

*MENTAL ILLNESS AND VIOLENCE: A REVIEW OF
GUN CONTROL LEGISLATION, PSYCHIATRIC
LITERATURE, AND THE REALITY OF PSYCHIATRIC
PRACTICE*

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DISCLOSURES

- No relevant financial disclosures



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A PREVIEW...

- What percent of violent crime is attributable to people with mental disorders?
 - Of this minority of violent crime, what percentage involves firearms?
 - Is there a federal law that mandates state reporting of mental health records to NICS?
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PRESENTATION OVERVIEW

- PART I – LAWS RELATED TO FIREARM POSSESSION BY THOSE WITH MENTAL ILLNESS
 - PART II – LITERATURE REVIEW ON VIOLENCE COMMITTED BY PEOPLE WITH MENTAL ILLNESS
 - PART III -- CLINICAL VIGNETTES—LIMITATIONS FACED BY PSYCHIATRISTS IN ATTEMPTING TO MINIMIZE RISK FOR VIOLENCE BY PATIENTS TO SELF AND OTHERS
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PRESENTATION OVERVIEW

- PART IV – BRIEF OVERVIEW ON CHILDREN/ADOLESCENTS AND GUN VIOLENCE
 - PART V – APA POSITION ON FIREARMS AND MENTAL ILLNESS
 - PART VI – CLINICAL GUIDELINES AND DISCUSSION
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PART I -- LAWS RELATED TO FIREARM POSSESSION BY
THOSE WITH MENTAL ILLNESS

THE 2ND AMENDMENT

A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.

THE RIGHT TO BEAR ARMS



- **District of Columbia v. Heller (2008)**
 - Landmark case
 - Plaintiffs challenged the constitutionality of a Washington D.C. handgun ban called the Firearms Control Regulations Act of 1975
 - The Court considered whether the prohibition on the possession of usable handguns in the home violated the Second Amendment to the Constitution
 - Supreme Court 5-4 decision: 2nd amendment protects an individual's right to possess a firearm for traditionally lawful purposes (ie, self-defense in the home)

THE RIGHT TO BEAR ARMS

- **McDonald v. City of Chicago (2010)**
 - Landmark case
 - Determined whether the 2nd amendment applies to the individual states
 - Individuals' right to "keep and bear arms" protected by the 2nd Amendment is incorporated by the 14th amendment Due Process Clause and applies to the states
 - Cleared up the uncertainty left in the wake of Heller decision as to the scope of gun rights in regard to the states

MENTAL ILLNESS AND GUN OWNERSHIP...

a controversial debate

- Columbine High School, Colorado
- Virginia Tech, Virginia
- Newtown, Connecticut
- Aurora, Colorado



“People who have mental health issues should not have guns... they could hurt themselves. They could hurt other people.”

- New York Gov. Andrew Cuomo; January 2013

“No matter what you do—guns, no guns, it doesn’t matter—you have people that are mentally ill, and they’re going to come through the cracks, and they’re going to do things that people will not even believe are possible.”

- Donald Trump; October 2015

However, it has been well established that mental illness does not account for most of the violence in society.

MENTAL ILLNESS AND GUN OWNERSHIP...

another perspective

“It is my constitutional right to bear arms. I’m not getting rid of them.”

- Veteran hospitalized with depression and suicidal ideation

“It is none of your business whether I own guns or not.”

