

SUSPENSION TO HEALTH/MH

**ERIE COUNTY LEGISLATURE**



25 Delaware Avenue  
Buffalo, New York 14202

**TO: Laurie A. Manzella, Clerk**  
**FROM: Judith P. Fisher, Legislator, 4<sup>th</sup> District**  
**DATE: January 21, 1999**  
**RE: Item to be referred to Health/Mental Health  
Committee**

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**Please refer the attached to the Legislature's Health/  
Mental Health Committee.**

2E-27

## Help for Mentally Ill

To the Editor:

As a social worker I was appalled at a statement made in a Jan. 11 letter by a fellow social worker: "It is time that we stopped dumping violent criminals on our mental hospitals and outpatient mental health clinics and instead put them in jail, where they belong."

It is unfortunate but true that some people who suffer from some forms of mental illness may, because of their delusions, hallucinations and paranoia, become violent. However, with the correct medication and community support programs, these symptoms can be relieved, and those formerly afflicted can become productive members of society.

Comprehensive community support programs can and do work. Unfortunately, few communities allocate the necessary resources to assist all those in need. Until we do, tragedies like the death of Kendra Webdale and the shooting of Capitol Hill security guards last year will continue to occur. ROSALIE MIGAS  
Madison, Wis., Jan. 13, 1989

*M. Migas*  
1-14-89

# Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods

Henry J. Steadman, PhD; Edward P. Mulvey, PhD; John Monahan, PhD; Pamela Clark Robbins, BA; Paul S. Appelbaum, MD; Thomas Grisso, PhD; Loren H. Roth, MD; Eric Silver, MA

**Background:** The public perception that mental disorder is strongly associated with violence drives both legal policy (eg, civil commitment) and social practice (eg, stigma) toward people with mental disorders. This study describes and characterizes the prevalence of community violence in a sample of people discharged from acute psychiatric facilities at 3 sites. At one site, a comparison group of other residents in the same neighborhoods was also assessed.

**Methods:** We enrolled 1136 male and female patients with mental disorders between the ages of 18 and 40 years in a study that monitored violence to others every 10 weeks during their first year after discharge from the hospital. Patient self-reports were augmented by reports from collateral informants and by police and hospital records. The comparison group consisted of 519 people living in the neighborhoods in which the patients resided after hospital discharge. They were interviewed once about violence in the past 10 weeks.

**Results:** There was no significant difference between the prevalence of violence by patients without symptoms of substance abuse and the prevalence of violence by others living in the same neighborhoods who were also without symptoms of substance abuse. Substance abuse symptoms significantly raised the rate of violence in both the patient and the comparison groups, and a higher portion of patients than of others in their neighborhoods reported symptoms of substance abuse. Violence in both patient and comparison groups was most frequently targeted at family members and friends, and most often took place at home.

**Conclusions:** "Discharged mental patients" do not form a homogeneous group in relation to violence in the community. The prevalence of community violence by people discharged from acute psychiatric facilities varies considerably according to diagnosis and, particularly, co-occurring substance abuse diagnosis or symptoms.

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**F**OR 75 YEARS, studies have attempted to estimate the prevalence of violence committed by people discharged from psychiatric facilities in the United States, and to compare that rate with the prevalence of violence by others in their communities.<sup>1,2</sup> These studies have been invoked in legal and policy debates concerning standards for hospital admission and discharge, for community placement and monitoring, and for tort liability.<sup>3</sup> Four methodological problems consistently have compromised this work: (1) existing studies use weak markers for the occurrence of community violence, such as reliance solely on official arrest records,<sup>3</sup> rehospitalization records,<sup>6</sup> or uncorroborated self-reports (see Swanson et al<sup>7</sup>; compare Lidz et al<sup>8</sup>); (2) due to these weak markers, descriptive information essential for understanding violence in context is often missing from existing studies<sup>9</sup>; (3) existing studies rarely have

reported data on the timing of violent acts, despite the implications for intervention that timing may have<sup>10</sup>; and (4) existing studies have tended to enroll only subjects who are presumed to have a high base rate of violence; eg, men with a history of violence.<sup>8,11</sup> Because different factors may be associated with violence among men than among women, and with repeated violence than with the first occurrence,<sup>12</sup> these inclusion criteria limit the generalizability of reported findings.

