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Mass Shootings and Mental Health Policy

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Research suggests that mass shootings can increase mental health stigma, reinforce stereotypes that people with mental illness are violent, and influence public policy. This article examines mental health policy initiatives resulting from the mass shootings in Sandy Hook, Connecticut and Aurora, Colorado within the context of existing research about mental illness, suicide, substance abuse and gun violence. Previous legislation that restricts access to firearms among persons with mental illness is reviewed. The article suggests that gun control legislation that focuses on persons with mental illness is not supported by research, may create barriers to treatment, and may have limited efficacy in promoting public safety.

Key words: mass shootings, mental illness, stigma, violence, mental health policy

Research suggests that mass shootings can increase mental health stigma, reinforce negative stereotypes that people with mental illness are dangerous and violent, and influence public policy, all of which can undermine treatment and recovery (Corrigan, 2004; McGinty, Webster, & Barry, 2013; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). The school shooting in Sandy Hook, Connecticut, of December 14, 2012, was the largest mass killing in the United States since the 2007 Virginia Tech shooting. The Sandy Hook shooting followed on the heels of the July 20, 2012 movie theater shooting in Aurora, Colorado.

These events engendered widespread public anger, renewed the debate on gun control, and led to several mental health policies at the state and federal level. These policies

have serious implications for mental health care, yet they were proposed and passed in the highly politically and emotionally charged aftermath of the shootings, a truncated process that left little opportunity for research-informed deliberation. This article examines current mental health policy initiatives resulting from the mass shootings in Sandy Hook and Aurora within the context of existing research about mental illness and gun violence. Previous legislative attempts to restrict access to firearms among persons with mental illness are reviewed. Implications for mental health services are raised.

The Sandy Hook and Aurora Shootings

On December 14, 2012, Adam Lanza shot and killed his mother while she slept in her bed. Armed with several semi-automatic weapons, he then forced his way into an elementary school, shot and killed 20 children and 6 adult staff members, and then killed himself. Public outrage over the shooting was immediate. The majority of the victims were young children, the attack was savage, without provocation, and seemingly random, factors which fueled anger, fear, and confusion among the American public. The Sandy Hook shooting happened six months after another horrific, similarly arbitrary, mass shooting in a movie theater in Aurora, Colorado.

That attack, in which 82 people were killed or wounded, also involved a shooter, James Holmes, who employed semi-automatic weapons. James Holmes was immediately arrested; during his trial, it was revealed that prior to the shooting, he sought mental health treatment at the University of Colorado, Denver, where he had been enrolled as a student. James Holmes was seen several times by Dr. Lynne Fenton, a psychiatrist who was employed as the director of student mental health services, and to whom Holmes later sent threatening letters. Dr. Fenton reported James Holmes to campus security, citing him at risk for homicidal behavior, although her report did not lead to protective custody. Both Dr. Fenton and the University of Colorado are the subject of numerous lawsuits alleging negligence for not having James Holmes involuntarily committed (McGhee, 2013). Days after the Sandy Hook shooting, Colorado Governor John Hickenlooper proposed increased funding for mental health services in his state because

the "common element of so many of these mass homicides seems to be a level of mental illness" (Moreno, 2013). Governor Hickenlooper's commentary notwithstanding, in Lanza's case, treatment records have not been publically released, and no prior assessment of risk for violence has been reported.

Mental Illness and Violence

The relationship between serious mental illness and violence is complex. Research suggests that demographic and economic factors, such as being young, male, and of lower socioeconomic status, are the major determinants of violence (Stuart, 2003). Although teasing out a causal connection between mental illness and violence is difficult, a large body of research shows that violence by people with serious mental illness, such as schizophrenia or bipolar disorder, is rare and accounts for approximately only 4 - 5% of violent acts (American Psychiatric Association, 1994; Appelbaum & Swanson, 2010; Fazel & Grann, 2006; Monahan et al., 2001). Moreover, when people with mental illness are violent, it is almost always interpersonal (87%), typically occurs in the home, and the targets are usually family and/or friends. In contrast, the vast majority of violent acts are associated with crime, not mental illness (Stuart, 2003). Persons with mental illness are far more likely to be victims, rather than perpetrators, of violence (Hiday, 1995; U.S. Department of Health & Human Services [HHS], 1999).

