SAMHSA and Violence

The possible association between schizophrenia and violence remains a contentious issue in mental health. This question is particularly emotive for those, like myself, who started their psychiatric careers at a time when massive asylums still dominated the landscape of mental health care, or the lack of care, and the struggle for civil rights for the compulsorily detained was just beginning. Those working for reform confronted the necessity of calming the exaggerated fears of the general population about the violent tendencies of the mad. Equally it was essential to overcome similar, though more politely articulated prejudices among those who controlled public mental health services, including most of our older colleagues. The question of an association was in those days as much a political as a scientific question, and it was in the guise of scientists that we answered politically. The efforts to minimize, or if possible explain away, the apparent association between schizophrenia and violence was remarkably effective, and up to a point beneficial to patients. Several generations of mental health professionals were taught there was no association, patient advocacy groups gratefully accepted the new wisdom, and even journalists and politicians became somewhat more constrained in evoking the fear of the murderous mad.

But in the end the question deserves to be answered empirically, both for our own scientific integrity, and far more importantly for the sake of our patients. If the association is wrongly dismissed nothing can be done to reduce the risks of possible violence, with its attendant disasters for victim and patient. Currently many mental health professionals refuse to accept that the reduction of the violence potential in their psychotic patients is any of their business.[1]

SAMHSA minimizes violence in mentally ill
SAMHSA minimizes violence as a problem associated with mental illness.[2]

A national study found almost 20% of persons with schizophrenia are violent in any 6 month period.[3]

SAMHSA can minimize rates of violence by diluting increased incidents of violence by the most seriously ill, with lower rates of violence among people with minor mental health issues, narrowly defining violence, only studying those receiving treatment and other statistical tricks. I wrote about these related to one particular study[4]

SAMHSA minimizes violence among mentally ill by blaming substance abuse
SAMHSA says increased violence is due to substance abuse and research does show substance abuse contributes, especially in transition age youth.[5] However, SAMHSA ignores the fact that a large percentage of people with mental illness use substances *as a result of the underlying illness*. By eliminating those with substance abuse from violence statistics they intend to minimize violence associated with the disorder.

The research shows even those who have schizophrenia and do not abuse substances are twice as likely as controls to have a violent incident[6]

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[1] Mullen PE (2009) Facing Up to Unpalatable Evidence for the Sake of Our Patients. PLoS Med 6(8): e1000112. doi: 10.1371/journal.pmed.1000112 avail at http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000112

[2] Slide 31 http://store.samhsa.gov/product/Informing-Public-Health-Strategies-Challenges-and-Opportunities-in-Behavioral-Health/SMA13-PHYDE011813 See: Page 2 of http://www.help.senate.gov/imo/media/doc/Hyde1.pdf

[3] The 6-month prevalence of any violence was 19.1%, with 3.6% of participants reporting serious violent behavior. Distinct, but overlapping, sets of risk factors were associated with minor and serious violence. "Positive" psychotic symptoms, such as persecutory ideation, increased the risk of minor and serious violence, while "negative" psychotic symptoms, such as social withdrawal, lowered the risk of serious violence. Minor violence was associated with co-occurring substance abuse and interpersonal and social factors. Serious violence was associated with psychotic and depressive symptoms, childhood conduct problems, and victimization. A national study of violent behavior in persons with schizophrenia. Swanson, Swartz MS, Van Dorn RA, Elbogen EB, Wagner HR, Rosenheck RA, Stroup TS, McEvoy JP, Lieberman JA. Also see collection of summaries of violence studies at http://mentalillnesspolicy.org/consequences/mental-illness-violence-stats.html

[4] I co-authored an article on how researchers of one major study (McArthur) reduced incidents of violence in their study. Violent fantasies By Sally Satel and D J Jaffe *Published in National Review July 28, 1998 pp. 36-38 a*vailable at http://mentalillnesspolicy.org/consequences/macarthur-violence-mental-illness.html

