HEALTHY MINDS POLICY INITIATIVE

# Mental health and violence in Oklahoma

The myths, the needs and recommended strategies

*Oklahoma experienced several high-profile cases of domestic murder-suicides 2021, raising questions about the link between mental illness and violence. Because disturbing examples like these receive extensive news coverage that also often includes references to mental illness, there is the danger that incorrect generalizations about the relationship between mental illness and the propensity for extreme violence may further stigmatize vulnerable people. In this brief, we summarize the complex and sometimes contradictory evidence about this relationship and provide often missing information on the scale or frequency of violence by people with mental illness. We also make recommendations for mental health programmatic and policy changes where research indicates they are warranted.*

## Key takeaways

- Despite media reports and popular belief, **mental illness is not widely associated with violence against others.** However, there are limited exceptions where a greater possibility of violence can be mitigated with appropriate strategies.
- **Suicide is Oklahoma's most urgent health-related violence problem**. Suicide rates are near all-time highs, and unlike most violent acts, suicide is heavily linked to mental illness.
- Oklahoma can make headway on its most difficult cases of mental illness, including the extraordinary cases where the risk of violence is higher. **We recommend five strategies to promote recovery, reduce strain on the criminal justice system and decrease violence**:

    1. Expand capacity to treat first-episode psychosis. People with untreated psychosis are at a greater risk for violence than the general population, and Oklahoma's capacity to treat first-episode psychosis falls short of the need.
    2. Target services to justice-involved Oklahomans with mental illness. The use of Critical Time Intervention (CTI) and Forensic Assertive Community Treatment (FACT) teams can support people with mental illness who have been involved in the criminal justice system and have high risk of future criminal behavior.
    3. Diagnose and treat more substance use disorders. Screening and treatment best practices must be expanded in primary care settings and beyond.
    4. Expand comprehensive suicide reduction. Efforts like the Zero Suicide initiative must be expanded.
    5. Expand implementation and quality improvement. Oklahoma is implementing many of these solutions, but not statewide. More robust funding and focus are needed for systemic impact. In addition, these models are often difficult for providers to implement, and quality is a frequent concern. Oklahoma should expand supports such as technical assistance for those implementing these programs.

## Background

In late January and early February of 2021, several cases of familicide, or murder-suicide involving family members, were covered heavily by local news outlets in Oklahoma. The media asserted that three of these cases involved issues of mental illness, while a fourth was discussed only in the context of domestic violence. In this last case, as well as one case that was framed as involving mental illness, the perpetrators died by suicide. Connections to mental illness in these cases that appeared in the press on television included a recent court-requested mental health screening, medication for bipolar disorder, and treatment for depression, addiction, and anger issues. However, none of the reported cases included information concerning formal clinical evaluations or diagnoses. While it may be likely that mental health issues were somehow involved in one or more cases, the fact that little effort seemed to be devoted to confirming formal diagnoses may indicate a "confirmation bias" in the direction of believing that mental illness is often to blame for horrific violence.

These and other similar cases of familicide thus raise concerns in affected communities that people living with mental illness may be dangerous, or even may need special restrictions as a group. In addressing these fears, it is important to understand the prevalence of people experiencing mental illness who engage in criminal violence, how this varies by type of mental illness, and what proportion of all criminal violence is committed by people living with mental illness. This information will help reduce undeserved stigma.[1]

## Mental illness and violence: The research

Before understanding any link between mental illness and violence, it is first important to understand what we mean by *mental illness* and what we mean by *violence*. It is natural to assume people who murder family members are mentally ill. These are behaviors that do not seem comprehensible unless some type of mental disfunction is behind them. But a proclivity toward being angry and aggressive, or a sudden burst of violent behavior, do not in themselves imply mental illness. In defining mental illness, we follow the conventional process of focusing on diagnoses such as major depression, bipolar disorder, and schizophrenia, which include specific symptoms related to severe emotional distress; impairments in functioning at home, school or work; and, in some cases, psychosis (e.g., delusions and hallucinations). These are specific, treatable diagnostic conditions and are the focus of the mental health treatment system. In this definition, we are excluding personality traits such as aggression and excessive distrust of other people that are neither necessary or sufficient to yield a diagnosis of mental illnesses such as major depression, bipolar disorder or schizophrenia.[2]