Suicide

Suicide was the 10th leading cause of death in 2010, resulting in more than twice as many deaths as homicides. Slightly more than half of all suicides (9,392) were committed with a firearm (Centers for Disease Control [CDC], 2010). Guns are highly lethal; persons who attempt suicide using a firearm are far more likely to die than those who employ other means. Research identifies both mental illness and access to a gun as among the leading risk factors for suicide (National Institute of Mental Health, 2010).

Although the strong association between suicide and guns suggests that strengthening prohibitions on gun ownership might be an appropriate strategy to deter suicide, suicide

prevention groups largely avoid being drawn into political battles over gun laws, reflecting an awareness of the power of pro-gun organizations. Cathy Barber, co-founder of the National Center for Suicide Prevention Training, cautions that raising suicide as part of gun control is a risky strategy.

When it comes up in the context of the gun legislation debate, it immediately turns off gun owners. Gun owners are the group that needs this information and they need it presented in a neutral way that isn't, 'Oh, here's another horrible thing about guns.' (Bendery, 2013)

Likewise, the U.S. Surgeon General stops short of calling for restrictions on gun ownership; instead, the surgeon general favors forming an alliance with gun owners as a suicide prevention strategy and focuses on the safe storage of firearms, rather than gun reduction. "Partnering with gun-owner groups to craft and deliver this message will help ensure that it is culturally relevant, technically accurate, comes from a trusted source, and does not have an anti-gun bias" (U.S. Department of Health & Human Services, 2012).

The Harvard School of Public Health examined gun ownership and suicide and found that states with high gun ownership have correspondingly higher rates of suicide than states with lower gun ownership (Miller & Hemenway, 2008). Mental health policies, including federal and state legislation, that restrict firearm access among persons with major depression and/or suicidal ideation could reasonably be expected to result in decreased fatalities.

Co-occurring Disorders: Mental Illness and Substance Abuse

Adults with co-occurring psychiatric and substance abuse disorders account for a large subset of persons with serious mental illness; this population is estimated to be slightly more than one quarter of all adults diagnosed with serious mental illness, totaling approximately 8 million people (Substance Abuse & Mental Health Services Administration, n.d.).

Although researchers conclude that mental illness does not lead to violence, a large body of studies found that co-occurring psychiatric disorders and substance abuse are associated with violence (Fazel & Grann, 2006; Swanson et al., 1997; Volavka & Swanson, 2010). Substance abuse, even in the absence of a psychiatric disorder, is associated with violence (Stuart, 2003). However, this relationship needs to be interpreted carefully. Substance abuse is largely associated with violence because of its criminal nature. The psychoactive effect of certain substances, primarily cocaine, methamphetamine, and alcohol, is considered to contribute to violence (Boles & Miotto, 2003).

Given the large body of research that suggests that mental illness, in and of itself, rarely leads to violence toward others, whereas substance abuse is associated with an elevated risk of violence, mental health policy designed to reduce gun violence and promote public safety might reasonably focus on substance abuse broadly, and more narrowly, on the subset of individuals with co-occurring disorders.

Federal Legislation

Federal gun control policy responses to the Sandy Hook and Aurora shootings strengthen legal prohibitions on gun ownership to individuals with histories of mental illness who are deemed at risk for violence to themselves and/or others. The primary federal vehicle for limiting access to firearms is the National Instant Criminal Background Check System (NICS), which was established under the 1993 Brady Handgun Violence Prevention Act, and which is used to run background checks on gun applications (National Instant Criminal Background Check System, n.d.). The Gun Control Act of 1968 prohibits gun ownership by any person who has been “adjudicated as a mental defective or committed to a mental institution” (Gun Control Act of 1968, Pub Law No. 90-618). It should be noted that “committed to a mental institution” refers solely to individuals who have been involuntarily committed to an inpatient setting. A report prepared for Congress about submission of mental health records to NICS and the Health Insurance Portability and Accountability Act (HIPAA) law clarified that “the definition explicitly excludes ‘voluntary admission,’ and

so would not apply to individuals voluntarily seeking treatment for mental illness in any setting” (Liu, Bagalman, Chu, & Redhead, 2013).

