (17.5):
- Without Substance Abuse: 3.3%
- With Substance Abuse: 11.1%

Patients (31.5):
- Without Substance Abuse: 4.7%
- With Substance Abuse: 22.0%
Common Risk Factors for Violence in the MacArthur Study

WHAT THE PERSON “HAS DONE”

- Prior crime and violence
Total Sample
19% Violent

Prior Arrests
None
9% Violent

Prior Arrests
Non-Violent
20% Violent

Prior Arrests
Violent
36% Violent
Common Risk Factors for Violence in the MacArthur Study

WHAT HAS BEEN “DONE TO” THE PERSON

- Pathological family environment: father used drugs, violence ↑ 100%
- Victimization: seriously abused as a child, violence ↑ 51%
Mental Illness and Violence

5 Bottom Lines
According to the best research estimates, approximately 4% of violence toward others in American society is attributable to mental illness. That is, if we could somehow cure all mental illnesses overnight, we would be left in the morning with a rate of violence that is 96% of what it is now.
2: But Mental Illness Does Play Some Role in American Violence

Mental illness modestly but clearly increases the likelihood of violence to others. In the MacArthur Violence Risk Assessment Study, for example, during the first several months after discharge from short-term psychiatric facilities, about 11% of people with a mental illness committed a violent act, compared to about 5% of their non-hospitalized neighbors.

Two facts need to be appreciated to understand this finding:
First, the violence committed by discharged patients was heavily mediated by substance abuse. Indeed, if the former patients were not abusing alcohol or other drugs after they were discharged from the hospital, their rate of violence to others was no different than the rate in their surrounding communities.

In fact, however, the discharged patients abused alcohol or other drugs twice as frequently as their non-disordered neighbors, and those who did engage in substance abuse had substantially elevated rates of violence to others.
Second, the most frequent type of violence that the discharged patients commit is hitting someone—most often, hitting a family member. In the MacArthur Study, only 3% of the violence committed by former patients involved using a gun, or threatening to use a gun, on a stranger.
Finding: 1 in every 140,000 people with schizophrenia will kill a stranger.

“Measures that ensure earlier treatment of psychosis and continued treatment in the community would be likely to prevent homicides of both strangers and family members.

However, the extreme rarity of these events means that identification of individual patients who might kill a stranger is not possible.”
Suicide among people with mental illness is much more common than violence to others. According to CDC data, the age-adjusted suicide rate for the total population was approximately twice as high as the homicide rate. Over 38,000 suicides occur in the U.S. each year, compared with roughly 16,000 homicides.

The American Federation for Suicide Prevention estimates that 90% of all people who die by suicide have a diagnosable psychiatric disorder at the time of their death.
4: Victimization is Much More Common Than Offending Among People with MI

It is often unappreciated that people with serious mental illness are far more likely to be the victims than the perpetrators of violence. For example, women with mental illness have 5 times greater risk than other women of being the victims of domestic abuse.
“[M]ental health professionals and other advocates for improved mental health services must exercise caution in their endorsement of proposals for increased mental health funding. Such offers are often premised on the proposition that the problem of violence is largely a problem of untreated mental illness, and its corollary that better treatment will preclude a repetition of mass shootings such as Tucson and Newtown...

However, tying the need for increased funding to public safety will lead to further demonization of people with mental disorders, as well as an inevitable backlash when it becomes clear that more mental health clinics or inpatient beds have not had a major impact on the prevalence of violence.”
Part 2: Mandated Community Treatment
Can *Voluntary* Community Treatment Reduce Violence?
Violence in 2nd 10-Weeks After Discharge, by Outpatient Treatment Sessions Attended in 1st 10 Weeks

- None: 14.0%
- 1 per month: 9.5%
- 1 per week: 2.9%

p < 0.0001, controlling for age, gender, race, education, marital status, substance use, diagnosis, and prior violence. Community comparison group = 4.6% violent.
### Views on Outpatient Commitment and Mental Health Services

<table>
<thead>
<tr>
<th>Bazelon Center</th>
<th>Treatment Advocacy Center</th>
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<tbody>
<tr>
<td>“[O]utpatient commitment penalizes the individual for what is essentially a systems problem. Lack of appropriate and acceptable community mental health services is the issue.”</td>
<td>“For [a] small subset of the most mentally ill, no amount of money spent on services will ever be enough to induce their compliance with treatment.”</td>
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## HOSPITAL ≠ COMMUNITY

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Housing as “Leverage”
A standard lease for a subsidized apartment for a person with mental illness

“Refusing to continue with mental health treatment means that I do not believe I need mental health services. I understand that since I am no longer a consumer of mental health services, it is expected that I will find alternative housing. I understand that if I do not, I may face eviction.”