The definition of violence is also important. The research literature on mental illness and violence uses an inconsistent array of definitions for violent behavior, only some of which match the type of criminal

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

[2] As defined in the American Psychiatric Association's Diagnostic and Statistical Manual-V, which is the recognized authority for guiding psychiatric diagnoses in the U.S.

actions that potentially cause the public to stigmatize people with mental illness. The broadest definition of a violent person is someone who reports that they have physically hurt another person in any way on purpose.[3] Narrower classification schemes use *convictions* for crimes such as homicide, assault or robbery.[4] The degree to which it can be concluded that people with mental illness have an elevated prevalence of violent behavior may depend on how violent behavior is defined.

## Extreme forms of violent behavior

Most of the recent academic research on violence and mental illness has been driven by concerns about mass public killings, as occurred recently in Atlanta, Georgia, and Boulder, Colorado. By definition, these cases exclude familicide and murders by criminal organizations such as gangs and drug cartels.

A common conclusion in the literature on mass public killings is that the small number and variability in these events limits our ability to draw rigorous connections between the role of mental illness and the perpetrator's actions. Most mass public murderers do not have clinical diagnoses of mental illness (Skeem & Mulvey 2020 estimate 20%), and for those who do, it is difficult to draw any firm conclusions about the causal impact of mental illness on the decision to commit mass murder.[5] For example, if mental illness were to drive an incident of mass public murder, we would expect the murderer to be experiencing symptoms of mental illness in the time period leading up to the act. A diagnosis many years before of a condition such as major depression, without current symptoms, makes the causal connection between mental illness and mass public murder more tenuous. We do not have data on the number of mass murderers who were experiencing current symptoms, so 20% likely is an upper bound on mental illness as a causal factor in mass murder.

Even if all people who committed mass murder had mental illness, this would not imply that people with mental illness are likely to commit mass murder. There are approximately 13.1 million adults with serious mental illness in the United States,[6] and less than 10 mass public shootings and 20[7] familicide mass shootings per year. Based on these magnitudes alone, we must conclude that in the US only the tiniest fraction of people with mental illnesses commit mass murder.

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[3] 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. page 490.

[4] Appelbaum, P. S. (2020, April). Violent acts and being the target of violence among people with mental illness—the data and their limits. *JAMA Psychiatry, 77*(4), 345–346. (p. 345 describing Sariaslan et al 2020.)

[5] Skeem, J., & Mulvey, E. (2020). What role does serious mental illness play in mass shootings, and how should we address it? *Criminology & Public Policy, 19*:85–108.

[6] Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* [page 44] (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

[7] Krouse, W. J., & Richardson, D. J. (2015, July). *Mass murder with firearms: Incidents and victims, 1999-2013*. Congressional Research Service. http://fas.org/sgp/crs/misc/R44126.pdf.

## More common forms of violence

Because of limitations discussed in the previous section, many research articles that address mental illness and mass murder switch focus to the relationship between mental illness and less severe types of violence. While the research here illustrates a higher rate of violence in this category, the research is limited and often contradictory. In general, people with serious mental illnesses account for only a relatively small portion of violent behavior.

Swanson (2015), adapting work from several other studies, showed that of people with mental illnesses, those in outpatient treatment had the lowest rate of engaging in any type of violence (8%), while representative community samples of people with mental illnesses, which included both treated and untreated people, had higher rates (10%). Discharged inpatients had higher rates (13%), while people who were involuntarily committed to psychiatric treatment had much higher rates of violence (36%). In comparison, the same cited studies reported a 2% rate of violence in the general population of people without mental illness. These varying rates are a function of screening for violence risk factors. But it is not necessarily mental illness that is the driver of the higher rates of violence in high-risk settings. As extensively documented by Skeem and Mulvey (2020),[8] the difference in rates of violence washes out in settings in which both people with and without mental illness have high rates of violence, such as correctional settings. Characteristics such as "past violence and other criminal behavior, impulsivity and poor anger controls, as well as the broader interpersonal trait of antagonism" are the risk factors for violence, and these are common to people with and without mental illness in correctional facilities.[9]