The 2007 Virginia Tech shooting focused widespread attention on increasing mental health reporting to NICS. In the Virginia Tech shooting, Seung-Hui Cho killed 32 people and wounded 17 others at Virginia Polytechnic Institute and State University. A report commissioned after the shooting reveals that Cho had a mental health record dating back to middle school. In college, he presented as threatening and isolative, both in class and socially. In 2005, following a student complaint of harassment, the police took Cho to a local community mental health center, where he was assessed by a clinical social worker who determined that Cho was mentally ill, presented an imminent danger to himself or others, and was unwilling to voluntarily enter treatment. The clinical social worker recommended involuntary hospitalization, located an available psychiatric bed, and contacted a judge to obtain a temporary detention order, which was issued. Cho was then taken to a psychiatric hospital, where he was evaluated by a staff psychologist, who found that Cho did not present an imminent danger and recommended against involuntary hospitalization. An attending psychiatrist evaluated Cho and concurred with the psychologist. Cho was released without receiving a primary diagnosis and was given a recommendation that he should seek outpatient treatment. No medication was prescribed. Cho was never reported to NICS (a lack of clarity concerning reporting requirements was subsequently cited). The issue was that Cho was not formally admitted to a psychiatric hospital, but rather ordered by the court for observation.

Further, HIPAA and FERPA (Family Educational Rights and Privacy Act) privacy laws were identified as factors inhibiting reports to NICS. Because Cho was not reported to NICS, he was later able to purchase two semi-automatic weapons, which he used in the 2007 attack (Virginia Tech Review Panel, 2007). The Virginia Tech shooting led to state legislation for mental health reporting to NICS. On April 30, 2007, Virginia Governor Timothy Kaine issued an executive order that eliminates the distinction between inpatient and outpatient settings as a criterion for reporting (Law Center to Prevent Gun Violence, 2012).

At the federal level, the Virginia Tech shooting precipitated the NICS Improvement Amendments Act of 2007 (NIAA), which was signed into law by President George W. Bush in 2008. Its intent was to increase record reporting to NICS by providing incentives for states. The NIAA also changed the standard for persons deemed to be “adjudicated as a mental defective” or “committed to a mental institution,” finding that such adjudications or commitments are “deemed not to have occurred” under certain circumstances, such as if “the person has been “fully released or discharged from all mandatory treatment, supervision, or monitoring” and when “the person has been found to be rehabilitated “through any procedure available under law” (NICS Improvement Amendments Act of 2007 [NIAA], Pub. L. 110-180).

This represents a change from prior law, under which the prohibition on persons “adjudicated as a mental defective” or “committed to a mental institution” was permanent. The Law Center to Prevent Gun Violence (2012) cautioned that this change would result in fewer mental health records being submitted to NICS; conversely, others suggested that the NIAA would increase mental health reporting (Norris & Price, 2009). NICS records have been increasingly populated with mental health records: In 1999, the first year for which data is reported, less than 1% of NICS denials were due to mental health reasons.

A large jump in mental health reporting took place between 2006 and 2009: In 2006, 405 denials were made for mental health reasons. By 2009, mental health reports had increased tenfold to number 4,811, perhaps reflecting the 2007 NIAA amendments that were passed in response to the Virginia Tech shooting. By July, 2013, the most recent year for which data are available, gun ownership denial based on mental health was the second largest category in the NICS database (28%), with close to 3,000,000 denials, far outpacing the number of denials because of a conviction of a criminal offense (1,601,781); a domestic violence conviction (93,219); and unlawful substance abuse (21,927). The only category that is greater than mental health denials of gun ownership is because of illegal immigrant status (5,427,994) (National Instant Criminal Background Check System, n.d).

The Sandy Hook and Aurora shootings renewed public and political attention on mental illness and gun control. Within this context, on March 6, 2013, Senator Lindsey Graham introduced the NICS Reporting Improvement Act of 2013. This bill seeks to “improve the effectiveness of the National Instant Criminal Background Check System by clarifying reporting requirements related to adjudications of mental incompetency, and for other purposes” (NICS Reporting Improvement Act of 2013). The NICS Reporting Improvement Act of 2013 expands the criteria to individuals in outpatient and inpatient settings. In order to remove obstacles that could hinder states from submitting mental health records to NICS, in April 2013, President Obama signed an executive order modifying the HIPAA privacy rule (HHS, 2013).