*For editorial comment  
see page 403*

This article reports data from the MacArthur Violence Risk Assessment

This article is also available on our Web site: [www.ama-assn.org/psych](http://www.ama-assn.org/psych).

From Policy Research Associates Inc, Delmar, NY (Dr Steadman, Ms Robbins, and Mr Silver); University of Pittsburgh School of Medicine, Pittsburgh, Pa (Drs Mulvey and Roth); University of Virginia School of Law, Charlottesville (Dr Monahan), and University of Massachusetts Medical School, Worcester (Drs Appelbaum and Grisso).

2m439

# New Evidence on the Violence Risk Posed by People With Mental Illness

## *On the Importance of Specifying the Timing and the Targets of Violence*

**T**HERE IS a widespread belief among the American public that people with mental illness pose a significant violence risk.<sup>1,2</sup> Moreover, the prevalence of this belief seems to have increased since the 1950s, when the issue was first systematically assessed.<sup>3</sup> Because this public perception of dangerousness plays a central role in fostering stigma, its validity demands empirical scrutiny.<sup>4,5</sup> To date, nearly every modern study indicates that public fears are way out of proportion to the empirical reality. The magnitude of the violence risk associated with mental illness is comparable to that associated with age, educational attainment, and gender<sup>6,7</sup> and is limited to only some disorders and symptom constellations.<sup>8,9</sup> Furthermore, because serious mental illness is relatively rare and the excess risk modest, the contribution of mental illness to overall levels of violence in our society is minuscule.<sup>10</sup>

*See also page 393*

The study by Steadman et al featured in this issue (p 393) makes 2 major methodological advances and yields results that further challenge the dangerousness stereotype. First, Steadman and colleagues reassessed former psychiatric patients every 10 weeks for a year following hospital discharge. While they found a modest elevation in rates of violence shortly after hospitalization, the elevation diminished rapidly and became indistinguishable from rates reported by residents in the communities to which patients were discharged. Second, Steadman et al asked about the targets of violence and found that the vast majority

(86%) of violent acts committed by former patients occurred within the context of family and friendship networks. Indeed, members of the Pittsburgh public who were violent were slightly (but not significantly) more likely to target strangers (22%) than were Pittsburgh patients (11%)! Public fears that patients with mental illness will attack them are sharply contradicted by such findings.

Those who follow the literature on mental illness and violence might be troubled by some results of Steadman et al, however, because they seem to deviate from previous research. Two kinds of studies are at issue. First are studies that either compare patients' and community controls' levels of violent behavior assessed retrospectively during broad periods or prospectively compare arrest rates of recently discharged patients with rates for the general population during periods of 1 year or so. Such studies generally report higher levels of violence among patients than among comparison community populations.<sup>11-13</sup> Second are epidemiological studies of community samples that assess violence levels among all cases, treated or not. Two large studies<sup>7,14</sup> have both reported elevated rates of violent behaviors among people with some (but not all) types of mental disorder, but again the time period covered is broad. While Steadman et al report higher rates of violence among patients both prior to hospitalization and during the first 10 weeks following discharge, they do not find evidence of an elevation during the bulk of the follow-up period.

While methodological differences in sample definition (eg, patients vs community cases), measurement (eg, self-report, arrest rates, and agency and collateral re-

ports), design (eg, case-control, cross-sectional, and retrospective and prospective cohort), and the like may account for the discrepancies, we believe that the most interesting conclusions emerge if one assumes that the findings from all study types are valid. Such an assumption suggests that people with certain types of mental disorders or symptom constellations have a modestly elevated risk for violence, and that this risk is most evident when symptoms are acute. For people who enter mental hospitals, this violence risk is highest during the period before, during, and shortly after hospitalization when patients are, on average, relatively symptomatic. But during the year following hospitalization and treatment, when psychiatric symptoms are likely to be waning, the risk for violence declines to the point where it is no different from the base level in the community.