It is also important to be more specific about the role of substance use disorders in violence. In an analysis of data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESCARC), Van Dorn et al (2012) found that the prevalence of the past year's violence was 0.83% for people without mental illnesses or substance use disorders, 2.88% for people with mental illnesses alone, and 9.97% for people with both mental illnesses and substance use disorders. For people with substance used disorders alone, the prevalence was similar to those with mental illness alone (2.86%). Based on these data, people with mental illnesses who do not have substance use disorders have higher rates of low-severity violence (the sample excluded people in jail or prison), but the underlying level is still quite low. Even for people who have both a mental illness and a substance used disorder, the majority (90%) are not violent.

The specific form of mental illness is also important. Van Dorn's analysis reports that in comparison to people without any mental illness or substance abuse, people with mental illness other than serious mental illnesses have 1.74 times the risk of violence, while people with serious mental illness such as schizophrenia, bipolar disorder and major depression have respectively 5.8, 5.9, or 2.9 times the risk.[10] Given that only a small proportion of people have a serious mental illness, the aggregate contribution of mental illness to the total amount of violence is small. Van Dorn's analysis claims a 19% decrease in the

[8] Skeem, J., & Mulvey, E. (2020). (p.94)

[9] Skeem & Mulvey (2001) as cited in Skeem, J., & Mulvey, E. (2020).

[10] Van Dorn, table 2. Odds ratios are reported.

incidence of violence if all of the extra risk from mental illnesses were eliminated. Swanson (2015), citing an analysis of a similar household survey in the 1990s, reported a much smaller contribution (4%) of mental illness to the total amount of community violence.[11] The discrepancy in estimates from Van Dorn and Swanson highlight the differences in method and definition that are common in research on mental illness and violence.

Although these results can draw a link between mental illness and violence, they should be interpreted with caution for several reasons. One is the difficulty in categorizing cases. Familicide and mass public murder may have clear definitions that allow researchers to categorize events easily. However, the more general category of *violent behavior* is much less clear and is measured inconsistently. For example, in Van Dorn's analysis of NESCARC data, the authors[12] explain that the self-reported data did not allow a separate analysis of violent acts performed in self-defense from those that were aggressive in nature. The criteria used to identify a violent act included unambiguous items such as rape, but potentially misleading criteria such as *having physically hurt another person in any way on purpose*. Its literal application would include many victims of crime, participants in many sports, police officers, and members of the military undergoing basic training as being violent. Obviously, these forms of violence are very different than familicide or mass murder. Furthermore, if we recognize that people with mental illnesses are subject to elevated rates of being victims of crime and violence, it is not clear what percentage of violence committed by people with mental illness is a reaction to victimization. As compared to the general population, people with mental illness experience much higher rates of poverty, homelessness and substance use disorders, all of which contribute to higher rates of victimization and the need to use force defensively.[13] Finally, as previously noted, measuring comparative rates of violence for people with and without mental illness depends critically on the population included in the analysis, with any reported increase disappearing in more violent populations. The above-cited NESARC study "targeted an adult civilian noninstitutionalized population that resided in the United States."[14] By excluding both members of the military and incarcerated people, the level of violent behavior (as defined) was likely lower than in the broader population, which increases the likelihood of finding that people with mental illnesses have elevated rates of violence.

## Comparison to Suicide in Oklahoma

Although mental illness in itself only makes at most a small contribution to violent crime, it plays a much larger role in suicide, which might be considered another serious form of violence. As compared to murder, suicide is much more frequent and has been increasing over time.