- Veteran hospitalized with psychosis

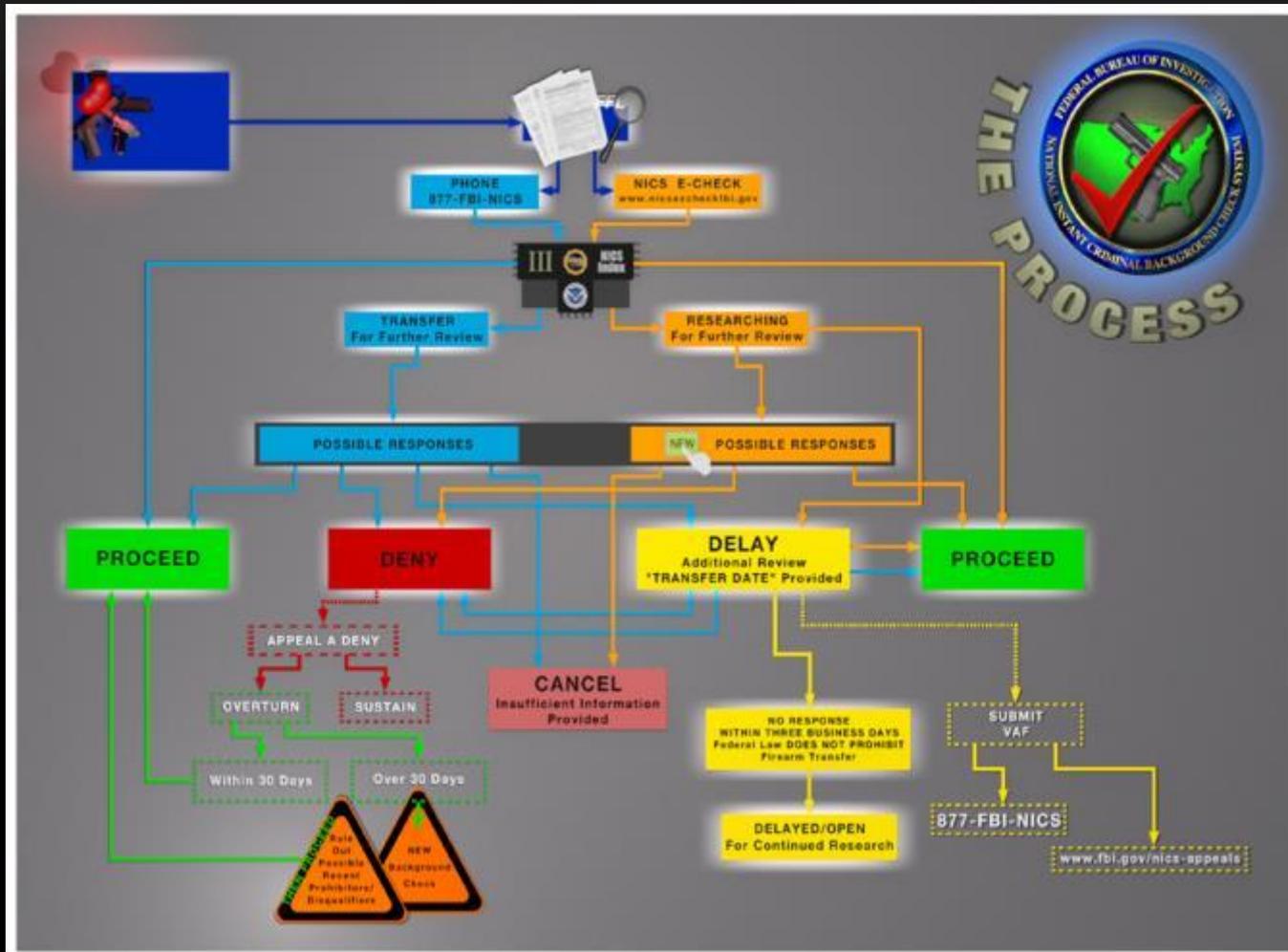
HISTORY OF GUN CONTROL FEDERAL LEGISLATION

- **Federal Gun Control Act (1968)**
 - Intended to regulate interstate transfers of firearms
 - Created categories of prohibited persons:
 - Involuntary Civil Commitment
 - Incompetent to manage affairs due to Mental Illness
 - IST, or NGRI
- **Brady Hand Gun Violence Prevention Act (1993)**
 - Established background checks
 - 5 day waiting period prior to an individual being allowed to purchase a handgun
 - Mandated creation of NICS

HISTORY OF GUN CONTROL FEDERAL LEGISLATION

- **National Instant Criminal Background Check System (1998)**
 - National database to allow background checks and identification of those who were prohibited from purchasing a firearm
 - State reporting voluntary
 - Concerns about confidentiality
- **NCIS Improvements Act (2007)**
 - S/p Virginia Tech shooting
 - Federal grant incentives for states to report

NICS FLOW CHART GRAPHIC



REPORTING TO NICS: SALIENT STATISTICS

- Between 1998 and November 2007 (Virginia Tech shooting occurred in April 2007), names in NICS of people with mental health records increased from 90,000 to 400,000
- Of all gun purchases blocked by the FBI (NICS) over the past 16 years (from 2014), fewer than 2% (14,613 attempted purchases) were due to mental health status
- About 9% of attempted gun purchases require further investigation by FBI (i.e. NICS search is not conclusive)
 - In 2012 alone, “72-hour default proceed” allowed 3,722 prohibited persons to buy firearms
 - Dylan Roof (Charleston church shooter) is an example of such a person in 2015

HISTORY OF GUN CONTROL FEDERAL LEGISLATION

- **President Obama's Executive Actions (2016)**
 - Discusses gun violence against others and self
 1. Background Checks—more effective and efficient; more examiners
 2. Increase ATF agents and investigators to enforce gun laws
 3. Increased research into gun safety technology
 - Mental Illness:
 - Calls for increased funding to help those with mental illness receive treatment
 - Expressly permitted certain HIPAA covered entities to provide to the NICS limited demographic/"necessary information" about these individuals
 - Noted that individuals with mental illness are more likely to be the victims of violence than perpetrators

HOW IS GUN OWNERSHIP AND MENTAL ILLNESS REGULATED IN THE UNITED STATES?

