Resource Document

Access to Firearms by People with Mental Illness

Approved by the Joint Reference Committee, June 2009

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This document was prepared by the Council on Psychiatry and Law. Special recognition to Debra A. Pinals, M.D., Richard J. Bonnie, L.L.B. and Paul S. Appelbaum, M.D. for their work on this document.

Reports of mass shootings and other serious firearm-related violence, such as the Columbine shootings of 1999 and the Virginia Tech shootings in 2007, are often accompanied by indications that the perpetrator had some emotional disturbance or mental illness. These incidents have raised growing concern about access to firearms[1] by people with mental disorders. Current federal law[2] and the laws of several states[3] bar purchase of firearms by specified categories of people, including persons with certain mental health histories, particularly involuntary hospitalization. These statutes aim to prevent sale of firearms to ineligible persons by requiring dealers to confirm the person's eligibility by running a "check" through the National Instant Criminal Background Check System (NICS). However, as became evident in the wake of the Virginia Tech shootings, most states do not now report information on mental health histories to the NICS. By enacting the NICS Improvement Act of 2007,[4] Congress sought to encourage the states to establish registries of persons who have had the mental health histories that make them ineligible to purchase firearms under federal law.

The American Psychiatric Association (APA) has previously emphasized the need to decrease access to firearms as one means of reducing violence.[5] This Resource Document summarizes the issues raised by use of mental health registries as a tool for curtailing firearm-related violence and suicide and offers suggestions about policies and practices that could reduce firearm-related violence and suicides by people with mental illness.

The Relationship Between Mental Illness, Firearms, Suicide and Violence

The vast majority of violence in our society is not perpetrated by persons with serious mental disorders. The best available estimates indicate that violent behavior attributable to mental disorder accounts for only 4 to 5% of the violence in the United States, [6] and that the rate of violence among people with mental disorders (without co-morbid substance abuse disorders) who have recently been discharged from psychiatric hospitals is about the same as the rate among people who live in the same neighborhoods.[7] Active substance abuse substantially increases the risk of violence by anyone, and particularly by persons with mental illness. The evidence also shows that the risk of violence among people with major mental disorders is elevated when they have histories of violence and are experiencing violent ideation. Research suggests that individuals with mental illnesses engaged in regular treatment are considerably less likely to commit violent acts than those who could benefit from, but are not engaged in, appropriate mental health treatment. [8-13] Though substance use and impulse control disorders may place people at greater risk of threatening violence using firearms, [14] violence perpetrated by persons with serious mental illness without substance use involvement does not characteristically involve firearms.

Suicide is a major public health concern, and mental illness is a major risk factor for suicide. According to the Center for Disease Control data, just over 52% of completed suicides were by firearm in 2005. Suicide was the 11th leading cause of all deaths that year. [15] Although data regarding suicide attempts are sketchy, suicide attempts outnumber completed suicides and many suicide attempts are related to firearms, though the use of firearms is more likely to lead to a completed suicide than are suicide attempts by other means. This raises genuine concerns about firearm access to persons with mental illness who may be at risk of suicide.

Mental Health Registries as a Strategy for Preventing Suicide and Violence: The Issues

The federal *NICS Improvement Act* establishes procedures for states to report to the NICS database the names of individuals previously subject to "commitment to a mental institution" and those "adjudicated as mental defective"; the latter category is defined by federal regulation to include persons adjudicated incompetent to manage their affairs in guardianship proceedings, incompetent to stand trial, or not guilty by reason of insanity.[16] State laws may also require reporting of other persons with mental health histories who are banned from purchasing firearms under state law (but not under federal law).

Striking the proper balance between the public interest in protecting public health and safety and the individual's interest in owning and carrying a firearm is complex. No one doubts the importance of preventing violence and suicide. Yet, there is no clear evidence as to whether, and how much, maintaining registries of people with certain mental health histories contributes to that goal. On the one hand, widespread availability of firearms in the United States, and the existence of a large secondary market outside regulatory control, inevitably limit the effectiveness of a strategy of curtailing firearms purchases by any particular group of people. One might also question whether the existence of such a registry would have prevented any of the mass killings that have evoked such support for them, and whether the expenditure of the hundreds of millions of dollars needed to create and maintain registries for persons with mental health histories could be better spent on interventions that might yield greater overall benefits to society, including broader public-safety targeted interventions. On the other hand, it is also possible to argue that restrictions on firearms purchase by anyone at elevated risk for violence, including people with particular mental health histories – and the registries maintained to enforce these laws – are warranted if they eliminate even one major incident of mass violence, not to mention the everyday firearm suicides and impulsive family killings that often go unnoticed by the media.