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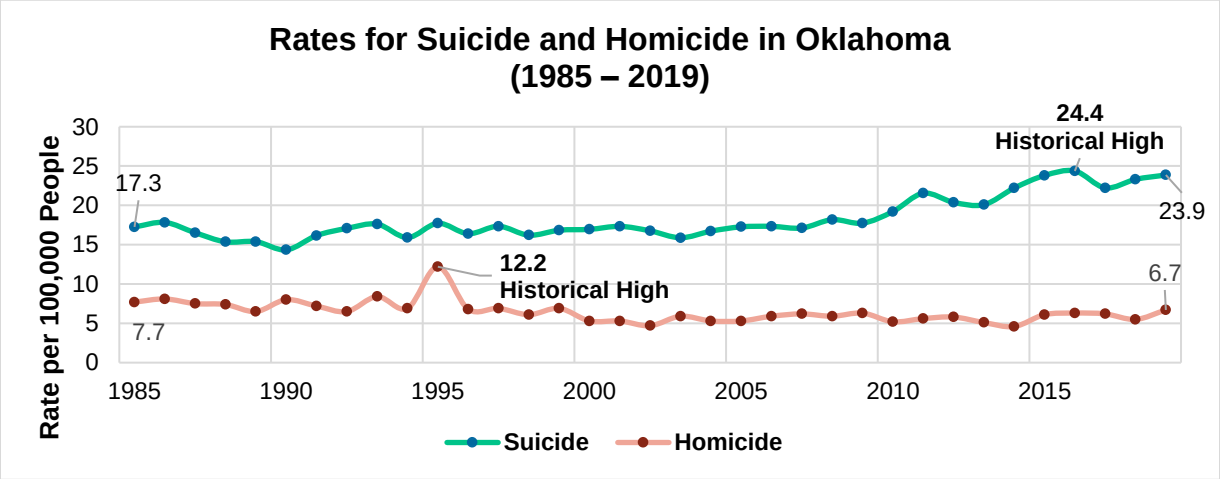
[11] Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015. Mental illness and reduction of gun violence and suicide: Bringing epidemiologic research to policy. *Annals of Epidemiology, 25,* 366–376. (Citing prior work analyzing the National Institute of Mental Health Epidemiological Catchment Area (ECA) study.)

[12] Van Dorn, R., Volavka, J., & Johnson, N. (2012). For peer review, this is on page 499, paragraph starting "In addition".

[13] Appelbaum, P. S. (2020). (p 345 describing Sariaslan et al 2020.)

[14] Van Dorn, R., Volavka, J., & Johnson, N. (2012). (page 488)

The chart below shows suicide and homicide trends in Oklahoma from 1985 through 2019.[15, 16] Over the reported period, the average suicide rate per 100,000 people was 18 suicides per 100,000—this is 3 times higher than the average homicide rate over the same time period (6 homicides per 100,000). In addition, the homicide rate over the past 10 years has not significantly changed, whereas the suicide rate has been steadily increasing. The highest rate of suicides occurred in 2016 (24.4 suicides per 100,000 people), with the second highest rate occurring in 2019 (23.9 per 100,000 people). The average rate of suicides from 2015 to 2019 (23.5 per 100,000 people) is four times as high as the average rate of homicides (6 per 100,000 people).




Just as most violence does not rise to the level of homicide, for adults, only about one death results from 31 attempts at suicide. In 2019, approximately 12 million US adults had serious thoughts of suicide.[17]

We have argued that mental illness only plays a small role in violent crime, and that it is a mistake to conflate the two. Although not all cases of suicide involve mental illness, the proportion of mental illness in deaths from suicide is much larger, with some research indicating that 90% of people engaging in serious suicide attempts had a mental health disorder at the time of the attempt.[18] In terms of lives lost from causes related to mental illness, suicide is unambiguously a greater problem than homicide.

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[15] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2005). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. www.cdc.gov/injury/wisqars

[16] Federal Bureau of Investigation. (n.d.). *Crime data explorer, Oklahoma*. https://crime-data-explorer.app.cloud.gov/explorer/state/oklahoma/crime

[17] 2019 National Survey on Drug Use and Health, page 48.