- Federal law prohibits possession of a firearm or ammunition by any person who has been “adjudicated as a mental defective” or involuntarily “committed to any mental institution.”
- NO federal law requires states to report the identifies of these individuals to the National Instant Criminal Background Check System (NICS) database
- States that do not submit records identifying people prohibited because of their mental health histories to NICS may nevertheless require a check of their own mental health records prior to a firearm transfer.
 - Forty-seven states have laws that require or authorize the reporting of some mentally ill people to the federal NICS database or a state database for use in firearm purchaser background checks
 - Categories of mentally ill to be reported vary immensely by state

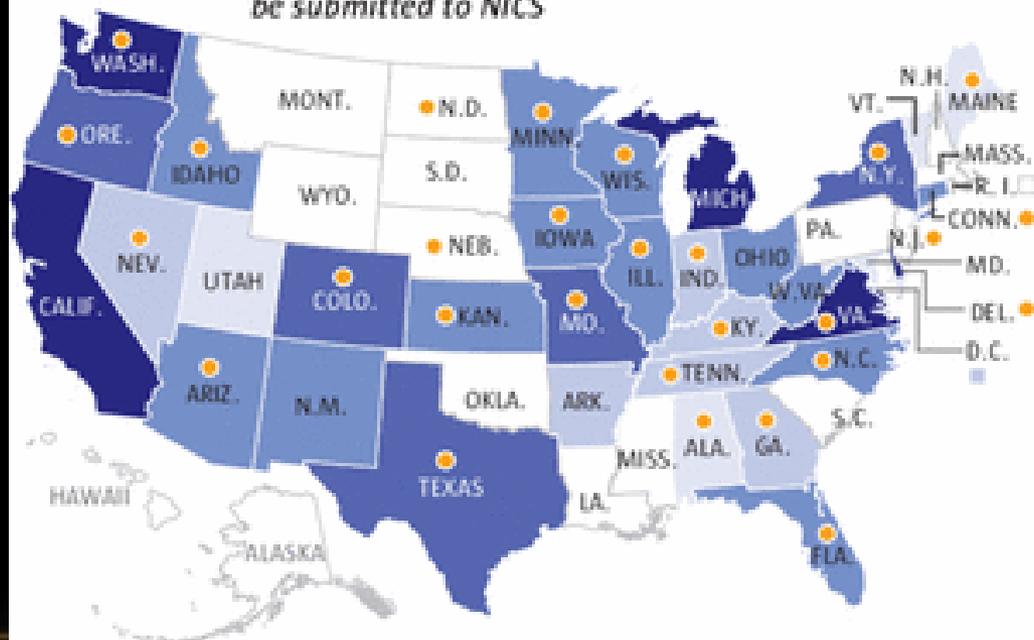
Mental-health reporting laws by state

A key tool used in keeping guns out of the hands of people who should not be buying them is a database called the National Instant Criminal Background Check System, or NICS. But the database is spotty. Not all states have laws requiring them to submit mental-health records, and among states that do, some submit far fewer records than others.

Mental-health records submitted per 100,000 residents (Oct. 31, 2012)

