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California's Mental Health Movement

How to Avoid Perpetuating Harmful Misconceptions about Mental Health Disabilities and Violence

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Introduction

Recent media coverage of mass shootings and other tragedies has fed the longstanding public misconception that people with mental disabilities are prone to violence. However, more than two decades of research has established that "most people who are violent are not mentally ill and most people who are mentally ill are not violent."[1] According to the U.S. Surgeon General, "the overall contribution of mental disorders to the total level of violence in society is exceptionally small."[2]

The media's perpetuation of the mythical link between mental disabilities and violence[3] has exacerbated our society's stigma and discrimination against mental health consumers. This paper will explore misconceptions concerning mental disabilities and violence and discuss the stigmatizing and discriminatory effects of those misconceptions including the overly broad restriction of individual freedom to exercise fundamental rights. The paper will conclude with suggestions on ways in which advocates, media representatives and individuals can avoid perpetuating those myths.

Mental Disabilities Are Not Alike: The Importance of Language

Part of the confusion in this area is a matter of language. This paper refers to "people with mental disabilities" because that term draws a parallel to people with physical disabilities, and because it does not focus on any particular diagnosis or label. However, the term "mental disability," like similar terms such as "mental illness" or "mental disorder," covers a wide range of conditions. Although mental disabilities as a whole are not linked to violent behavior, some correlation has been found between violence and substance use disorders and certain personality disorders. Because of this discrepancy, it is important to use precise language when discussing this issue.

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[1] National Association of State Mental Health Program Directors & Council of State Governments Justice Center, *Responding to a High-Profile Tragic Incident Involving a Person with a Serious Mental Illness: A Toolkit for State Mental Health Commissioners (*2010) (NASMHPD Toolkit) at p.81, available at: http://www.nasmhpd.org/docs/publications/docs/2010/ViolenceToolkit_Bkmk.pdf, *citing* Friedman, R.A. (2006). Violence and Mental Illness – How strong is the link? *New England Journal of Medicine*, 355(20), 2064-2066.

[2] U.S. Surgeon General, Mental Health: A Report of the Surgeon General (1999) (Surgeon General Report) at p.4, available at: http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf.

[3] This paper discusses violence in terms of violence toward others. Self-injurious behavior can also be described as violence toward oneself. However, that type of violence is outside the scope of this paper.

In the words of the United States Surgeon General "'mental health' and 'mental illness' are not polar opposites but may be thought of as points on a continuum."[4] Clinicians make classifications along this continuum through periodic revisions of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). Prior to 2013, the DSM classified mental disorders under five "Axes." This classification system distinguished conditions commonly referred to as "mental illnesses," including schizophrenia, bipolar disorder, depression and substance-related disorders (Axis I diagnoses) from other conditions, including personality disorders and developmental or intellectual disabilities (Axis II diagnoses). In 2013, the fifth revision of the DSM (DSM-5) abolished the Axis system, classifying all of these conditions as different types of "mental disorder."[5]

Like physical illnesses, disorders that previously fell under Axis I are diagnosed through observation and measurement of various signs and symptoms. In contrast, personality disorders (previously classified under Axis II) are defined as a pattern of thoughts and/or actions that fall outside of the "norm" as described in the DSM. Certain personality disorders, such as antisocial personality disorder, are defined largely by a pattern of violent behavior.

Most research on mental disorders and violence has focused on people with disorders that previously fell under Axis I ("mental illnesses"), primarily schizophrenia. As discussed below, this research has not established a significant correlation between mental illnesses and violence. However, research has shown that substance use is linked to an elevated risk of violence. And, by definition, certain types of personality disorders are associated with patterns of antisocial or violent behavior.

Since different types of mental disorders have different (if any) relationships to violence, precise language is critical. It is important to avoid using general – and sometimes outdated - terms such as "mentally disturbed," "psychotic," or

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[4] Surgeon General Report, *supra* note 2 at p.4.

[5] The DSM-5 defines a mental disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (DSM-5) (2013) at p.20.

"troubled" when describing an individual who was involved in an incident of violence. In most cases, the person's mental health status is irrelevant and should be left out of the conversation. When it is relevant, precision requires specifying whether the individual or group of individuals has a particular mental disability, personality disorder, substance use disorder or developmental or intellectual disability, and explaining the relevance of that diagnosis. Resources are available to help ensure that language used to describe people with mental disorders is respectful and not unintentionally stigmatizing.[6]

Misconceptions about Violence and Mental Disabilities

The misconception of a link between violence and mental disabilities has been identified since the 1950s, and appears to be getting stronger over time.[7] This myth is based on society's need to identify reasons for senseless acts that have tragic consequences, and the imprecision that results when we try to explain the incomprehensible. In our search for meaning behind mass shootings and other acts of violence, we have drawn conclusions that fly in the face of evidence, and cast unwarranted aspersion on people who identify, or have been identified, as having a mental disability.