State Legislation

There are significant variations among state laws concerning prohibitions on firearm access for persons with mental illness. As noted above, state reporting to the NICS database is voluntary; as of October 16, 2012, 38 states required or authorized mental health reporting to the NICS database as well as maintaining in-state databases. Eight states only collected mental health records in-state and did not report data to NICS. Most states only reported persons who had been involuntarily committed to an inpatient unit (Law Center to Prevent Gun Violence, 2012).

The Sandy Hook shooting prompted new state mental health laws. New York State quickly passed the New York Secure Ammunition and Firearms Enforcement Act (SAFE). Several other states followed suit, with legislation either passed or pending in Colorado, Connecticut, Maryland, Oregon, Ohio, and Florida (Goode & Healy, 2013). On May, 21, 2013, Washington Governor Jay Inslee, after a Seattle shooting by a man with a history of domestic violence left five people dead, signed a law entitled “An act relating to accelerating expansion of mental health involuntary commitment laws.” This law speeds up the involuntary commitment process by allowing it on the basis of reports from friends or family (SB 5480–2013-14).

NY SAFE was signed into law by Governor Andrew Cuomo on January 15, 2013. It makes reporting to NICS mandatory and includes, as proposed in the NICS Reporting Improvement Act of 2013, persons in outpatient settings and/or voluntary psychiatric admissions who are deemed at risk for violence. NY SAFE is codified as Mental Hygiene Law (MHL) 9.46 and covers physicians, psychologists, licensed clinical social workers, and nurses, all of whom must report to their local director of community services (DCS) or his/her designees, any person who, in their reasonable professional judgment, is at risk of harming themselves or others. The DCS then reports the information to the New York State Department of Criminal Justice, which keeps the information in a state database for no fewer than five years and reports the data to NICS. If the person has a firearm license, it can be suspended or revoked, and local law enforcement can be dispatched to remove the firearm.

NY SAFE stipulates that "a report is not required when, in the mental health professional's reasonable professional judgment, a report would endanger him or her or would increase the danger to the potential victim or victims" (New York Secure Ammunition and Firearms Enforcement Act [NY SAFE] n.d.). Further, it provides legal protection for professionals: "if a mental health professional uses 'reasonable professional judgment' and 'good faith' when making a determination, this decision cannot be the basis for any civil or criminal liability." NY SAFE also extends mandatory (assisted) outpatient commitment to one year (previously, the maximum duration was six months), and it requires that an evaluation of the need for continued outpatient commitment occur 30 days before it expires. In the event that such a recommendation is made, NY SAFE provides a mechanism to petition for the renewal of the outpatient commitment order. Oddly enough, given the connection between substance abuse and violence, NY SAFE "does not apply to services provided in an OASAS [Office of Alcohol and Substance Abuse] certified program when a mental health professional (as defined in the law) is solely providing substance use disorder services to the patient" (NY SAFE, n.d.).

Noting that licensed clinical social workers are among the mental health professionals identified by NY SAFE, the New York State Chapter of the National Association of Social

Workers argued that NY SAFE undermines client confidentiality, potentially creates barriers to services, and promotes the criminalization of persons with mental illness (National Association of Social Workers–NY State Chapter, n.d.).

On March 11, 2013, the U.S. Department of Veterans Affairs (VA) issued a statement that they will not require mental health professionals to follow MHL 9.46 provisions, calling it a violation of civil rights and raising concerns that NY SAFE would deter veterans from seeking needed treatment, such those diagnosed with post-traumatic stress disorder (PTSD). The VA argued that federal laws protecting the confidentiality of veterans' treatment records take precedence over conflicting state and local laws (Virtanen, 2013).