 < 1 1 - 9 10 - 99 100 - 499 500 - 999 1,000 +

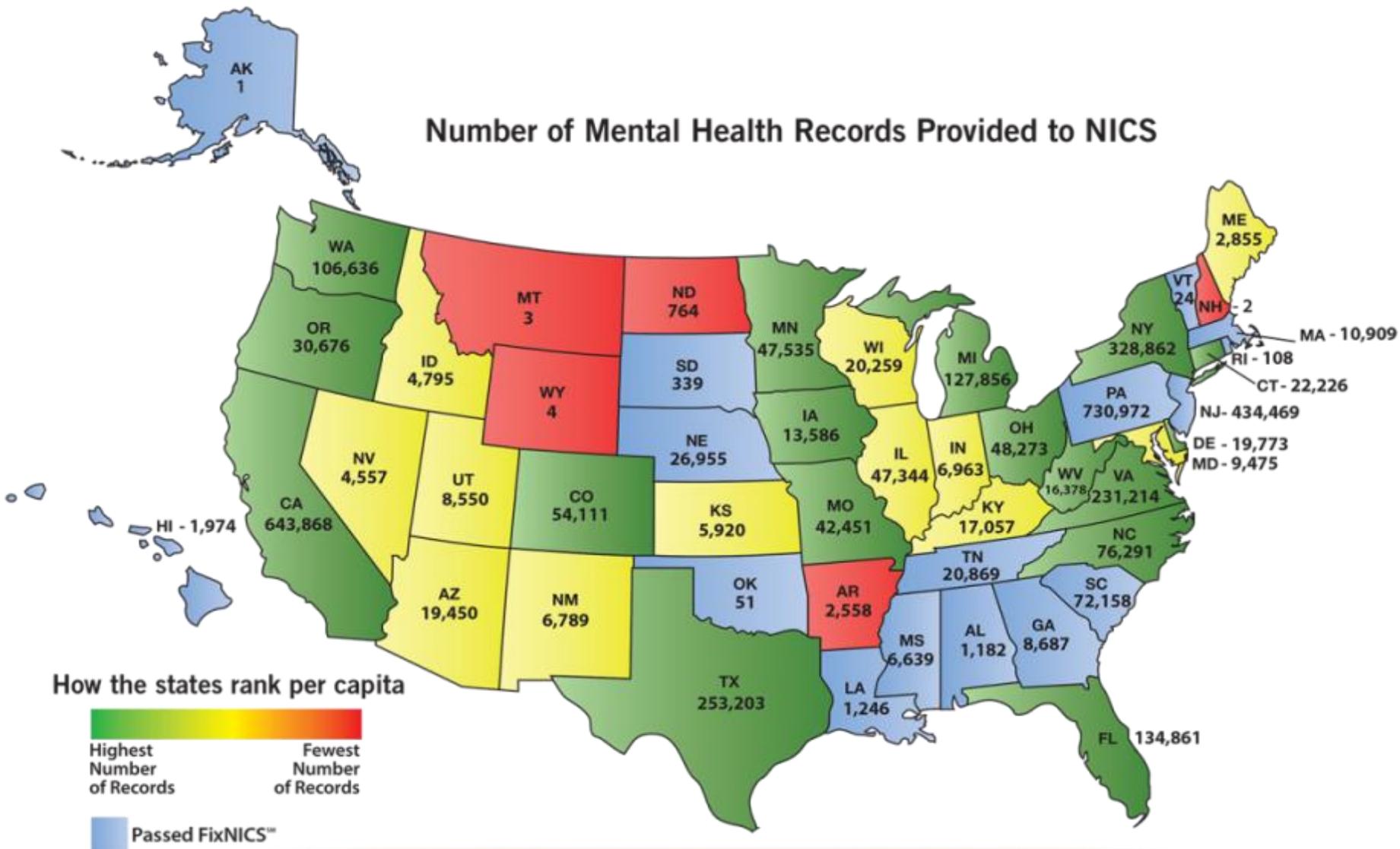
 States with law requiring mental-health records be submitted to NICS



Sources: *Mayors Against Illegal Guns*, Law Center to Prevent Gun Violence

THE SEATTLE TIMES

Number of Mental Health Records Provided to NICS



STATE VARIATION IN MENTAL HEALTH REPORTING—EXAMPLES:

- Categories of mentally ill people to be reported vary immensely by state
 - Inpatient vs. Outpatient
 - Involuntary vs. Voluntary
 - Guardianship
- Who reports varies by state
- Time period for reporting varies by state

PART II – LITERATURE REVIEW ON VIOLENCE COMMITTED BY
THE MENTALLY ILL

or

DOES IT MAKE SENSE TO MAKE LAWS THAT PROHIBIT
PERSONS WITH MENTAL ILLNESS FROM HAVING ACCESS TO
FIREARMS?

FIREARM OWNERSHIP

- Behavioral Risk Factor Surveillance System—2001, 2002, 2004
 - 1/3 of adults live in households where there is a firearm
 - Data from General Social Survey—percentage of households with firearms has dropped from 1/2 to in early 1990s to 1/3 by 1999

LITERATURE OVERVIEW

- Studies largely suggest that mental illness alone is not a risk factor for violence towards others
 - Certain subsets of the mentally ill may be at higher risk for violence towards others
- Studies suggest that mental illness is a risk factor for suicide
 - Over 60% of death involving firearms in 2010 were suicides, 35% were homicides, 4% were accidents, deaths by legal intervention

LITERATURE OVERVIEW

- Thus, gun legislation that targets the mentally ill in an attempt to decrease mass shooting/public shootings is likely misguided
- There are other factors that place people at higher risk for violence than mental illness alone