Aside from debates about the cost-effectiveness of mental health registries as a strategy for reducing firearm violence and suicide, major questions can also be raised about the fairness of singling out people with mental health histories, such as a single episode of involuntary hospitalization, as a ground for denying them a right to purchase and carry a firearm, especially in a society in which ownership of firearms is a constitutionally protected individual right.[17] Concerns about discrimination are heightened when the statutory exclusion is categorical rather than being based on an individualized risk determination. On the other side, some argue that categorical exclusions based on previous incidents of violence or self-harm by people with mental illness are justified even without individualized risk determinations.

Questions have also been raised about the possibly counterproductive effects of mental health registries. Persons with treatable mental disorders may delay or avoid obtaining treatment because of concern about adverse consequences should their conditions become known to others or because they are unwilling to forfeit their right to use firearms for legitimate purposes (e.g., hunting), especially in regions of the country where recreational firearm use is deeply embedded in the culture. Although the statutes typically prohibit disclosures of registry information for purposes other than determining eligibility for firearms purchases, the security of any registry can be compromised.

Whatever one's views about the justifiability of using mental health registries as a strategy for preventing firearms violence, it appears that such an approach

is likely to be implemented or expanded in many states. In the wake of the federal NICS Improvement Act, which makes federal grant funds available, states now have an incentive to create registries in accord with the requirements of that Act. If the state decides to establish a registry, the reporting procedures should be fairly designed and applied in a properly tailored fashion. This Resource Document provides guidance to policymakers in the design and implementation of such registries and accompanying statutes in order to minimize unwarranted discrimination against people with mental illness.

Making Firearms Mental Health Registries More Fair

In principle, properly tailored mechanisms for restricting firearm purchase by specific persons or groups at significantly elevated risk of violence or suicide are justified from a public safety perspective. The challenge, however, is to define the class of individuals at elevated risk with sufficient specificity and accuracy to enhance safety without creating an unacceptable imbalance between benefits and drawbacks. Factors that could make registries more useful, and prevent unfair discrimination, include straightforward and well-founded parameters for inclusion, exclusion, removal, and appeal. The two major deficits of the existing generation of state statutes are that they rely on broad categorical criteria for disqualification and that they typically include no procedures for removing oneself from the registry.

In principle, it would be best if the criteria aiming to identify people at heightened risk of violence were not limited to people with mental disorders or histories of commitment, and focused more broadly on actuarial risk factors proven to be significant predictors of violence, such as prior episodes of violence, documented incidents of loss of control while intoxicated, and so on. Involuntary civil commitment per se is too broad because many persons are committed not because of perceived risk of violence but because of incapacity or decline in functioning unrelated to dangerousness. Moreover, a single incident of involuntary commitment many years earlier may no longer have any behavioral relevance. The problem of over-inclusiveness is compounded if states also require reporting of persons who have been hospitalized voluntarily (which federal law does not require). [18]

Federal law makes people who have been "committed to a mental institution" ineligible to purchase a firearm[19] and the NICS Improvement Act gives states a financial incentive to include such people in the registry, even if state law does not forbid them to purchase firearms. It is therefore likely that an incident of involuntary commitment *to a hospital* will continue to be used as one of the predicate reporting criteria for the foreseeable future. Nonetheless, it is possible that states may have some flexibility in deciding what categories of proceedings and orders constitute "commitments to a mental institution." For example, the federal regulations state that the disqualification does not apply to mandatory "observations" or voluntary admissions, [20] suggesting that judicial orders for involuntary examination or precautionary hospitalization do not constitute "commitments."

Another section of the federal law bans firearm purchases by a person who has been adjudicated to be "danger to himself or others" in any legal context, including outpatient commitments, but it does not apply to outpatient commitments based on non-dangerousness criteria. [21] Thus, not everyone committed to outpatient treatment needs to be included in the database in order to preserve the state's eligibility for federal funds. Moreover, regardless of the initial criteria for inclusion in the database, the NICS Improvement Act leaves the states some leeway in deciding when to remove someone from the database, and more individualized assessments would clearly be permitted in that context.

In sum, to the extent allowed by federal law, state statutes requiring reporting of people who have been "committed to a mental institution" should be narrowly tailored so that they focus on factors that specifically relate to risk of violence, such as a recent documented history of violence, a recent documented history of substance abuse, a recent involuntary civil commitment based on dangerousness to self by virtue of suicidal ideation or attempts, or dangerousness to others, or a period of incarceration within a prescribed period after an episode of serious violence. Any state statutes restricting firearm purchases based on mental health histories should also include a meaningful and realistic appeals process allowing restoration of equal rights after a reasonable period of time during which there has been no demonstrable evidence of risk of violence to self or others.