Construed in this way, the study by Steadman et al refines our understanding of the link between mental illness and violence by pinpointing when in the course of mental illness violent behavior is most likely to occur. Two key features differentiate the design used by Steadman and colleagues: they studied people who had been treated and assessed their violent behaviors during periods that were sufficiently distal from the index hospitalization to allow symptom remission to occur. Of course further research is required to determine whether treatment and time to recuperate are in-

This article is also available on our Web site: [www.ama-assn.org/psych](http://www.ama-assn.org/psych)

cused of being a conservative, I find much to agree with in this interesting, if somewhat polemical, essay on the law of criminal responsibility. Wilson is a fine writer whose concerns about the criminal justice system will strike a chord with many readers. He supports law's traditional commitment to individuals' responsibility for their actions rather than the use of social, psychological, and biological theories to excuse those actions.

Thus Wilson objects to the growing use of expert testimony from psychiatrists and social scientists. He uses the notorious example of Dr. James Grigson, a Texas psychiatrist who, in one of his many assessments of African-American convicted murderers, assured a court that there was a "100 percent and absolute" chance that the defendant would kill again, even though Grigson had never examined the defendant. Wilson does not report, however, that the APA censored Grigson and filed an amicus curiae brief with the Supreme Court against him.

There are, of course, many examples of so-called "experts" whose expertise is dubious and who abuse their credentials for financial reasons. However, Wilson's conviction that this situation reflects the ambiguity of the social sciences as disciplines ignores the many trials in which both sides bring in conflicting expert opinions about ballistic, chemical, or biological evidence.

Wilson also expresses considerable skepticism about the "battered woman syndrome" as a basis for defense arguments that have been used to defend women who kill their husbands. He notes that the evidence for such a syndrome is highly questionable, but that, perhaps because of our sympathy for battered women, both courts and legislatures have seemed eager to accept it. As the law can't discriminate by gender, Wilson notes, this circumstance inevitably led to a man's claiming a "battered person syndrome" as a defense for killing his brother.

Wilson also provides critiques of various uses of the insanity defense,

including Judge David Bazelon's *Durham* criterion of nonresponsibility if the act was the "product of mental disease or defect" and the American Law Institute's somewhat less inclusive standard. He argues that such standards establish responsibility by establishing causality, which fails because there are many causes of crimes that are irrelevant to establishing responsibility.

*Moral Judgment* also contains persuasive arguments against minimizing responsibility because of alcoholism, cultural and ethnic difference, posttraumatic stress, and other

popular explanations of individual crimes. Sometimes Wilson is too persuasive. Thus in his view, the Bernard Goetz trial decision went wrong because the jury used a subjective test of self-defense, the outcome of the O. J. Simpson trial depended on inappropriate questioning of jurors, the Rodney King trial floundered on misuse of an expert witness, and the Dan White trial came to its peculiar end due to the doctrine of diminished capacity. Perhaps the author is right, but racial hatred and homophobia probably played at least as large a role as these legalities.

### The Right to Refuse Mental Health Treatment

by Bruce J. Winick, J.D.; Washington, D.C., American Psychological Association, 1997, 427 pages, \$59.95

Jan C. Costello, M.A., J.D.

In *The Right to Refuse Mental Health Treatment*, Professor Bruce Winick of the University of Miami Law School explores the important issues raised by the involuntary administration of mental health treatment techniques to both civil patients and criminal offenders. When does an individual have the right to refuse treatment? When can the state override a competent individual's refusal? What are the legal and therapeutic consequences of recognizing a right to refuse treatment?

Part I of the book surveys the various treatment techniques, focusing on their benefits as well as their potential for abuse. Professor Winick establishes a continuum of intrusiveness, starting with psychotherapy and then, in ascending order of intrusiveness, behavior therapy, psychotropic medication, electroconvulsive therapy, electronic stimulation of the brain, and finally psychosurgery. This section of the book seems primarily intended as a source of information for the nonclinician. However, it will benefit the clinician as well by en-

couraging consideration of degrees of intrusiveness and how the patient may experience each type of therapy.

The second part, encompassing more than half the book, explores the sources of legal restrictions on mental health treatment imposed by state law. Although this section first concisely surveys state and federal statutory sources as well as international law, the major emphasis, appropriately, is on constitutional law. Professor Winick explains how courts have found a right to refuse treatment grounded in the first, eighth, and 14th amendments. He then considers each of the treatment techniques and analyzes when it may constitutionally be imposed against an individual's will.

This section provides a clear and insightful overview of the constitutional theory as well as an in-depth discussion of the major cases. A careful explanation of the principles of constitutional interpretation, including different standards of scrutiny, will be especially valuable to clinicians interested in understanding the law and policy concerns underlying the courts' decisions.