[5] http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000120

[6] Schizophrenia patients were significantly more likely than controls to be guilty of violent and non-violent offences, and to have been involved in family violence. Even schizophrenia patients without comorbid substance-use disorders had a significantly elevated risk of violence. They were more than twice as likely as controls to have a violent conviction. The elevation of violence risk in schizophrenia patients was higher in females The increased risk of violent offending in schizophrenia cannot be solely attributed to the effects of comorbid substance misuse, although comorbidity certainly heightens the likelihood of criminality. In addition to offending, people with schizophrenia are more likely than community controls to come to the attention of police via their involvement in family violence incidents. Schizophrenia is a particularly strong risk factor for violence in females. http://www.ncbi.nlm.nih.gov/pubmed/23379839

SAMHSA minimizes violence by changing the subject to victimization
SAMHSA minimizes violence by claiming the "mentally ill are more likely to be victims than perpetrators.[7] The claim is questionable because the population defined as mentally ill in perpetration studies are generally very large (to lower incident rates) and small in victimization studies (to increase incident rates). Likewise the definition of perpetration is narrow in studies of violence (to decrease number of incidents), while the definition of being a victim is broad in victimization studies (to increase number of incidents). *(Note: The preceding is believed to be true, but the research to document is in process.)*

SAMHSA fails to admit the difference between rates of perpetration and victimization may be moot because the reasons people with schizophrenia are victimized are the same reasons they become perpetrators: Lack of treatment. Lack of treatment cannot only can cause people with serious mental illness to act out it can cause them to be easily victimized. A new study out this month found:

> Compared to community controls, patients with schizophrenia-spectrum disorders were significantly more likely to have a record of violent and sexually violent victimization, ***but less likely to have an official record of victimization overall.*** Over the approximate period of deinstitutionalization, the rate of recorded victimization has more than doubled in schizophrenia-spectrum patients, but stayed relatively constant in the general community. People with schizophrenic-spectrum disorders are particularly vulnerable to violent crime victimization; although co-morbid substance misuse and criminality both heighten the chances of victimization, they cannot fully account for the increased rates. Deinstitutionalization may have, in part, contributed to an unintended consequence of increasing rates of victimization amongst the seriously mentally ill.[8]

SAMHSA minimizes violence among mentally ill by pretending increased early identification is the solution.
SAMHSA, the President, and Congress's reaction to violence by persons with mental illness is to promote earlier identification of people with mental illness as the solution.[9] SAMHSA simultaneously claims mental illness not really associated with violence and if you give them more money they will reduce violence by increasing early intervention.

Our 25 years of experience suggests that provisioning of services, not identification is the issue. Families know their loved ones are ill, beg for treatment and cannot get it. It is services, not identification that is lacking. Our examination of records of violence in persons with mental illness in MD,[10]OH,[11]PA[12], NY,[13] WV[14], and various counties in California, found most persons with mental illness who ultimately became violent were already known to the mental health system. Likewise law enforcement officers are being killed by persons who were already identified but didn't receive treatment.[15]

This is also true of most people with mental illness who go on to become a "psychotic killer on rampage" headline. The were previously identified, but not receiving treatment. (Ex. Andrew John Engeldinger[16] (killed six in Minnesota) Cho (the Virginia Tech shooter); James Holmes (Gabrielle Gifford's shooter), and Ian Stawicki[17] (Seattle café shooter who's father will talk to the public.))