The design and implementation of procedures for enforcing dangerousness-based disqualifications from firearms purchase or possession should be evidence-based. If the statutory criteria require individualized assessment, they should include meaningful participation from qualified clinical professionals, whose experience with social, safety, law enforcement and clinical contexts can provide important perspectives as well as the necessary scientific and clinical expertise.

Restricting Access to Firearms During a Crisis

The debate regarding creation and maintenance of a national registry as a primary legal tool for keeping firearms out of the hands of people with mental illness has obscured a potentially useful strategy for reducing firearm violence or suicide -- temporary removal of a firearm from a person's custody during periods of acutely elevated risk.[22] Some states (e.g., California[23]) permit removal of firearms from people during mental health emergencies and restrict access during the period of commitment. Specified clinicians in these states can work with appropriate personnel to facilitate removal of firearms from persons they believe are at significant risk of harm to themselves or others. Indiana and Connecticut[24] allow firearms to be removed from imminently dangerous individuals, whether or not they have mental illnesses. Under the Connecticut statute, the state's attorney or two police officers can file a complaint in court whereby temporary seizure of firearms of persons posing risk of imminent personal injury to self or others may be authorized for up to 14 days. After the initial firearm removal period, a court might extend the order for up to a year if it finds, after a hearing, that the danger persists. Under this statute, a history of confinement in a psychiatric hospital is only one factor that the judge may consider, in addition to several non-clinical factors, in evaluating the danger the person presents.

These firearm removal provisions have some attractive features. First, by focusing on immediate risk, rather than on a person's mental health history, they are more carefully tailored than history-based reporting statutes to prevent firearm violence and suicide. The approach taken in Indiana and Connecticut is particularly commendable because it addresses dangerousness per se, and discards the mistaken premise that acute violence risk is associated exclusively with mental illness and thereby avoids the issue of discrimination raised by statutes that target people with mental illness. Second, they provide clear legal authority for police to remove firearms from possibly dangerous individuals even if no crime has been committed. Third, they clearly establish the legal framework for psychiatrists and other clinicians to inform police of an apparent danger and the accompanying need to remove firearms. Moreover, the authority to initiate such a removal procedure provides a potentially useful source of leverage for psychiatrists and other clinicians trying to convince the patient to yield the firearm voluntarily to a family member or other temporary custodian.

The APA believes that laws permitting the temporary removal of firearms from individuals believed to be imminently dangerous are sensible from a public policy perspective, and would help psychiatrists respond prudently to genuine threats posed by their patients. As already indicated, the authority to remove firearms in a crisis should not be limited to situations involving people with mental illness. However, many other important and difficult issues must be addressed in drafting statutes related to firearm access, and the California, Connecticut and Indiana approaches differ from one another in relation to the criteria that trigger removal, whether the police may effectuate a removal in the absence of a warrant, and whether the procedure is independent of the commitment process and necessarily triggers the reporting requirements of federal law. [25] All these issues merit further study.

Conclusion

Experience suggests that maintaining a comprehensive and accurate database of persons barred from firearms purchases is a difficult and expensive endeavor that probably has only a slight impact on access to firearms by individuals who are strongly motivated to obtain them, especially given the likelihood that such persons could acquire firearms through alternative means. Also, large databases require clear reporting guidelines and can engender tracking systems that may not be followed. Further research on these initiatives will be needed as they evolve. Nevertheless, this Resource Document has attempted to provide additional information to guide state efforts as they may seek to reduce access to firearms by people with mental illness. As state statutes evolve along these lines in response to the NICS Improvement Act, it remains important to bear in mind that the risk of violence and suicide by individuals with mental illness could be reduced more cost-effectively by investing in proven methods of prevention as well as treatment for people with mental illness who do not otherwise have access to care. As indicated above, improving treatment adherence and alleviating the symptoms of severe mental illness can be key factors for decreasing the small portion of community violence that is associated with serious psychiatric disorders. The most effective interventions for reducing risk of injuries that may occur when people experience crises are to provide them with services needed to prevent such crises in the first place and to defuse the crisis when one occurs. In those situations, a procedure enabling the police to remove firearms would be useful.

The APA strongly believes that measures that increase recognition, diagnosis, access to care, quality treatment, appropriate follow up, and community understanding of mental illness -- and those that decrease underfunded and inadequate care, treatment dropout, premature discharge, and social stigma -- will ultimately have the greatest yield in terms of reducing violence and suicide and other social costs associated with mental disorders.

Notes and References

1 The definition of firearms is sometimes unclear, and may or may not be limited to handguns or other firearm categories.