Part 3 considers the therapeutic consequences of recognizing a right

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to refuse treatment. Will it increase or decrease the likelihood that treatment will be effective? Will it change the therapist-patient relationship in ways that enhance or diminish its therapeutic potential? Will it have a positive or negative effect on offender recidivism? The book concludes by encouraging patients and clinicians to explore ways of using legal devices such as advanced directives or durable powers of attorney for health care to preserve patient autonomy while permitting appropriate treatment.

This is an impressive first volume in the American Psychological Association's new Law and Public Policy Series. The book is thoroughly researched, well organized, and clearly written without oversimplification. The author, a preeminent scholar in the field of mental health law, is familiar with and sensitive to the differing perspectives of professionals from the fields of law, psychiatry, and psychology. As co-ordinator of the exciting concept of therapeutic jurisprudence, he uses a genuinely interdisciplinary approach that should help both clinicians and lawyers achieve a deeper understanding of the complex issues raised by the right to refuse treatment.

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The material is presented in an organized fashion and is very readable. The various chapters are of sufficient depth to be informative, but not exhaustive. In the final analysis, the editors have put together an organized and complete book that is not only interesting but also easy to read.

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### Forensic Aspects of Sleep

edited by Colin Shapiro and Alexander McCall Smith; New York City, John Wiley & Sons, 1997, 208 pages, \$69.95

Stephen Noffsinger, M.D.

*Forensic Aspects of Sleep* is a comprehensive look at the legal ramifications of sleep disorders, encompassing both the criminal and the civil aspects of the law. The editors make a convincing argument in the book's introduction that due to the considerable recent progress in our understanding of sleep and its disorders, as well as increased attention by the courts, this topic is worthy of our attention.

The book is written on a level easily comprehended by the physician with even a passing knowledge of sleep physiology. An introductory chapter is entirely devoted to an overview of sleep physiology and sleep disorders, with subsequent chapters also giving the reader basic knowledge about sleep medicine. The various sleep disorders and their diagnostic criteria are presented early in the book.

One of the book's highlights is an in-depth analysis of sleep disorders

and their relationship in the law to insanity. The authors do not assume the reader has extensive knowledge about forensic psychiatry, and they provide a good introduction to the basics of criminal law and insanity before delving into the specifics of sleep disorders and insanity. An analysis of the relevant case law in this area is provided; however, the contributors choose—not surprising, given that they are primarily Canadian—to review Canadian and English case law and forego case law from the United States. I found this to be a pleasant surprise, as U.S. case law can be easily obtained from other sources by readers with a special interest in it.

The chapter devoted to the civil liability issues arising out of sleep deprivation and sleep disorders is comprehensive and instructive. Of particular interest to the clinical psychiatrist is the section dealing with the civil liability of the psychiatrist whose sleep-disordered patient harms a third party as the result of his sleep disorder—for example, the narcoleptic patient who falls asleep while driving and causes an accident. Other topics covered include what appear to be new research findings about men

### Social Control Through Law

by Roscoe Pound, with a new introduction by A. Javier Trevino; New Brunswick, New Jersey, Transaction Publishers, 1942 and 1997, 138 pages, \$19.95 softcover

Steven J. Schwartz, B.A., J.D.

Roscoe Pound was both the dean of the Harvard Law School for more than 20 years, from 1916 to 1936, and the dean of contemporary jurisprudence for a like period. Combining an academic proficiency in botany with a deep study of legal theory, he more or less invented the study of sociological jurisprudence. His 1942 seminal work, *Social Control Through Law*, posits a theory of law that was highly controversial in the early 20th century but has now become rather routine: that law is not derived from certain immutable principles that flow ineluctably from a few natural truths, but rather is relativistic, shaped by the time and context of historic forces. According to Pound, the principles of law evolve through time and are inherently intertwined with the legal, social, and political events of various periods.

This book, originally published in 1942 by Yale University Press and recently reprinted with a new introduction by A. Javier Trevino, offers little new information or perspective on contemporary dilemmas. The

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Dr. Noffsinger is director of forensic psychiatry for the Northcoast Behavioral Healthcare System in Northfield, Ohio, and assistant professor of psychiatry at Case Western Reserve University School of Medicine.