Meadows Mental Health Policy Institute

Mental Illness and Violence: Current Knowledge and Best Practices – February 2020

In the aftermath of mass violence and the furor of the 24-hour news cycle, the words "mental illness" are often used to try to explain a perpetrator's actions. In many cases, the assumption that mental illness had to be involved in these incidents drives the public debate about solutions. This kind of coverage might raise awareness of how important mental health care is, but it is ultimately problematic because too often it also spreads inaccurate definitions of "mental illness" and imposes further stigma on those who actually suffer from bona fide mental health conditions.

Although some mental illnesses, such as **untreated psychotic disorders**, are associated with an increased risk of violence toward others, most mental health conditions are associated with a comparable or lower risk.[1] The major exceptions are **depression** and other **mood disorders**, which are the primary drivers of violence directed at the self, with suicide rates in the United States increasing significantly in recent years.[2] Among youth and young adults, suicide is now the second leading cause of death, and rates have increased and now surpass historical highs last seen in the 1970s. Suicide is the third leading cause of death among non-elderly adults, and their rates are now also at historical highs. For more information on suicide trends, see the Meadows Mental Health Policy Institute's 2018 report, *Severe Violence Trends: Suicide, Murder, Mass Shootings, School Shootings – August 2018*.

In this paper, we define "mental illness," discuss which diagnoses may have higher rates for violence and describe evidenced-based treatments that can help reduce the risk of violence.

What Is Mental Illness?

Mental illnesses are discrete and *treatable health conditions* involving distress or functional impairment related to thinking, emotion, or behavior. Examples of diagnosable and treatable mental illnesses include **anxiety**, **depression**, **bipolar disorder**, **post-traumatic stress disorder**, and **schizophrenia**.

---

[1] Meadows Mental Health Policy Institute. (2018, May). *What we know about violence and mental illness: A preliminary summary of current research*. Dallas, TX: Author. Retrieved from https://www.texasstateofmind.org/wp-content/uploads/2018/11/What-We-Know-About-Violence-and-Mental-Illness-2018_05_24PreliminaryReport.pdf

[2] Planalp, C., & Hest, R. (2019). *Suicide rates on the rise: National trends and demographics in suicide deaths from 2000–2017*. State Health Access Data Assistance Center, Robert Wood Johnson Foundation. Retrieved from https://www.shadac.org/sites/default/files/publications/National%20Suicide%20Rates%20Brief_10.2019.pdf According to this study, from 2000 to 2017, the U.S. suicide death rate increased from 10.4 to 14.0 per 100,000 people, an overall increase of 35 percent—representing an additional 3.6 deaths per 100,000 people per year; the rate of increase doubled from 2009 to 2017 compared to the rate of increase from 2000 to 2008.

There are also negative, antisocial traits (emotional, cognitive, and behavioral) associated with typical human functioning, such as anger, temper, hate, envy, grievance, impulsivity, and reactivity. These human traits, while in many cases undesirable and problematic for individuals, families, and communities, are unfortunately normal human behaviors. While a range of human activities can be employed to counteract these problematic traits – parenting, education, faith practices, some types of psychotherapy, policing, and the justice system – these traits are *not illnesses*. Antisocial behavior, for example, is not on its own sufficient to warrant diagnosis of antisocial personality disorder, which involves an ingrained pattern of predatory behavior and lack of conscience that is very difficult in most cases to treat successfully, but which does constitute an illness.

Conversely, normal humans are also capable of carrying out extreme acts in many circumstances, such as parents defending their children. In addition, many people in a pique of rage are capable of violence. When substance use is added to the mix, the range expands significantly. Ideology and training can also teach people to normalize extreme acts, both admirable (such as firefighters and warriors) and detestable (such as terrorism, racism, and bigotry). All of these are primary drivers of violence more highly associated with violent acts than even the most highly correlated mental illnesses.[3]

People who engage in violence may have traits such as these that are associated with their violence and which cause others to see them as profoundly different from the norm, but which are not *treatable mental illnesses*. The consensus among researchers and experts is that factors other than mental illness, including ideology, personal grievance, and antisocial character traits within the normal range of human behavior (sometimes related to past trauma or made worse by mental illness or substance use), are the most common factors motivating violence generally and mass murder in particular. Whether one terms it dysfunction or evil, such behavior does not constitute a diagnosable and treatable health condition.

What Does Research Show About the Association Between Mental Illness, Mass Murder, and Violence More Generally?

Although incidents of mass murder have a devastating impact on the affected communities and create fear and concern in society as a whole, deaths from mass public shootings[4] are rare compared to other types of violence. In 2016, we closely examined the research on mass murder and found that mental illness does not predict mass murder, including school shootings, because mass shootings and other forms of mass murder are so rare and multi-

[3] Sariasian, A., et al. (2016). Triggers for violent criminality in patients with psychotic disorders. JAMA Psychiatry, 73(8), 796-803.