[18] Beautrais, A. L., Joyce, P. R., Mulder, R. T., Fergusson, D. M., Deavoll, B. J., & Nightingale, S. K. (1996, August). Prevalence and comorbidity of mental disorders in persons making serious suicide attempts: A case-control study. *The American Journal of Psychiatry, 153*(8), 1009–1014. https://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.153.8.1009

## Recommendations

As we have noted, in the US a significant majority of people with mental illnesses are not violent. However, under certain circumstances, people with mental illnesses are more at risk for committing violent acts than people without mental illnesses. Partly for this reason, but also because outcomes for people with mental illnesses will generally be better, Oklahoma should endeavor to expand evidence-based behavioral health practices that will mitigate risk.

### Expand capacity to treat First Episode Psychosis (FEP)

Oklahoma should expand access to First Episode Psychosis Care to match the estimated annual need for this evidence-based practice—that is, to meet the need represented by the annual incidence of first episode psychosis in the state. Based on epidemiological studies of first episode psychosis, we estimate that at least 370 Oklahomans experience a first episode of psychosis each year. However, the current collective capacity of the two FEP Care teams in the state (one in Tulsa and one in Oklahoma City) can only address one fifth of that need, as the two teams combined serve a maximum of 70 people at any given point in time.[19]

People with untreated psychosis are at a greater risk for violence than the general population[20] and the longer they go untreated, the longer they and those around them have to face that risk. Again, the majority of people experiencing a first episode of psychosis are not violent, but the minority who are at risk for being violent need access to early treatment. FEP Care has been shown to yield good client outcomes and to be cost-effective. It is especially effective for people who receive treatment earlier in the episode.[21] Through the use of federal block grant dollars, FEP Care has been funded in select Oklahoma communities. However, Oklahoma should consider including it in the Medicaid state plan, as has been done in some other states. And, because not doing so represents a potential parity violation, commercial insurers also need to include it in their health plans. Recently, a case rate model for FEP Care has been developed and is being implemented or reviewed for implementation in other states, including Nebraska.

### Target services to justice-involved Oklahomans with mental illness

Forensic Assertive Community Treatment: Oklahoma should introduce the evidence-based Forensic Assertive Community Treatment (FACT) model in several locations around the state. FACT meets the

[19] The NAVIGATE version of FEP Care is followed in Oklahoma. The average expected length of stay on a NAVIGATE team is about two years, so the collective capacity of these two teams should not actually be expected to meet the needs of one fifth of those in need but, rather, about one tenth.

[20] 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.

[21] 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. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2015.15050632
Rosenheck, R. et al. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin*, 42(4), 896–906. doi:10.1093/schbul/sbv224

needs of a sub-group of people with serious mental illness who have had criminal justice system involvement. Not all of the people who could benefit from FACT have histories of violence, but because preliminary research indicates it generally improves forensic outcomes (re-offending, new arrests, and new jail bookings)[22] and because no other model is more promising at this time, FACT should be tested in several Oklahoma communities to determine whether outcomes in these communities are as promising as outcomes seen in the research literature and in other states.

FACT has not yet been implemented in Oklahoma, but several community mental health providers in the state have years of experience implementing the Program for Assertive Community Treatment (PACT) model, upon which FACT is based. And, because the Certified Community Behavioral Health Clinics program in Oklahoma requires implementation of PACT, a growing number of providers soon will have the capability to implement this intensive, multidisciplinary team-based program for people with mental illnesses who have had the most difficulty living and working independently in the community. During the 2020 legislative session, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) requested funding from the state legislature to implement FACT in select Oklahoma communities, but the request was not approved.

Critical Time Intervention: Oklahoma also should expand the availability of evidence-based Critical Time Intervention (CTI) services for people who have been released from jail to help reduce their risk of re-offending. Oklahoma has successfully implemented this approach for certain sub-groups in the criminal justice system and in specific locations around the state, but not statewide. A successful Oklahoma example comes from the Reentry Intensive Care Coordination Teams (RICCTs) program for women released from prison, which is implemented by Family & Children's Services of Tulsa. In the five years following release from prison, women in the RICCTs program had lower recidivism, fewer inpatient admissions, much higher service engagement, and more than double the average income compared to a control group.[23] RICCTS is based on the CTI model, which has been found to increase ex-prisoners' engagement with mental health and physical health treatment, according to published studies.[24]

## Diagnose and treat more substance use disorders

Because untreated substance abuse is associated with a greater risk of violence, including in people with mental illnesses, Oklahoma should expand at least two key evidence-based practices:

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[22] Cusack, K. J. et al. (2010). Criminal justice involvement, behavioral health service use, and costs of Forensic Assertive Community Treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363. doi:10.1007/s10597-010-9299-z

[23] Data were obtained from a February 2019 data brief distributed by ODMHSAS and ODOC entitled, "Mental Health Re-Entry Program."