Research has shown that selective media reporting reinforces the public's stereotypes linking violence and mental disabilities.[8] In 2012, the Entertainment Industries Council's Team Up project conducted a survey of how California newspapers report on people with mental health issues.[9] The survey found that 37 percent of the English language articles surveyed, and 70 percent of the Spanish-language articles, framed people with mental disabilities in a negative light.[10] The report noted that negative portrayals of people with mental disabilities are likely to give the public "a skewed picture of individuals living with mental illness and the experiences of recovery."[11]Examples of these negative portrayals include:

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[6] *See, e.g.,* Disability Rights California, *People First Language in Mental Health*, available at: http://www.disabilityrightsca.org//pubs/CM0201.pdf
[7] Surgeon General Report, *supra* note 2 at p.7
[8] *Id.* at p. 8.
[9] Entertainment Industries Council, *Analysis of English and Spanish Language Newspaper Coverage of Mental Health Issues in California* (Fall 2012)I(EIC report), available at: http://www.eiconline.org/wp-content/uploads/California-News-Media-Analysis-2012.pdf
[10] *Id.* at p.1
[11] *Id.*

- In a Meet the Press interview in December 2012, National Rifle Association chief Wayne LaPierre blamed people with mental disorders for mass shootings, calling them "monsters [that] walk the street," and arguing for a "national database of these lunatics."[12] The media widely repeated these statements, fueling unsupported speculation that a national registry of people with mental disorders would somehow lower rates of gun violence.

- In a survey of 70 major U.S. newspapers in 2002, researchers reported that 39 percent of all stories published about people with mental illnesses focused on dangerousness – the single largest area of the media's coverage of mental health. In contrast to stories that discussed mental health treatment or public policy, those that touched on violence were far more likely to be front page news.[13]

Reality: The Missing Link

The inaccurate and imprecise use of statistics is also largely responsible for misconceptions about mental disorders and violence. In sharp contrast to widespread public opinion, only a small amount - about four percent - of violence in the United States is actually attributable to mental illness.[14] Furthermore, while the American mental health system is similar to that of other highly-resourced nations, we have a dramatically higher rate of gun violence.[15]

While mental disability is, at best, a weak indicator of violence, other variables have shown to have stronger associations.[16] "Indeed, most of the strongest predictors of violence are common to both persons with serious mental disorders and those without, suggesting that the impact of the disorders per se is slight."[17] For example, research shows that people who fit within the following groups do

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[12] http://www.salon.com/2012/12/23/nras_wayne_lapierre_call_me_crazy/ (December 23, 2012).
[13] NASMHPD Toolkit, *supra* note 1, at p.87, *citing* Corrigan, P.W., Watson, W.C. et al. (2005). Newspaper stories as measures of structural stigma. Psychiatric Services, 56(5), 551-556.
[14] National Academy of Sciences, Reference Manual on Scientific Evidence (3rd Ed.), (National Academies Press 2011) (NAS Reference Manual) at p.847.
[15] Yonkers, K. (2014), Stop Blaming Mental Health for Gun Violence. The Problem is Guns. Washington Post, December 26, 2014, available at: http://wapo.st/1AVYJNa
[16] NASMHPD Toolkit, *supra* note 1 at pp.29, 43, 82.
[17] NAS Reference Manual, supra note 14 at p.847.

have a statistically increased risk of violence – whether or not they also have a mental health diagnosis:

- People with substance use disorders;[18]
- People with types of personality disorders that are defined by psychopathy or antisocial behavior;[19]
- People in their late teens and early twenties;[20]
- People with low socioeconomic status;[21] Males;[22]
- People who have inadequate natural or social supports;[23]
- People with a history of physical abuse;[24]
- People who have a criminal history[25] or a parent with a criminal history; and[26]
- People who experience employment instability.[27]

Other considerations in evaluating statistical correlations between mental disorders and violence include:

- People with mental disabilities are more likely to be the victims rather than the perpetrators of violence.[28]
- "Violence committed against strangers is rare. The people most likely to be the targets of violence by a person with or without a mental disability are