Decoupling Mental Illness from Gun Control

The United States is ranked as having the highest number of privately owned guns in the world (gun ownership rate), although survey data suggests a decline among household gun ownership rates from an average of 50 percent in the 1970s to 35 percent in the 2000s. This trend may not represent an actual decrease in the number of guns in the United States, but rather a shift among gun ownership patterns in which growing numbers of households do not own guns, but those that do, own multiple firearms (Tavernise & Gebeloff, 2013). Although determining the precise number of guns in America is difficult because many guns are not legally registered, the United States, which has 5% of the world's population, owns 50% of the world's guns (United Nations Office on Drugs and Crime, 2007).

The deep attachment that many Americans have to guns is rooted in the history of the nation, codified in Second Amendment rights, and is woven into the fabric of a gun culture (Hofstadter, 1970). Legislative attempts to limit and restrict gun ownership rights are highly politicalized and are fought by the powerful National Rifle Association, a group which opposes gun control legislation, but embraces the narrative that gun violence is caused by people with mental illness. NRA Executive Vice President Wayne LaPierre argues that mentally ill people are the root cause of violence and that more

access to guns, and armed security in schools for example, is needed to curb gun violence (Edelman, 2013).

Mental health advocates welcomed the opportunity to put mental health issues on the political agenda after decades of budget cuts, but agreed that mental health should be decoupled from gun control legislation (Boyer, 2013). In response, on June 3, 2013, President Obama hosted a National Conference on Mental Health in which he shifted the focus from gun control to treatment. He vowed to bring mental illness “out of the shadows” and to combat stigma. President Obama presented a plan for a media campaign that would target young people, and which would convey the message that it is ok to talk about mental illness. He pledged to provide more assistance to veterans who need mental health care, promised resources to train 5,000 new mental health professionals, and vowed to finalize rules under the Affordable Care Act that would enforce mental health parity. Mental health advocates, although pleased with Obama’s overall focus, remain only cautiously optimistic, because parity laws do not alleviate the devastating impact of cuts to Medicaid spending. Between 2009 and 2012, states cut a total of \$4.35 billion in public mental health spending from their budgets, leading to a severe shortage of services (Honberg, Kimball, Diehl, Usher, & Fitzpatrick, 2011; Pickler, 2013).

Implications

Concerns raised by the mental health community focus on the potential for these policies to weaken client confidentiality and reinforce treatment barriers. Several professional associations, including the American Psychiatric Association, the American Psychological Association, and the National Association of State Mental Health Program Directors, oppose the federal proposal to weaken HIPAA privacy laws. The National Alliance on Mental Illness (NAMI), the nation’s largest mental health advocacy group, issued the following statement:

NAMI shares the goal of reducing gun violence in America and believes that firearms and ammunition

should not be easier to obtain than mental health care. At the same time, NAMI strongly advocates that people should not be treated differently with respect to firearms regulations based on stereotypical assumptions about mental illness and its relationship to violence. We believe that the current NICS law is based on faulty assumptions about the relationships between mental illness and violence, not grounded in science. We therefore do not support amending the HIPAA Privacy Rule to create a special exception for reporting of mental health records to the NICS database. (Fitzpatrick, 2013, para. 2)

Another major area of concern is the potential for these policies to criminalize persons with mental illness. Violence prediction is inexact, and laws based on clinical assessments that prospectively predict violence based on clinical assessments are associated with civil rights violations, such as incarceration and involuntary psychiatric commitment (Monahan & Steadman, 1994).

Conclusion

The Sandy Hook and Aurora shootings were shocking and horrific. The legislation that followed in their wake sought to limit access to firearms among persons with mental illness. These laws may have limited efficacy in promoting public safety because, as previously discussed, the research documents that the vast majority of persons with mental illness are not violent, and that only 4 - 5% of violence toward others is associated with mental illness. Further, these laws may do more harm than good, because they deter people from seeking needed treatment, undermine client confidentiality, contribute to erroneous stereotypes (e.g., the mentally ill are dangerous), and criminalize mental illness. On the other hand, these laws may reasonably be expected to reduce suicide rates; evaluating their impact on suicide is an important area for future research. Finally, given that substance abuse is associated with an increased risk for violence, public policies that are based on empirical research and that target specific segments of the substance abusing population who are considered at an elevated risk for violence may be efficacious in promoting public safety.

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