Issue Brief

Violence and People with Mental Illness Served in the Public Mental Health System

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Violence and mental illness are inextricably linked in the public mind. It takes only one dramatic news story to reinforce that conception. There is considerable evidence - much of it collected through work done at CMHSR - that suggests that the public picture is incorrect. Although violence is a significant problem in the lives of people with mental illness, they do not appear to be significantly more involved in violent incidents than their neighbors and others of similar social backgrounds. Nonetheless, a program that would significantly reduce the amount of violence in their lives would be a major benefit to both people with mental illness and their friends and families. Unfortunately, there is as yet no evidence that clearly demonstrates programmatic success.

Research findings on mental illness and violence

Research about violence and mental illness has, over the last decade, yielded some clear findings with important implications for mental health policy and services. Some of these are:

- Violence is a frequent and persistent problem in the lives of many people with mental illnesses. Depending on the sample, between 30% and 50% of people with mental illness are involved in at least one incident of physical violence every 6 months.[1, 2]

- Although the findings cannot be said to be definitive, it does not appear that people with mental illness are more likely to be perpetrators than victims.

- Moreover, they do not appear to be substantially more likely to be involved in such incidents than their neighbors, unless they also have significance sub stance abuse problems.[2]

- People with mental illness have a much higher rate of involvement in violence if they also have a significant substance abuse problem.[3, 5]

- However, among people with mental illness who do not have co-occurring substance abuse problems, the frequency of violence is only modestly higher than that of people who are not mentally ill and live in similar neighborhoods.[2] Thus, mental illness by itself may not be a significant predictor of violence.

- People with severe mental illnesses (e.g. schizophrenia) are less likely than people with less severe disorders such as depression to be involved in violent incidents.[3]

- Most violent incidents are fights between two people rather than clear perpetrator-victim situations[4] which suggests that treatment of the individual's mental illness is unlikely to be a complete solution.

- There are several different effective methods of distinguishing which people with mental illness are most likely to be involved in a violent incident.[3, 6]

Policy implications

Although predicting violence is a major issue for mental health practitioners when dealing with forensic patients or when determining whether involuntary commitment criteria apply, housing, employment, and symptom reduction are more often the focus of care planning in community care. While these are very important issues in community care, managing violence may be equally important in some cases. In Massachusetts violence is still often ignored in spite of Department of Mental Health (DMH) support for training of community providers in violence assessment. Yet research has consistently shown that violence is a serious problem in the lives of people with mental illness.

Because violence is a problem that may interfere with the social adjustment of people with mental illness, it should be taken as a serious issue in the design of community mental health services. Moreover, since psychosis does not appear to play a substantial role in these incidents and, indeed, people with mental illness are as likely to be victims as perpetrators, medication and other treatments that are aimed exclusively at treating the mental illness appear unlikely to be successful in reducing violence.

The reciprocal nature of the violence, and the apparent evidence that the frequency of violence involving people with mental illness is similar to that of their neighbors suggests that interventions for people with mental illness should not be substantially different from those for people involved in violence who are not mentally ill. Anger management, conflict resolution and other interventions might significantly reduce a serious problem that interferes with the active participation of people with mental

illness in the community. However until a systematic study demonstrates the effectiveness of such an approach with the mentally ill population, we lack clear evidence of an appropriate treatment modality

In Massachusetts, DMH's support for training and efforts of CMHSR faculty to assist police and probation officers to manage people with mental illness who are in trouble with the law have clearly made some progress. There remains a need for systematic programs, in Massachusetts and elsewhere, to assist publicly served mentally ill clients with anger management and conflict resolution techniques.

References

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