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[18] NASMHPD Toolkit at pp.29, 43, 82.
[19] NAS Reference Manual, *supra* note 17 at pp.847, 848.
[20] *Id.* at p.848.
[21] NASMHPD Toolkit, *supra* note 1 at pp.29, 81; NAS Reference Manual, *supra* note 17 at p.848.
[22] NASMHPD Toolkit, *supra* note 1 at p.82; NAS Reference Manual, *supra* note 17 at p.848.
[23] NASMHPD Toolkit, *supra* note 1 at p.29.
[24] *Id.* at p.29.
[25] NAS Reference Manual, *supra* note 17 at p.847.
[26] NASMHPD Toolkit, *supra* note 1 at p.29
[27] *Id.* at p.29; NAS Reference Manual, *supra* note 17 at p.848.
[28] NASMHPD Toolkit, *supra* note 1 at pp.29, 43, 81, 84.

> family members and friends who are in their own homes or in the individual's home."[29]

Even if a person falls within one or more groups that have been found to have a statistical correlation with violence, it is very difficult to predict whether *that individual* poses an increased risk. "Despite knowledge of identified risk factors for individuals with mental illnesses as a group, we cannot accurately predict when any particular individual will be violent. Risk assessment is, at best, an inexact science."[30]

In 1981, John Monahan, a preeminent mental health researcher, famously concluded that when mental health professionals predicted that a person would be violent, they were twice as likely to be wrong as right.[31] In 2011, the National Academy of Science's Reference Manual on Scientific Evidence, which federal judges consult in interpreting scientific evidence, concluded that the current state of the art "probably" allows well-trained clinicians to assign people whom they have personally examined as having a high-, medium, or low-risk of future violent behavior.[32] However, "[o]pinions about the risk of future violence by persons whom the evaluator has not examined have never been validated, and there are persuasive reasons to believe that such predictions are not likely to be highly accurate."[33] Similarly, in 2010, the National Association of State Mental Health Program Directors concluded: "Ultimately, it may never be possible to predict with certainty when any individual in society - with or without a mental illness – will commit a violent act."[34]

Negative Effects of Misconceptions about Violence and Mental Disabilities

A professor of psychiatry at Yale University recently wrote that the "obsession with mental health as the root cause of gun violence is not only silly; it's dangerous."[35] One danger is that the perpetuation of misconceptions about violence and mental disorders can increase stigma against people with a wide

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[29] *Id.* at p.30. *See also* Surgeon General Report, *supra note 2* at p.7; NAS Reference Manual, *supra* note 19 at p.847.
[30] NASMHPD Toolkit, *supra* note 1 at p.29.
[31] NAS Reference Manual, *supra* note 20 at p.849, *citing,* John Monahan, *The Clinical Prediction of Violent Behavior* (1981).
[32] NAS Reference Manual, *supra* note 20 at p.850.
[33] *Id.* at p.851.
[34] NASMHPD Toolkit, *supra* note 1 at p.43.
[35] Yonkers, *supra* note 18.

range of mental health issues. In 2003, The President's New Freedom Commission on Mental Health found that, "Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment."[36]

In 2009, the California Department of Mental Health issued a *Strategic Plan on Reducing Mental Health Stigma and Discrimination*, echoing the U.S. Surgeon General's statement that stigma is "the most formidable obstacle to progress in the arena of mental illness and health."[37] The Strategic Plan went on to report that stigmatization against people with mental disabilities "is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance….It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society."[38]

Although tragic incidents involving people with mental illnesses as perpetrators are relatively rare, they tend to draw intense media coverage that can increase stigma.[39] "One of the most predictable reactions to a high-profile, tragic incident involving a person with a history or diagnosis of serious mental illness is renewal of fears and stereotypes about the connection between mental illness and violence. Frequently, these reactions frame news stories and lead to calls for more coercive interventions, including increasing outpatient commitment and

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[36] *President's New Freedom Commission on Mental Health* (2003), http://govinfo.library.unt.edu/mentalhealthcommission/reports/reports.htm

[37] California Department of Mental Health, California Strategic Plan on Reducing Mental Health Stigma and Discrimination (California Strategic Plan) (2009) at p.9 (citation omitted), available at: http://www.dhcs.ca.gov/services/medi-cal/Documents/CDMH_MH_Stigma_Plan_09_V5.pdf, *quoting* U.S. Surgeon General's Report.

[38] Surgeon General Report, *supra* note *2* at p.6. See also California Strategic Plan at p.10 ("Stigma, and the discrimination that can result from mental illness, can cause shame, despair, prejudice, and hopelessness.")