[24] Jarrett, M., et al. (2012). Continuity of care for recently released prisoners with mental, illness: A pilot randomized controlled trial testing the feasibility of a critical time intervention. *Epidemiology and Psychiatric Services, 21*(2), 187–193. DOI: https://doi.org/10.1017/S2045796011000783
See also, Angell, B. et al. (2014). Engagement processes in model programs for community entry from prison for people with serious mental illness. *International Journal of Law and Psychiatry, 37*(5), 490–500. doi:10.1016/j.ijlp.2014.02.022

- Screening, Brief Intervention, and Referral to Treatment (SBIRT): The state should help expand the current efforts of ODMHSAS and the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) to help primary care practices and providers implement the evidence-based SBIRT approach to detecting and treating alcohol abuse, substance abuse, and common mental health conditions such as depression among primary care patients. Because it includes a focus on both substance use disorders and mental health conditions, the model can address co-occurring mental illness and substance abuse. To date, ODMHSAS and OPHIC have successfully helped a few dozen primary care practices implement the SBIRT model. SBIRT can reduce the risk of alcohol and substance use becoming harmful, help providers successfully treat depression, and even play a role in preventing suicide, including among youth. However, the extant efforts of ODMHSAS and OPHIC merely represent the tip of the iceberg of what is possible, and hundreds more practices in Oklahoma need their assistance. Fortunately, billing codes are available that enable providers to obtain reimbursement for these services. Factors that limit the expansion of training and technical assistance (TA) in SBIRT are funding for the training/TA and the capacities of ODMHSA and OPHIC. A financing model is needed as well as a pyramid/train-the-trainer model to expand TA/training capacity for dissemination and adoption.

  Among other reasons, SBIRT is important because it allows the health system to treat mental illnesses and substance use conditions early in their development, thereby decreasing the risk that these conditions will spiral out of control. However, in some instances, the combination of mental illness and a substance use condition will be too difficult for primary care-based providers to handle. In these instances, in which a person has a mental illness such as bipolar disorder or schizophrenia and a substance use condition, a referral to specialty behavioral health care will be necessary.

- IDD Treatment: Another approach to addressing substance abuse and mental illness is to develop more capacity in community mental health providers to deliver evidence-based Integrated Dual Disorders Treatment (IDDT) for people who are coping with mental illness and co-occurring substance abuse.[25] IDDT can be implemented both as a team-based program, much like PACT or FACT, and it can be used to guide the more general development of a mental health provider agency's co-occurring capability. However, in lieu of implementing IDDT teams, Oklahoma could ensure that it has enough PACT and FACT teams whose staff are "co-occurring capable" or fully trained to implement the principles of IDDT within the PACT or FACT program.

## Expand comprehensive suicide reduction

It is important that Oklahoma develop comprehensive approaches to addressing suicide. The aforementioned SBIRT program is an identified evidence-based practice for detecting suicidal thinking and addressing it before people attempt to harm themselves. As we noted above, mental illness has a

[25] Drake, R.E., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*(4), 469–476.

relatively small contribution to overall community violence toward others, but it is strongly associated with death from suicide. With a statewide expansion of SBIRT, Oklahoma could put itself in a stronger position to decrease both accidental drug overdoses and deaths from suicide. This would be especially likely if in addition to the SBIRT model, Oklahoma widely disseminated the successful Zero Suicide model that is now being promoted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), among others.[26] Oklahoma also should consider prevention programs such as Youth Aware of Mental Health that are geared specifically for youth and that in empirical studies have been found to reduce suicidal thinking and suicide attempts.[27]

## Expand implementation and quality improvement

It is beyond the scope of this paper to fully explore the issues involved in disseminating and adopting these evidence-based practices that can yield better outcomes for people with behavioral health conditions, their families and their communities. However, we will highlight two considerations.

