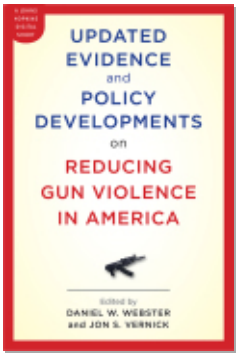
Updated Evidence and Policy Developments on Reducing Gun Violence in America



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Published by Johns Hopkins University Press

Thinking Differently about Mental Illness, Violence Risk, and Gun Rights

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Politicians and pundits called the Newtown massacre "unspeakable." That did not stop anyone from speaking about it. In the year following the Sandy Hook shooting, words poured out by the millions—in the mass media, task-force hearings, legislative debates, and difficult private conversations. After all that talk, what has been accomplished to prevent gun violence?

Some said the problem is all about guns. Others blamed our violent culture. But many Americans—across the political spectrum—concluded that gun violence is about *mental illness*. A post–Sandy Hook national opinion poll found a majority of gun owners as well as non-gun owners favored "increasing government spending to improve mental health screening and treatment as a strategy to prevent gun violence" (Barry et al. 2013). Is that the answer?

The average adult in this country believes that the average person with mental illness is dangerous (Pescosolido et al. 1999). That this media-fueled belief is wrong does not make it less influential in driving public support for violence prevention strategies targeting mental illness (McGinty et al. 2013; The Economist 2013).

One approach is to expand mandatory psychiatric treatment for purportedly dangerous mentally ill persons—to make them behave less dangerously (Torrey 2008). This is the idea behind broadening the scope of involuntary outpatient commitment as part of a gun violence prevention law, as New York State did in its (Newtown-inspired) Secure Ammunition and Firearms Enforcement (SAFE) Act of 2013. Another approach is to limit access to lethal means for persons assumed to be risky by dint of mental health adjudication. Our chapter in *Reducing Gun Violence in America* (Swanson et al. 2013) evaluated that second approach, as implemented in a single state. What can be made of it now?

The centerpiece of our essay was an empirical study of whether a state's policy of reporting gun-disqualifying mental health adjudication records to the FBI's National Instant Criminal Background Check System (NICS) can reduce violent crime in the community. We had assembled a longitudinal database of matched mental health, court, and arrest records for 23,292 persons diagnosed with schizophrenia, bipolar disorder, or major depression who were receiving services in Connecticut's public behavioral healthcare system. We found a statistically significant 6% reduction in violent crime in gun-disqualified individuals attributable to Connecticut's initiating a policy of reporting records to NICS in 2007.

On one level, our study's take-home message was simply that states should proceed to report mental health adjudication records to the NICS—that this actually works to reduce violent crime. A lot of states seem to have gotten that message. Indeed, the number of mental health records deposited with the Federal Bureau of Investigation's background check database rose 77% in one year—from 1.8 million in November 2012 to 3.2 million in November 2013. By comparison, the number of records in the NICS for other categories of prohibited persons rose by 21% in 2013 (FBI 2013a, 2013b).

On another level, our study suggested a more complex answer than simply populating the NICS with states' civil commitment records. The NICS mental-health-reporting effect was indeed statistically significant, but it was substantively trivial; the policy affected only 7% of the study population of persons with serious mental illness, while 96% of the violent crimes recorded for that population were committed by persons who were *not* exposed to the policy. As a result, the estimated net reduction in violent crime in the population was miniscule—a tiny fraction of 1%.

Involuntary commitment orders are uncommon in Connecticut; federal firearms law is nested in widely variable state commitment practices (Appelbaum

and Swanson 2010). In many states, police commonly detain persons who are in a mental health crisis and transport them to a treatment facility, where they are briefly held before either being discharged or persuaded to sign into the hospital voluntarily. Neither of those dispositions currently results in gun disqualification in most states, notwithstanding elevated risk of harm to self or others that may coincide with involuntary hospitalization.