SUMMARY OF STUDIES—ECA STUDY

- Epidemiological Catchment Area Study
 - Examined relationship between mental disorders and violence
 - Statistically significant but fairly modest positive association between violence and mental illness
 - 12-month prevalence of violence among people with schizophrenia, bipolar disorder, or major depression → 12%
 - 7% prevalence for population with these diagnoses alone and no substance abuse issues
 - By comparison, 2% prevalence in population with neither mental disorder nor substance abuse

ECA STUDY

- Lifetime rates of violence estimated as:
 - 15% for populations with no mental disorder
 - 33% for those with only mental disorder
 - 55% for those with mental disorder plus substance abuse issues
- Increased risk in certain subgroups studied:
 - young males
 - lower SE status
 - problems with alcohol or illicit drug use (with or without mental illness)

STUDIES: MACARTHUR VIOLENCE RISK ASSESSMENT STUDY



- MacArthur Violence Risk Assessment Study
 - Followed over 1000 psychiatric patients for 1 year following discharge
 - Compared patient violence to that of neighbors
 - Found substance abuse as comorbidity that was responsible for much of the violence in discharged patients
- Ongoing delusions were not associated with a higher risk of violent behavior

STUDIES: NATIONAL EPIDEMIOLOGICAL SURVEY ON ALCOHOL AND RELATED CONDITIONS

- National Epidemiological Survey on Alcohol and Related Conditions
 - Survey of 32,653 persons from representative US households
 - Lower rates of violence than in ECA, but overall: 2.9% of persons with serious mental illness alone committed violent acts in a year (compared with 0.8% of non-mentally ill population)
 - Co-occurring substance use and mental illness had rate of 10%

STUDIES: COMPARISON OF RISK ASSOCIATED WITH DIFFERENT SETTINGS

- Studies that have examined prevalence of violence in psychiatric patients have varied in results based on clinical setting; meta-analytic studies have found rates of violence as below:
 - Outpatient settings--8%
 - Discharged hospital settings—13%
 - Psychiatric emergency settings—23%
- Retrospective studies of involuntarily committed patients—36%
- Studies of first episode psychosis patients in period preceding treatment—37%



STUDIES: FIVE-STATE STUDY

- Five-state study
 - Analyzed 802 patients with severe mental illness receiving services in public behavioral health care systems
 - Circumstances such as poverty, history of trauma, abusing drugs were found to correlate with violence
 - Those who only had serious mental illness without these factors were found to have annual rates of violence no different from population without mental illness → 2%

STUDIES: CATIE TRIAL

- CATIE trial
 - 1445 participants, large multisite randomized trial
 - Identified subgroups of patients with different levels of violence, all with “same” mental illness of schizophrenia
 - 1/3 of sample had antisocial behavior the preceded onset of mental illness and were twice as likely to have engaged in recent violent behavior (28% vs 14%) than counterparts who had no history of antisocial behavior
 - Risk of violence did not decline when adherent to medications
 - Overall, study found that in patients with untreated symptoms of delusional thinking, suspiciousness, or perceived persecution, risk for violence was three times higher than in those without symptoms



A MORE DEFINITIVE LINK: MENTAL ILLNESS AND SUICIDE (VIOLENCE TOWARDS SELF)

- 61% of all firearm fatalities are suicides
- 19,393 of 31,672 firearm fatalities in US in 2010
- 21-44% of victims had identified mental health problems, 16-33% had a documented history of treatment
- Study shows standardized mortality ratio of 10-20 for patients with bipolar disorder or depression, and mortality rate of 13 for patients with schizophrenia
- Risk factors: self-harm behaviors, substance abuse, psychological factors such as hopelessness, depressive symptoms, **availability of firearms** and exposure to media reporting of suicide



STUDIES REGARDING: GUN ACCESS AND SUICIDES

- Studies show declines in suicide in males when laws enforce background checks or otherwise regulate access to firearms
- Study examined effects of Brady Law across all states (i.e. gun background checks and waiting periods)
- Study found that handgun ban decreased suicide rates by 23% (or 6 suicides by firearms per month, with no rise in suicides by other means per month)
- No difference in gun access between populations with mental illness as opposed to without mental illness
 - National Comorbidity Study Replication-Study--nationally representative sample of adults residing in community (5,692)
 - 34.1% of persons with lifetime mental disorders had access, 4.8% carried a gun, and 6.2% stored gun in an unsafe manner compared with 36.3% without lifetime mental disorder having access, 5.0% carrying gun, and 7.3% storing gun unsafely