In 41 states, the mean rent for a 1-bedroom apartment exceeds 100% of federal disability benefits.
Money as “Leverage”
Money managers ("Representative payees")

“You are receiving benefits based on the mental health problems that you have. The Social Security Administration requires that you be involved in mental health services so that you will feel better. [Otherwise,] you may lose your benefits.”

~ 1,000,000 people in the U.S. receive benefits for psychiatric disability through a “rep payee”
Jail as “Leverage”
Treatment as a condition of probation

“The court may provide, as further conditions of a sentence of probation...that the defendant ... undergo available medical, psychiatric, or psychological treatment.” 18 U.S. Code § 3563.

In addition, ~400 mental health courts are now in operation in the U.S.
Hospitalization as “Leverage”

“Outpatient Commitment”

A civil court-order requiring a person to accept mental health services in the community.

- **Conditional discharge:** meets inpatient commitment criteria
- **Alternative to hospitalization:** meets inpatient commitment criteria
- **Preventive commitment:** does **not** meet inpatient commitment criteria.
The Prevalence of Mandated Treatment in the Community
### Prevalence of Mandated Community Treatment

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<th>Form of Leverage</th>
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## Prevalence of Mandated Community Treatment

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<tr>
<td>Obtaining Money</td>
<td>12</td>
</tr>
<tr>
<td>At Least 1 Form</td>
<td>51</td>
</tr>
</tbody>
</table>
Outpatient Commitment: The Mixed State of the Evidence

- Cochrane Collaboration (2012), Compulsory community and involuntary outpatient treatment for people with severe mental disorders: “The evidence found in this review suggests that compulsory community treatment may not be an effective alternative to standard care.”

- Burns et al, The Lancet (March 2013): “In well coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty.”
NEW YORK STATE
ASSISTED OUTPATIENT TREATMENT
PROGRAM EVALUATION

Submitted under Contract with the New York State Office of Mental Health

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Outpatient Commitment in New York: “Assisted Outpatient Treatment” (AOT)

- adult with mental illness, who has
- a history of lack of compliance with treatment:
  - hospitalized ≥2x within past 3 years; or
  - ≥1 acts of serious violence toward self or others within past 4 years; and
- “is unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community.”
Outpatient Commitment in New York:
“Assisted Outpatient Treatment”

- People on an AOT Order (in past year)
  - New York State = 3,073
  - New York City = 1,877

- Length on AOT:
  - < 12 months = 46%
  - >12 months = 54%

- “Removals” by police:
  - New York State = 479
  - New York City = 345
Main Findings of the NYS AOT Study

- Increased medication possession rates
Exhibit 3.10 Adjusted percent* with at least 80% medication possession in month by AOT status

*Adjusted probability estimates were generated from repeated measures regression models controlled for time, region, race, age, sex, diagnosis, and co-insurance status. Models were also weighted for propensity to initially receive AOT and to receive more than 6 months of AOT.

Source: Medicaid and OMH records.
Main Findings of the NYS AOT Study

- Increased medication possession rates
- Reduced inpatient admissions
Exhibit 3.8 Adjusted percent* with psychiatric inpatient admission in month, by AOT status

*Adjusted probability estimates were generated from repeated measures regression models controlled for time, region, race, age, sex, diagnosis, and co-insurance status. Models were also weighted for propensity to initially receive AOT and to receive more than 6 months of AOT.

Source: Medicaid claims and OMH admissions data.
Main Findings of the NYS AOT Study

- Increased medication possession rates
- Reduced inpatient admissions
- Reduced inpatient days
Exhibit 3.9. Adjusted* average inpatient days during any 6 month period, by AOT status

*Adjusted mean estimates were generated from repeated measures regression models controlled for time, region, race, age, sex, diagnosis, and co-insurance status. Models were also weighted for propensity to initially receive AOT and to receive more than 6 months of AOT.

Source: Medicaid claims and AOT Evaluation database.
Main Findings of the NYS AOT Study

- Increased medication possession rates
- Reduced inpatient admissions
- Reduced inpatient days
- Reduced arrests
% Arrested Per Month

Adjusted for time, age, sex, race, region, education, and diagnosis

Pre-AOT: 3.7
Current AOT: 1.9
Main Findings of the NYS AOT Study

- Increased medication possession rates
- Reduced inpatient admissions
- Reduced inpatient days
- Reduced arrests
- No significant differences between AOT and non-AOT recipients in perceived coercion, working alliance, treatment satisfaction, or life satisfaction
Main Findings of the NYS AOT Study

- Increased medication possession rates
- Reduced inpatient admissions
- Reduced inpatient days
- Reduced arrests
- No significant differences between AOT and non-AOT recipients in perceived coercion, working alliance, treatment satisfaction, or life satisfaction
- If on AOT > 12 months, benefits continue after AOT order ends.
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References:
www.macarthur.virginia.edu