In April 2013, Connecticut passed wide-ranging gun safety legislation that was intended to address the problem of presumably risky people having access to guns. The new law vastly expanded the mental health criteria for firearms disqualification in the state: it prohibits persons from accessing guns for six months following *any voluntary hospitalization* for mental health treatment. This could include anyone who comes knocking on the door of a mental health facility who could benefit from an inpatient stay and is able and willing to consent to admission. Many mental health stakeholders in Connecticut reacted to this provision with alarm. Some clinicians, in particular, expressed concern that it might deter people in a mental health crisis from seeking hospital treatment (Rama 2013).

New York's SAFE Act provided another instructive example of the hazards of crisis-driven policy. Governor Andrew M. Cuomo and state lawmakers rushed to enact sweeping new gun regulations just weeks after the Sandy Hook shooting. The law requires mental health professionals to report to the police the names of patients who threaten to harm themselves or others, to the end that law enforcement may revoke any handgun permit possessed by a reportedly risky mentally ill person. The reporting mandate on mental health clinicians provoked strong controversy and created strange bedfellows, as the psychiatric establishment and gun rights advocates—neither having been consulted in advance—both opposed the SAFE Act for entirely different reasons (Appelbaum 2013; Swanson 2013).

We do need better mental health care in America. An estimated 3.5 million people with serious mental illnesses are going without treatment (Kessler et al. 2001). That is scandalous. But *mentally ill people are not the cause of the violence problem*. If schizophrenia, bipolar disorder, and depression were cured, our society's problem of violence would diminish by only about 4% (Swanson 1994). Does that mean mental illness is irrelevant to gun prevention policy? The answer is no, for two reasons.

One reason is suicide, which accounts for 61% of gun deaths (Centers for Disease Control and Prevention 2013). Mental illnesses are a strong contributing

factor in suicide. Another reason, as mentioned, is that people with serious mental illness who encounter the involuntary treatment system pose an elevated risk for violence toward themselves or others *under certain circumstances and during certain times,* such as the period following an involuntary hospitalization. Temporarily limiting access to firearms for people with mental illnesses—during the particular period when risk is heightened—amounts to a meaningful public health opportunity.

The opportunity must be tempered by the reality that a constitutional right is at stake. The reason that federal law predicates gun prohibition on involuntary civil commitment is not only about the putative correlation of gun violence risk with the dangerousness criteria for commitment. It is also about the civil commitment process itself; that an adversarial court proceeding, with representation of the parties by counsel, affords people due process for the restriction of liberty in hospital confinement and, by proxy, for the removal of a constitutional right to bear arms.

The practical problem with the current federal approach, as implemented variously across the states, is that it misses a lot of people at risk who never get committed, while it prohibits gun ownership by many people after they no longer pose a risk of harming others or themselves. As such, the criteria are both underinclusive and overinclusive.

In theory, we could solve one part of the problem by simply expanding the category of gun-disqualified persons to include anyone who might be at risk. But that introduces another problem—the possibility of infringing on people's civil rights without due process. And just focusing on persons with mental illness puts a very low ceiling on the proportion of violence that could possibly be prevented. It is time to think differently about gun violence as a public health problem. From that perspective, a fair and effective policy should start with *risk*, not mental illness.

The Consortium for Risk-Based Firearms Policy has crafted state and federal policy recommendations premised on three ideas: (1) that gun violence could be reduced by time-limited restrictions on gun access by persons based on evidence of their individual risk of harming themselves or others; (2) that a history of any kind of violence—particularly with criminal justice involvement—is a better predictor of future gun violence than is the broad category of persons diagnosed with serious mental illnesses; and (3) that expanding gun disqualification based on evidence of risk must achieve balance with policies that offer a timely opportunity for a clinically informed restoration of rights (CRBFP 2013a, 2013b).

In the end, following these principles could help us find our way to more effective policies that will meaningfully reduce the scourge of gun violence in America while safeguarding the rights of lawful gun owners. The problem is multifaceted and longstanding. There is no quick fix. But in the current environment where guns have become a radioactive political symbol, one can only hope that a risk-based approach to limiting firearms would emerge as at least one square inch of common real estate between those who are most concerned with the individual right to bear arms and those inclined toward greater regulation of guns in the public interest. We desperately need a place to start.

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