2 *NICS Improvement Act of 2007*

3 Bureau of Justice Statistics, *Survey of State Procedures Related to Firearms Sales, 2005*, NCJ 214645, November 2006

4 By way of background, the *Brady Handgun Violence Prevention Act of 1993* was enacted to provide a five day waiting period in order to complete a background check of handgun purchasers. In 1998, the National Instant Criminal Background Check System (NICS) provisions replaced the waiting period of the *Brady Act*, and provided a mechanism for the Federal Bureau of Investigation (FBI) to maintain a database of individuals who could be prohibited from purchasing certain firearms. The *NICS Improvement Act of 2007* (H.R. 2640), which was signed into law in January 2008, amends the *Brady Handgun Violence Prevention Act* in several ways, including a requirement for states to develop and improve automation and transmittal of record information to federal and state record repositories regarding background information of potential firearm purchasers, such as information related to mental health adjudications and commitment records. The law also directs the Attorney General to issue funding grants to assist states in the development of these record repositories and information sharing mechanisms.

5 American Psychiatric Association, *Position Statement on Homicide Prevention and Gun Control* (1993) and *Position Statement on Doctors Against Handgun Injury* (revised; 2001)

6 Swanson JW (1994). Mental disorder, substance abuse, and community violence: An epidemiological approach. In Monahan J and Steadman H (Eds.), *Violence and Mental Disorder.* Chicago: University of Chicago Press, 101-136.

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8 Elbogen MS, Van Dorn RA, Swanson JW, Swartz MS, Monahan J (2006). Treatment engagement and violence risk in mental disorders. *British Journal of Psychiatry* 189: 354-360.

9 Monahan J, Steadman HJ, Silver E, Appelbaum PS, Robbins PC, Mulvey EP, Roth LH, Grisso T, Banks S (2001). *Rethinking Risk Assessment.* New York, Oxford University Press.

10 Skeem J, Monahan J, Mulvey E: Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. *Law and Human Behavior* 26:577–603, 2002

11 Swanson JW, Swartz MS, Van Dorn RA, Volavka J, Monahan J, Stroup TS, McEvoy JP, Wagner HR, Elbogen EB, Lieberman JA. (2008). Comparison of antipsychotic medication effects on reducing violence in people with schizophrenia. *British Journal of Psychiatry* 193:37-43.

12 Swanson JW, Swartz MS, Elbogen E (2004). Effectiveness of atypical antipsychotic medications in reducing violent behavior among persons with schizophrenia in community-based treatment. *Schizophrenia Bulletin*, 30 (1), 3-20.

13 Swanson JW, Swartz MS, Borum RB, Hiday VA, Wagner HR, Burns BJ (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176, 324-331.

14 Casiano H, Belik SL, Cox BJ, Waldman JC, Sareen J (2008). Mental disorder and threats made by noninstitutionalized people with weapons in the national comorbidity survey replication. *J Nerv Ment Dis.* 2008 Jun;196(6):437-45.

15 Kung H-S, Hoyert JX, Murphy SL (2008). Deaths: Final Data for 2005. *National Vital Statistics Reports*, 56(10). Available at http://www.cdc.gov/nchs/deaths.htm, accessed 8/10/08.

16 The *Brady Act*, as well as many state registry statutes, use highly anachronistic and stigmatizing terminology to refer to persons with mental disorders. Even if these laws are retained, they should be amended to use more descriptive and less stigmatizing language.

17 *District of Columbia v. Heller*, 554 U.S. ___ (2008)

18 See, e.g, *Virginia Code Ann.* Section 37.2-819 (requires reporting of persons who agreed to voluntary admission after being detained under an involuntary examination order -- called a "temporary detention order" in Virginia)

19 18 *U.S.C*. § 922(d)

20 27 *C.F.R*. Section 478.11.

21 The statute disqualifies a person who has been "adjudicated as a mental defective." 18 *U.S.C.* § 922(d). Under the regulations, however, this awkward and archaic term is defined to include a person who has been determined by a court or other body to be "a danger to himself or to others," (which would cover outpatient commitment orders predicated on dangerousness), as well as a person who "lacks the mental capacity to contract or manage his own affairs (as in a guardianship order). Thus, it does not include the kind of findings that typically are required for mandatory outpatient treatment. See 27 *C.F.R.* Section 478.11.

22 States might consider statutes that authorize a permanent removal of firearms in cases when, based on an individualized determination, there is a significant probability that the person's violence-related symptoms will recur based on a prior history of relapse and deterioration. If a state statute authorized permanent removal based on such a finding, firearm purchase presumably would be forbidden as well.

23 *California Welfare and Institutions Code* 8100-8108

24 *Indiana Code* 35-47-14-1; *Connecticut General Statutes* 29-38C

25 If properly crafted, a temporary seizure would not trigger the federal registry provision; reporting would be required only when the removal order is based on a formal finding, after adjudication, that the patient presents a danger to himself or others as a result of mental illness.