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**Violence and schizophrenia: who is the perpetrator and who is the victim?**

In November 2022, the Mayor of New York City issued a new directive instructing police to transport homeless persons with apparent severe mental disorders, such as schizophrenia, to the psychiatric hospital if they appear unable to meet their basic needs, departing from the previous standard that required someone to be a danger to him/herself or others in order to be hospitalized. This directive represents a major setback to decades of efforts by human rights activists and mental health professionals to limit involuntary treatment for schizophrenia through community-based care, social interventions, and peer-supported decision-making.

Unfortunately, this Mayor's policy aligns with the public misperception of people with schizophrenia as being dangerous or violent, reinforced by rancorous and ill-informed media reporting on rare episodes of gun violence and stabbing by persons with psychosis. This public misperception seems to be further validated by recent scientific publications[2] which suggest an association between schizophrenia and violence. Here we critically appraise the available evidence in this respect and argue that common interpretations of this evidence are deeply flawed.

First, many samples included in these publications[2] are based on obsolete diagnostic criteria and/or diagnoses other than schizophrenia, and the operationalization of violence is often vague (e.g., "broad interpersonal violence perpetration" or "serious trouble with the law").

Second, these analyses[2] fail to fully adjust for confounding risk factors linked with social determinants and correlated with both violent behaviour and schizophrenia. Amongst these shared risk factors are male gender, young adulthood, non-white race, marginalized subgroups or ethnic minorities, and social adversity/poverty[3]. The social determinants associated with schizophrenia trigger "social biases" leading to a greater likelihood of being perceived as violent or threatening, and an escalation of encounters with the police or forensic pathways.

Perhaps the most important examples of such social biases are those which are racially motivated. The 2017 Race Disparity Audit by the UK government (www.gov.uk/government/publications/race-disparity-audit) indicated that non-white individuals are more likely to come into contact with mental health services through the police, and to be referred to forensic pathways. The audit also established that black men are over ten times more likely to be compulsorily detained in psychiatric hospitals than whites. In the US, structural racism continues to affect all aspects of society, not least the law and its enforcement and the practice in health care systems, worsening the historic socio-economic disparities associated with violence and trauma experienced by black people with schizophrenia.

Third, the above research[2] ignores the clinical stages of the disorder. Violent behaviour by people with schizophrenia is relatively infrequent, and most people with schizophrenia are not dangerous[4]. However, a small number may become aggressive, mostly during the acute or first episode stage, when their hallucinations and delusions are not yet detected and adequately treated (i.e., during untreated psychosis)[4]. Comorbidity with substance use and antisocial personality disorder or previous forensic history, themselves major risk factors for violence, are often present in acute psychotic stages, further complicating the association between schizophrenia and violence. Generalizing the occurrence of aggressive behaviour, which predominantly occurs in these acute stages, is a misrepresentation of the lived experience of schizophrenia.

Fourth, it is challenging to disentangle unprovoked violence, such as that resulting from responding to a command hallucination, from reacting antagonistically to a person behaving threateningly. This is not an infrequent occurrence for persons with schizophrenia, particularly those who are homeless. Indeed, the lived experience of people with schizophrenia indicates

that such individuals are the victims of violence by others in the community more often than the general population[5], for example, reporting higher rates of childhood trauma (odds ratio: 2.87)[3]. People with a lived experience of schizophrenia also report high victimization rates by mental health professionals and families, including physical violence, verbal violence, restraint, neglect of basic human needs and rights, deception, and lack of informed consent. National registry studies have confirmed that the onset of schizophrenia is associated with an increased risk of being subject to crime, and violent crime in particular[6].

Fifth, the above research[2] ignores that the most common form of violence associated with schizophrenia is not directed at others but at oneself, which is very often the result of social exclusion, harassment and stigmatization. A recent meta-analysis of 135 cohort studies demonstrated a nine-fold increase in suicide risk compared to the general population (risk ratio: 9.76)[7], with most self-harming acts reported during a first acute episode and in younger patients[8].

For all these reasons, there is a high risk of reverse causality and confounding in the observed association between schizophrenia and violence[2], which is not fully accounted for by epidemiological studies. One must interpret such studies in the broader context of the lived experience of people with psychosis, especially for persons who belong to historically marginalized or discriminated groups, such as black and indigenous peoples in white-majority countries. Simply reporting epidemiological findings, without controlling for such contextual factors, risks perpetuating the public fear of persons with schizophrenia, stigmatizing people affected by the condition, and exposing them to further discrimination and violence, which may itself trigger aggressive responses.

Future epidemiological studies must not only control for all known social determinants and substance use, but also for the clinical stage of psychosis. Such studies must triangulate data from in-depth case series of persons deemed violent to unpack the complex cause-effect relationships between schizophrenia and violence. Findings should be critically and cautiously appraised, actively including the views of persons with lived experience of schizophrenia[5] and human rights activists, as in the present paper, to better balance the power between patients and health care providers and to have patients fully included in all policy processes[9].

In conclusion, we argue that research which reports an association between violence and schizophrenia has too often been flawed by methodological limitations, and its findings risk exposing people with schizophrenia to further discrimination, violence, and loss of fundamental freedoms and human rights. Policies that seek to reduce the association of schizophrenia and violence, including self-inflicted harm, must not focus on involuntary hospitalization and coercive treatment of persons with schizophrenia. They should instead prioritize more effective training of police and emergency services to avert these outcomes and address the social determinants associated with schizophrenia, including insufficient access to housing and community-based health care. Importantly, policies should fund and support community-wide preventive and early intervention services, to reduce the duration of untreated psychosis and implement timely evidence-based treatment[5].

These latter policies respect the dignity and agency of persons with psychosis and align with the human rights protections set out in the Convention of the Rights of Persons with Disability and the charters developed by patients and family organizations (www.gamian.eu/patient-charter-schizophrenia).

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