LITERATURE SUMMARY

- Some studies show increased rates of violence by people with mental illness compared to people without mental illness, some show no difference
- There are other factors that might be impacting violent behavior more than mental illness alone:
 - comorbid substance use disorders
 - antisocial personality disorder
 - history of violent behavior
 - history of being traumatized or victimized
 - first episodes of untreated psychosis
- Suicide (violence towards self) has stronger correlation with mental illness but may also be influenced by factors such as substance use; access to guns

PART III – CLINICAL VIGNETTES:
LIMITATIONS FACED BY PSYCHIATRISTS IN ATTEMPTING TO
MINIMIZE RISK FOR VIOLENCE BY PATIENTS TO SELF AND
OTHERS

CASE 1

- Veteran R: 58 yo man, still active in reserves, brought in to ED by police after he surrendered following barricading himself in his home with guns, threatening to shoot police then himself, intoxicated on alcohol.
 - Admitted involuntarily
 - Patient declined need for treatment, either for depression or his alcohol use disorder (“I just drank too much”)
 - Indicated feeling that his financial situation was hopeless, nothing left for him
 - Refused to discuss removing guns from his home

CASE 1: CONTINUED

- Clinical assessment: depression, alcohol use disorder AND appeared to be at imminent risk to self and others
- Patient continued to decline need for treatment, did not defer to treatment during his deferral conference and opted to proceed with commitment hearing
- Judge granted petition for hospitalization and mandated outpatient treatment, included specific clause that patient is not to have access to firearms
- Discussed with him that, under federal law, he will never be allowed to possess or handle firearms again—very angry

CASE 1: CONTINUED

- Limitations we faced as psychiatrists:
 - Contacted sheriff's office re: court order and asked if they would be able to remove guns from patient's home
 - Faxed court order to the sheriff, prosecutor reviewed, determined that the sheriff did not have authority to remove guns
 - "Order is directed at the patient, not at law enforcement"

CASE 2

- Veteran O: 68 yo man, multiple medical problems, severe alcohol use disorder and depression, brought to ED after standoff with police lasting 6 hours, threatened to shoot police if they entered his home, ***guns confiscated***
 - Had called national crisis line in the midst of a severe headache and had threatened to shoot himself, wellness check was called to his home
 - Patient was admitted involuntarily after he was brought in by police
 - 4th psychiatric admission in 4 months for suicidal ideation and threats in the context of intoxication

CASE 2 (CONT.)

- Patient asked repeatedly to sign himself into the hospital as a voluntary patient
- He said that this is the worst that he had felt, was tearful, seemed genuine in wanting help for his depression and for alcohol cessation
- Given recurrent hospitalizations and lack of follow through with outpatient treatment, inpatient team felt need to continue with involuntary hospitalization
- Attorney who was assigned to him was overtly pro-gun rights and encouraged patient to defer to treatment

CASE 2 (CONT.)

- Deferral in place
 - Patient subsequently started making comments that he did not feel the need for any treatment as an outpatient and that he planned to get access to guns as soon as ATO expired (i.e. 90 days)
 - On day prior to hearing, he told me that he did not need treatment, so I demanded commitment hearing
 - Attorney tried to convince me to not do this because a commitment order would result in patient's gun ownership being illegal
-

CASE 2 (CONT.)

- Michigan has new substance abuse law that allows for commitment for substance abuse disorders
 - I made it clear that patient has depressive symptoms that seem exacerbated by his drinking and that the recommended treatment would be for both depression and substance abuse treatment
 - Judge granted petition for hospitalization and mandated outpatient treatment
-

CASE 2 (CONT.)

- Patient was unhappy with result, said he would appeal
 - Continued to deny need for treatment
 - Told treatment team that he would continue to drink, did not care if this resulted in jail time
-

SUMMARY

- Comorbid substance abuse disorders seemed to be disinhibiting these individuals with depression to the point of suicidal thinking and gestures with firearms (consistent with data in literature about substance abuse problems being a risk factor for violence)
- Civil commitment does not guarantee that a patient will not have access to guns—there is no guarantee that law enforcement will remove guns that the patient already possessed

SUMMARY

- There is no mechanisms to guarantee that patients who have histories of threatened violence to self or others will not end up in NICS registry
 - Michigan has not passed laws mandating reporting of these individuals
 - Those who are *voluntary* patients will not be reported