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[7] See: Page 2 of http://www.help.senate.gov/imo/media/doc/Hyde1.pdf
[8] BMC Psychiatry. 2013 Feb 20; 13(1): 66. [Epub ahead of print] A case-linkage study of crime victimization in schizophrenia-spectrum disorders over a period of deinstitutionalization. Short TB, Thomas S, Luebbers S, Mullen P, Ogloff JR. Available at http://www.ncbi.nlm.nih.gov/pubmed/23425519
[9] http://www.whitehouse.gov/issues/preventing-gun-violence also Slide 14 at http://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf
[10] Mental Illness Tragedies in MD http://mentalillnesspolicy.org/states/maryland/MDPreventableTragedies.pdf
[11] Mental Illness Tragedies in OH http://mentalillnesspolicy.org/states/Ohio/prevntabletragediesohio.pdf
[12] Mental Illness Tragedies in PA http://mentalillnesspolicy.org/states/Pennsylvania/preventabletragediesPA.pdf
[13] Mental Illness Tragedies in NY http://mentalillnesspolicy.org/kendras-law/mentalillnesstragediesnys.pdf
[14] Mental Illness Tragedies in WV http://mentalillnesspolicy.org/states/westvirginia/wvpreventabletragedies.pdf
[15] http://mentalillnesspolicy.org/crimjust/120LEOSkilledbyMentallyIll.htm
[16] http://en.wikipedia.org/wiki/2012_Minneapolis_workplace_shooting
[17] http://www.trutv.com/library/crime/blog/2012/05/31/seattle-cafe-shooting-rampage-ends-in-suspects-suicide/index.html

OTHER ISSUES

Following are issues raised about SAMHSA by someone with knowledge.

Unqualified Leadership
SAMHSA moved away from a skill based system of programming to a purely political one. The person managing the prescription drug initiative is neither a physician or a nurse.[18] The person managing criminal justice is neither a lawyer or trained in criminal justice.[19] The person managing the HIV initiative is neither a true public health person or someone with a medical background.[20] The person managing the health information technology issue has no health information technology background.[21] SAMHSA has finally hired a Chief Medical Officer, but that person won't show up for three months.[22]

Diverts funds away from Congressionally Approved Expenditures
Congress appropriated $3.5 million to conduct "Military Families Initiatives Policy Academies" Alcoholism and Drug Abuse Weekly (1/16) wrote an article about SAMHSA getting the $3.5 million for military families policy academies. At the end of the article SAMHSA Regional Administrator Kathryn Power stated

> "The balance of the $3.5 million, after the $2 million is spent on two policy academies, will be used for "more intense and detailed technical assistance, perhaps a demonstration project, maybe some peer support." Said Power (citing Kathryn Power). "These are things I'm thinking about as strategic lead."

SAMHSA should not be considering doing anything else with the appropriated funds when the language specifically targets policy academies. In fact, the 2012 appropriations conference language states:

> "The conferees expect that SAMHSA shall not make changes to any program, project, or activity as outlined by the budget tables included in this Statement of the Managers without prior notification to the House and Senate Committees on Appropriations."

The SAMHSA website notes that the FY 2012 President's Budget request included $10 million for a Military Families Initiative ($3.5 million for Policy Academies and $6.5 million for direct service grants). The Congress chose to fund only the policy academies ($3.5 million) and not the direct service grants. Had the Congress believed that both activities should be funded at the reduced level of $3.5 million, it would have simply appropriated that amount for the Military Families Initiatives, leaving it up to SAMHSA to divide up the reduced amount.

Duplicates efforts
Both Congress and the President have stated a desire to reduce duplication of effort and diffusion of responsibility among government agencies. Both CDC and HRSA do substance abuse prevention and behavioral health statistics and SAMHSA is moving back to the same building that houses HRSA by 2015. SAMHSA's role is duplicative. It would be an ideal time to eliminate SAMHSA and start merging it's functions elsewhere. Congress can streamline the government by using a small agency like SAMHSA as an example. We have previously cited benefits of moving Evidence Based Practices Program to NIMH, PAIIMI, to the Attorney General's Office, and other efficiencies

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[18] http://www.samhsa.gov/About/bio_harding.aspx
[19] http://www.samhsa.gov/About/bio_huang.aspx
[20] http://www.linkedin.com/pub/gretchen-stiers/6/785/526
[21] http://www.samhsa.gov/about/clarkbio.aspx
[22] http://profiles.ucsf.edu/elinore.mccance-katz