[4] Mass public shootings and associated fatalities are defined as public shooting incidents that are neither gang-related nor suicide-related and result in four or more gun-related fatalities.

determined that no factor or combination of factors, including mental illness, can predict them.[5] Subsequent comprehensive reports in 2019 on mass violence[6] and targeted school violence[7] have reached the same conclusions.

However, when we focus on the much more common occurrence of homicide in general, research shows a statistically significant relationship between homicide and one particular type of mental health condition when untreated – **psychosis**, which includes very severe symptoms such as hallucinations (hearing or seeing things that are not there) and delusions (false and sometimes bizarre beliefs). *When untreated*, psychosis does increase the risk of committing homicide: people with untreated psychosis are 15 times more likely to commit homicide.[8] People experiencing a first episode of psychosis have a dramatically elevated risk of suicide and other mortality – 24 times the average risk for people of the same age, primarily associated with a greater risk of suicide and elevated cardiometabolic risk factors.[9]

Examining violence in general, most people with mental illnesses are, on average, comparable in risk with people who do not have mental illnesses, and people with severe mental illnesses are slightly more violent. Whereas estimates of violence in the general population range from just under 1% to 2%,[10] a large epidemiological sample that controlled for the effect of substance use found that people with mild to moderate mental health conditions had a 12-month rate of just under 2%[11] (comparable to findings for the general population) and people

---

[5] Meadows Mental Health Policy Institute. (2016, September). *Mental illness and mass murder: What the research does and does not tell us*. Dallas, TX: Author. Retrieved from https://www.texasstateofmind.org/wp-content/uploads/2019/11/Mental-Illness-and-Mass-Murder-FINAL-Sept-2016.pdf

[6] National Council for Behavioral Health. (2019, August). *Mass violence in America: Causes, impacts and solutions.* Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2019/08/Mass-Violence-in-America_8-6-19.pdf

[7] Drysdale, D., Driscoll, S., Blair, A., Carlock, A., Cotkin, A., Johnston, B., Foley, C., et al. (2019). *Protecting America's schools: A U.S. Secret Service analysis of targeted school violence.* United States Secret Service National Threat Assessment Center, U.S. Department of Homeland Security. Retrieved from https://www.secretservice.gov/data/protection/ntac/Protecting_Americas_Schools.pdf

[8] Nielssen, O., & Large, M. (2010). Rates of homicide during the first episode of psychosis and after treatment: A systematic review and meta-analysis. *Schizophrenia Bulletin, 36*(4), 702–712.

[9] Schoenbaum, M. et al. (2017). Twelve-month health care use and mortality in commercially insured young people with incident psychosis in the United States. *Schizophrenia Bulletin*, *43*(6), 1262–1272. Retrieved from https://doi:10.1093/schbul/sbx009

[10] Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R., & Deb, K. S. (2016). Violence and mental illness: What is the true story? *Journal of Epidemiology and Community Health, 70*(3), 223–225; Van Dorn, R., Volavka, J. & Johnson, N. (2012). Mental disorder and violence: Is there a relationship beyond substance use? *Social Psychiatry and Psychiatric Epidemiology, 47*, 487–503.

[11] Elbogen, E. B., & Johnson, S. C. (2009, February). The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 66*(2), 152–161. Estimates can vary based on the samples used and on the time period under study. For example, Elbogen & Johnson used a two- to three-year period and Van Dorn, R., Volavka, J. & Johnson, N. (cited above) used a 12-month period in their analyses. Unless otherwise cited, all data in this paragraph are from this source.

with serious mental illnesses had a slightly higher rate of violence of just under 3% over a 12-month period. However, the slightly elevated rate among people with severe mental illness is driven by a subset of symptoms associated with violence (such as psychosis with homicide and depression with suicide) as well as factors that also drive violence in the general population, including anger and a history of social deviance,[12] substance abuse and addiction, parental history of criminal activity, history of physical and or sexual abuse, history of juvenile detention, recent victimization, divorce or separation in the past year, and housing instability. All of these are factors separate from the underlying illness that are disproportionately experienced by people with mental illnesses and that also exacerbate the risk of violence.