PART IV -- BRIEF OVERVIEW ON
CHILDREN/ADOLESCENTS AND GUN VIOLENCE

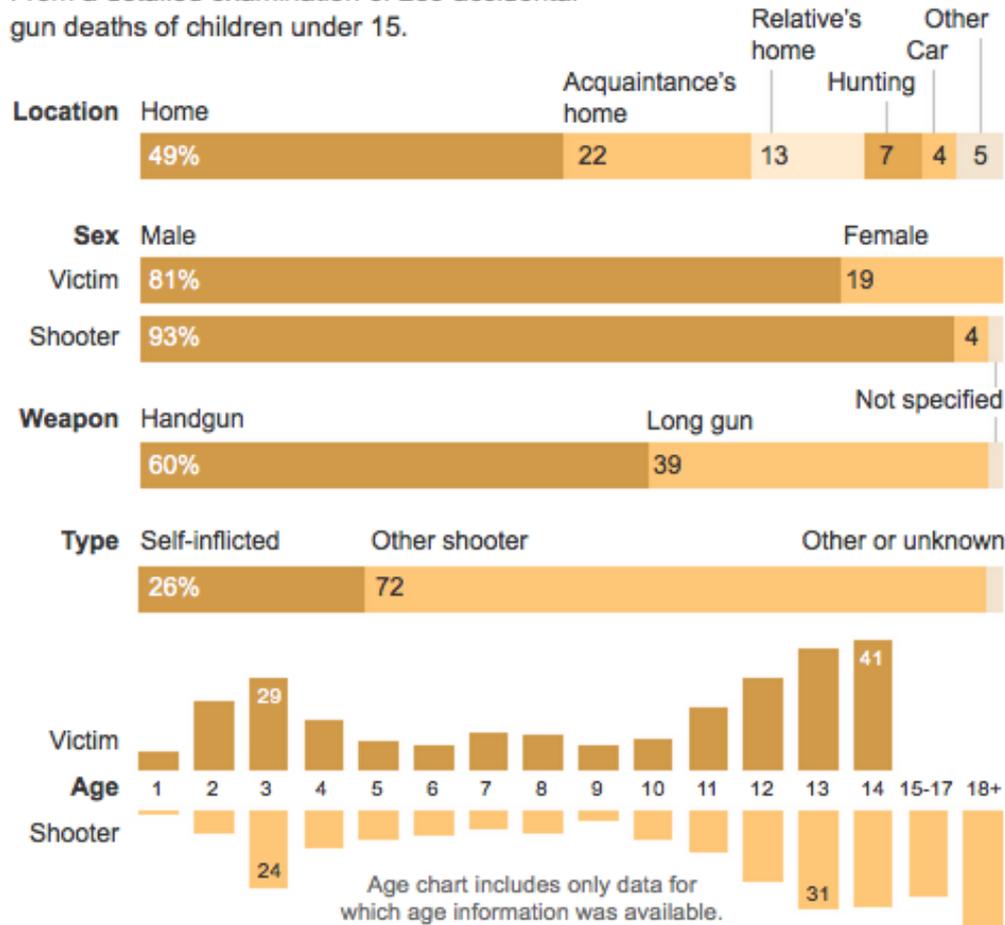
CHILDREN AND GUNS

- 60% of accidental firearm deaths of children involve handguns
- Average handgun victim is younger
 - Younger children more likely to shoot themselves
 - 50% of accidents occur in children's homes
 - 33% occur at home of friend or relative
- Children most often shoot other children
 - Children affected come from all walks of life
- N.R.A. opposes safe storage laws, says children more likely to be by falls poisoning or environmental factors
- N.R.A. claims adult criminals who mishandle firearms more responsible



A Census of Tragedy

From a detailed examination of 259 accidental gun deaths of children under 15.



Based on a detailed examination of 259 gun deaths of children under 15 from jurisdictions that make death records public, including California, Georgia, Minnesota, North Carolina and Ohio, as well as Bexar, Tarrant and Harris Counties in Texas; Broward and Orange Counties in Florida; and Cook County, Ill.

SCHOOL SHOOTINGS AND MENTAL ILLNESS

- **Common Misperceptions:**
 - “Lone Commando“ gunman responsible for mass shootings at schools
 - Perception that gun violence is caused by people with severe mental illness “snapping”
- **Reality:**
 - No known profile that aids the early identification of a mass killer
 - Only a small proportion of school shooters have a psychotic illness
 - Mass shootings usually not impulsive acts, but rather product of careful planning
 - Only a small % of gun-related homicides take place in schools, colleges, universities

SUGGESTED INTERVENTIONS FOR GUN VIOLENCE RELATED TO CHILDREN/SCHOOLS

- Screening/ mental health resources for troubled youth in K-12 should be increased.
 - Not likely to have a direct effect on mass shootings; but indirect evidence suggests that improving access to mental health resources will have significant effect on other public health issues (drugs, alcohol, learning disabilities, youth suicide, and school violence.)
- Anti-bullying programs should be taught and supported.
- Funding for threat assessment teams in K-12 schools and IHES
- Improved communication between school administration, security, threat assessment teams, law enforcement, mental health services
- Students at all levels should be educated to take all threats seriously and report to appropriate personnel
 - “If you hear something, say something.”