First, ODMHSAS has a long history of training health and behavioral health providers in evidence-based practices. As mentioned above, a current example is their work with OPHIC in helping primary care providers implement the SBIRT model. In addition, as we mentioned above, ODMHSAS has promulgated Critical Time Intervention in a few locations. However, from a financing perspective, these and many others examples are pertinent in that they rely on special grant funding or federal block grant dollars. A more robust approach would be to ensure that all of the evidence-based practices described above are specifically included in the Medicaid state plan and that Medicaid managed care companies include these evidence-based practices in their health plans as reimbursable services.

Although ODMHSAS has a long history of training providers and otherwise preparing them to deliver evidence-based practices, it does not have the requisite capacity to provide training and technical assistance to meet all of the needs in the state. Oklahoma should consider developing a center of excellence to address the intersecting needs of people with mental illnesses and substance use disorders, and the reduction of what experts refer to as “criminogenic risk” (the likelihood of reoffending). Even training from experts does not always immediately result in competent delivery of an evidence-based practice,[28] so the center of excellence would also need to provide ongoing assessments of model implementation fidelity as well as guidance to providers on how to continually enhance their programs over time.

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[26] See a summary of the evidence for Zero Suicide’s effectiveness at https://zerosuicide.edc.org/evidence
See also, Coffey, C.E., et al. (2013, Aril). An update on perfect depression care. Psychiatric Services, 64(4). https://doi.org/10.1176/appi.PS.640422

[27] Wasserman, D. et al. (2015). School-based suicide prevention programmes: The SEYLE cluster-randomised, controlled trial. *Lancet, 385*(9977), 1536–1544. doi: 10.1016/S0140-6736(14)61213-7
See also a review of suicide prevention best practices that describes research on Youth Aware of Mental Health and other programs: Platt, S., & Niederkrotenthaler, T. (2020). Suicide prevention programs: Evidence base and best practice. *Crisis*, *41* (Suppl 1), S99–S124. https://doi.org/10.1027/0227–5910/a000671

[28] Kikkert, M. et al. (2018). Effectiveness of Integrated Dual Disorders Treatment in severe mental illness outpatients with a co-occurring substance use disorder. *Journal of Substance Abuse Treatment, 95*, 35–42. doi: 10.1016/j.jsat.2018.09.005

## Conclusion

In this paper, we have summarized some of the most important literature on the relationship between mental illness, particularly serious mental illness, and violence. Although the majority of people in the U.S. with serious mental illnesses are not violent, mental illness often is highlighted over other factors that may be even more pertinent. The stigma towards mental illness often both drives these decisions concerning the reporting on high-profile murders and is exacerbated by the emphasis on mental illness.

There are approximately 13.1 million adults in the U.S. who experienced serious mental illness in the past year. Each year, there are a few dozen cases of mass murder, including familicide, public murders, and gang- and crime-related mass murders. We do not know exactly how many mass murderers suffer from mental illness, and of those who do, how many suffer from concurrent symptoms. But based on the available data, most people who commit mass murder do not have conditions such as depression, bipolar disorder or schizophrenia. It is readily apparent that the vast majority of people with mental illness do not commit mass murder.

Much of the research literature includes the claim that in the U.S., people with mental illness have higher rates of violent behavior than people without mental illness, particularly if the definition of violence is very broad and mental illness includes co-occurring substance abuse. But the measured increase in rates of violence is small, and even for U.S. residents with co-occurring conditions, most do not often engage in violence. For those who do, it is not clear how much of the higher rates is attributable to living in locations with greater insecurity and resulting defensive use of violence. Since the level of underlying violence varies dramatically across space and time, universal claims that people with mental illness pose an additional danger or risk of violence are not informative or meaningful.

In terms of lives lost, suicide is a much more significant problem, as reviews of trends in suicide and murder reveal. Also, the connection between suicide and mental illness is much stronger than murder and mental illness. There are treatment options that can help people with mental illness recover and help reduce the risk of suicide and other violent behavior.