One group of people with mental illness – those with **mood disorders such as major depression** – are, as an entire group, no more likely than the general population to hurt others, though they are more likely to harm themselves.[13] People with **anxiety disorders**, in contrast, are no more likely to harm themselves than the general population and also no more likely to harm others; a subset with certain anxiety disorders are less likely than average to harm others.[14]

Treatment and Reducing the Risk of Violence

Each year, about 3,000 Texas youth and young adults ages 14 to 35 years first experience an episode of **psychosis**.[15] These individuals do not typically receive care and treatment until five years after the initial onset of psychosis.[16] Studies show that the longer treatment is delayed, the worse the outcome, both for the individual and for society.[17]

---

[12] Skeem, J., Kennealy, P., Monahan, J., Peterson, J., & Appelbaum, P. (2015, April 24). Psychosis uncommonly and inconsistently precedes violence among high-risk individuals. Psychological Science, 4(1), 40–49. Retrieved from https://doi.org/10.1177/2167702615575879

[13] Harford, T. C., Chen, C. M., Kerridge, B. T., & Grant, B. F. (2018). Self- and other-directed forms of violence and their relationship with lifetime DSM-5 psychiatric disorders: Results from the National Epidemiologic Survey on Alcohol Related Conditions−III (NESARC−III). *Psychiatry Research, 262*, 384–392. Retrieved from https://doi.org/10.1016/j.psychres.2017.09.012

[14] Harford, T. C., Chen, C. M., Kerridge, B. T., & Grant, B. F. (2018). Note that for both mood disorders and anxiety disorders, the disorder categories included the full range of mild, moderate, and severe disorders.

[15] This estimate was calculated by using data reported in Kirkbride et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the social epidemiology of psychoses in East Anglia [SEPEA} Study. *American Journal of Psychiatry, 174*(2), 143–153. The incidence rates for ages 16–35 years reported in Kirkbride et al. (2017) were applied to Texans of the same ages, and we also derived conservative, extrapolated estimates for Texans ages 14–15 years, since other studies have found first episode psychosis (FEP) can occur in those ages, as well. However, FEP incidence varies considerably, depending on a community's rate of migration, poverty rate, crime rate, and other factors. Therefore, FEP incidence can vary considerably across different Texas communities. Our estimates likely are biased downward for urban areas.

[16] Wang P. S., Berglund P. A., Olfson M., & Kessler R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research, 39*(2), 393–415.

[17] Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., et al. (2015, October 20). Comprehensive versus usual community care for first episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, 173*(4), 362–372. Retrieved from https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2015.15050632

Those same studies demonstrate that treatment works. People with psychosis are much less likely to commit homicide when they receive effective care,[18] and treatment efficacy increases the earlier that intervention begins after symptoms emerge. A team-based approach, **Coordinated Specialty Care (CSC)**, starts assertive and intensive treatment as early after the initial psychosis as possible. The sooner CSC is accessed following the onset of psychotic symptoms, the better. For more information, see the Meadows Mental Health Policy Institute's 2020 report, *Coordinated Specialty Care for Texans – February 2020*.

Investment in another evidenced-based treatment, **Multisystemic Therapy (MST)**, can also improve outcomes for thousands of Texas youth at greater risk of becoming violent because of a mix of mental illness and social factors. MST is a well-established, highly researched, and cost-effective family and community-based treatment for at-risk youth with intensive needs and their families.[19] It has proven most effective for treating youth who have committed violent offenses, have serious mental health or substance abuse concerns, are at risk of out-of-home placement, or have experienced abuse and neglect.[20] MST has been proven to reduce violent crimes by 75%, compared to routine congregate and other care as usual,[21] with long-term reductions enduring two decades post-treatment. For more information, see the Meadows Mental Health Policy Institute's 2020 report, *Multisystemic Therapy for Texas Youth – February 2020*.

Finally, for people who require inpatient care to minimize a risk of violence to themselves or others, community treatment capacity is a concern. As our forensic population continues to increase and represent a growing percentage of our state hospital system capacity, there are fewer inpatient beds available for civil commitments. Increased attention on perceived threats in reaction to recent tragedies will add additional pressures on this system. Although the 86th Texas Legislature funded an additional 50 community beds for inpatient care, a request for an additional 25 beds went unfunded, and the inpatient system will experience more demand in the next biennium as the population grows and rates of need continue to increase.

---

[18] Nielssen, O., & Large, M. (2010). Rates of homicide during the first episode of psychosis and after treatment: A systematic review and meta-analysis. Schizophrenia Bulletin, 36 (4), 702–712.
[19] Hengeller, S. W., & Shoenwald, S. K. (2011). Evidence-based interventions for juvenile offenders and juvenile justice policies that support them. *Social Policy Report, 25*(1): 1–20.
[20] MST Services. (2018). *Multisystemic Therapy (MST) research at a glance, short version.* Retrieved from https://cdn2.hubspot.net/hubfs/295885/MST%20Redesign/Marketing%20Collateral/Case%20Study%20and%20Reports/Research%20at%20a%20Glance%202019-%20Short%20Version.pdf
[21] MST Services. (n.d.). *What makes MST such an effective intervention*. Retrieved from https://cdn2.hubspot.net/hubfs/295885/MST%20Redesign/White%20Paper/White%20Paper%20-%20What%20Makes%20MST%20an%20Effective%20Intervention.pdf