[39] NASMHPD Toolkit, *supra* note 1 at p.44.

hospitalization."[40] Increased fears and stereotypes can also lead to victimization of people with mental disabilities, and more potential for violence.[41]

As noted above, in its most overt and egregious form, stigma results in outright discrimination. Individuals are treated differently and their rights are restricted, not because of an individualized determination of ability, but rather as a result of a label. Unfounded fears of violence lead to unlawful discrimination in a wide range of areas, including housing, child custody, employment, and restrictions on the purchase and possession of firearms. [42]

Suggestions to Avoid Perpetuating Misconceptions

Below are some tips that advocates, media representatives and other individuals and organizations can use to avoid perpetuating harmful misconceptions about mental disorders and violence:

1. Use precise language.

- Only mention an individual's (apparent) mental disorder if it is relevant to the discussion.

- If it is necessary to mention an individual's (apparent) mental disorder, be specific as to whether it is a mental illness, a substance use disorder, an antisocial or other type of personality disorder, or a developmental or intellectual disability.

- When discussing people with mental disorders, use non-stigmatizing, people-first language.

2. Be careful when using statistics.

- Make sure that statistics are relevant and that they mean what you say they mean.

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[40] *Id.* at p.29.
[41] *Id.* at p.44.
[42] For example, in 2013, the U.S. Equal Employment Opportunity Commission (EEOC) received 25,957 charges of disability-based employment discrimination. EEOC, *Charge Statistics FY 1997 Through FY 2013*, http://www.eeoc.gov/eeoc/statistics/enforcement/charges.cfm. In 2010, disability-based discrimination was the most common form of discrimination charged in complaints filed with the U.S. Department of Housing and Urban Development (HUD), representing 48% of the 10, 155 housing discrimination complaints filed that year. HUD, *The Status of Fair Housing,* http://www.huduser.org/portal/pdredge/pdr_edge_research_040612.html

- Keep in mind that statistics give information about groups of people and probabilities – they do not say anything about a particular individual.

- Make sure that any information concerning an individual's mental health status is from a reliable source.[43]

- Look for opportunities to cover stories about people with mental disabilities from a positive angle.[44]

3. Oppose registries that restrict people with disabilities from owning firearms solely because of their mental health diagnosis, status or history.

Recent incidents of gun violence have prompted suggestions that governments should establish registries of individuals with mental disabilities, for the purpose of restricting their right to own or use firearms. However, since research has not established a significant link between mental disorders and violence, advocates and elected officials should oppose registries that restrict people with disabilities from owning or using firearms solely on the basis of their mental health diagnosis, status or history. Any firearms registries should be based on individual determinations or whether a person is unsafe to use or own a firearm. To avoid potential discrimination, these safety criteria should be applied equally to everyone.

4. Avoid making a connection between improved mental health treatment and the reduction of violence on a systemic level.

Everyone with a mental health disability should have access to appropriate, voluntary mental health treatment. However, because the link between mental disability and violence has not been substantiated, it is not accurate to report that more or better mental health services would have a direct impact on the rate of violence. The positive effects of improved access to a full range of mental health services may have an indirect impact on violence rates by affecting other risk factors such as poverty or substance use. However, any reporting on that indirect impact should be specific

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[43] See EIC Report, *supra* note 11 at p.1.

[44] I*d.* ("Finding opportunities to cover stories with a positive angle of hope and recovery is another important way of balancing out the overwhelming negative coverage and providing an alternative perspective on people living with mental illness."

enough to avoid the stigma and public confusion that are caused by inappropriately connecting mental disabilities with violence.

A 2004 study found that compared to subjects who participated in an anti-stigma program, subjects who received information showing a link between mental health and violence were no more willing to support public funding of mental health services, were more likely to have negative attitudes and fear about people with mental disorders, and were less likely to help them or their families. The researchers concluded that "community groups should not use information about the link between mental illness and violence in an attempt to improve resources for mental health programs."[45]

It is tempting to take advantage of any opportunity to improve access to voluntary mental health services. However, suggesting mental health treatment as a way to reduce violent crime perpetuates misconceptions about violence and mental disorders, exacerbates stigma and discrimination, and runs the risk of distracting the discussion away from more meaningful solutions. Therefore, the temptation should be avoided.

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[45] NASMHPD Toolkit at p.87, *citing* Corrigan, P.W., Watson, A.C. et al. (2004), Implications of educating the public on mental illness, violence, and stigma. *Psychiatric Services, 55(5),* 577-580.

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