- PART V– APA POSITION ON FIREARMS AND MENTAL ILLNESS

2014 APA POSITION STATEMENT

The vast majority of persons with mental illness do not commit violent crimes

Require background checks and waiting periods on all gun sales

Require safe storage of all firearms

Regulate so only can be fired by owner or with owners permission

Ban possession grounds of colleges hospitals except law enforcement



APA POSITION

- Assure physicians and health care professionals are free to make appropriate inquiries of patients
- Research and training regarding causes of firearm violence should be national priority
- Ban access to those whose conduct indicates risk to others whether or not they have been diagnosed with a mental disorder
- Risk Based Criteria
- Fair Restoration Process
- Encouragement of Voluntary Treatment and removal of Barriers to Care
- Flexibility for Clinical Judgement

GOALS TO CONSIDER

- Fair and reasonable process for Restoration
 - Early identification of mental disorders
 - Improve access to care
 - Appoint a presidential commission
-

- PART VI– CLINICAL GUIDELINES AND DISCUSSION

ASSESSING SAFETY

- Inquire about mood, suicidal thinking
- Observe the patient for changes in their affect (i.e. do they appear more depressed, more anxious than their baseline?)
- ***Obtain collateral information from family or friends***
- ***Does the patient appear to warrant evaluation in the ED?***
If any doubts whatsoever, the answer is yes.

NOT ACUTELY SUICIDAL, BUT...

- Inquire about firearm ownership (access, storage, etc.) and willingness to not have access to firearms
 - Attempt to work with patient's family to have firearms removed
 - Discuss the need to avoid alcohol and other substances that might alter mental status
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THE REALITY...

- If a patient refuses to engage in such a discussion, and there is no family support...
 - All we can do is document our thorough assessment, recommendations, and risk reduction efforts.
 - As patients will tell us: “It is my Constitutional right to own guns.”
-

FINAL QUESTIONS TO CONSIDER

- How many of you feel qualified to discuss firearm safety with a patient?
- How many of you DO discuss firearm safety? Do any of you live in a state with “gag laws”?
- How do you feel about the idea of reporting patients to a registry (i.e. outpatient psychiatrists vs. inpatient psychiatrists)?



The image is a screenshot of a Fox News website page. At the top left is the Fox News logo with the tagline 'Fair & Balanced'. To the right is a search bar and a 'ON AIR NOW' section featuring a small portrait of a man and the text '3a^{ET} Huckabee hosted by Mike Huckabee'. Below this is a navigation menu with tabs for Home, Video, Politics, U.S., Opinion, Entertainment, SciTech, Health, and Travel. Under the Opinion tab, several names are listed: Michael Goodwin, Karl Rove, Judith Miller, Juan Williams, Dana Perino, and Amb. John Bolton. The main headline of the article is 'Colorado shooting a reminder that psychiatry, not gun laws, needs fixing'. Below the headline is the byline 'By Dr. Keith Ablow / Published July 25, 2012 / FoxNews.com'. The article features a large portrait of a man, identified as James Holmes. Below the portrait is a caption: 'This photo provided by the University of Colorado shows James Holmes. University spokeswoman Jacque Montgomery says 24-year-old Holmes, who police say is the suspect in a mass shooting at a Colorado movie theater, was studying neuroscience in a Ph.D. program at the University of Colorado-Denver graduate school. Holmes is suspected of shooting into a crowd at a movie theater killing at least 12 people and injuring dozens more, authorities said. (AP Photo/University of Colorado) (2012 AP)'. At the bottom left of the article is a small portrait of Dr. Keith Ablow. To the right of this portrait is a short paragraph: 'The case of James Holmes, the man who killed 12 people in Aurora, Colo., and injured dozens more, has absolutely nothing to do with the availability of guns. Such individuals — twisted or hobbled by disorders of the mind — can always find ways to turn the demons that haunt them'.

FINAL QUESTIONS

- If you have a patient who has access to a gun and a history of violent behavior in the past but with no current identified victim, how do you handle this?
 - Or the patient has a history of suicidal thoughts and current access to a gun, how do you handle this?
- In your experiences, do patients who have had violent behaviors exhibit comorbidities discussed in literature review?
- Before this talk, how familiar were you with APA's position statement and resource document, and do you find it helpful?

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