

## COMMENTARY

# Challenging the Political Assumption That “Guns Don’t Kill People, Crazy People Kill People!”

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Every time an infamous mass shooting takes place, a storm of rhetoric sweeps across this country with the fury of a wild fire. “Why are we letting these people carry guns?” “Why were they not hospitalized?” “The government needs to crack down on this issue!” What is the government’s response to these cries of concern? Politicians and the media attempt to ease public fears by drawing tenuous connections among a handful of poorly understood tragedies. The salient commonality is that these high-profile shooters had some history of mental illness. A cursory review of the Internet will paint a troubling picture of publicly unverifiable diagnoses: James Holmes, of the Aurora theater shootings, may have had schizophrenia. The Virginia Tech shooter, Seung-Hui Cho, supposedly had a past diagnosis of major depressive disorder. Adam Lanza, who was responsible for the massacre at Sandy Hook Elementary School, possibly presented with a history of autism spectrum disorder and obsessive–compulsive disorder.

A fallacy has ensued whereby the actions of a few troubled individuals have effectively molded national policy. Presumptions that mental illness is causally tied to firearm violence and that guns are too easily acquired by such persons have given rise to laws that categorically restrict people with mental health concerns from exercising a Constitutional right. Underlying these reforms appears to be a

revised idiom, “Guns don’t kill people—crazy people kill people.” The purpose of this commentary is to address these assumptions and provide suggestions for managing this critical threat.

### Firearm Violence Is a Serious Problem

Although school shootings and mass killings capture the media spotlight, they account for a relatively small percentage of homicides and gun violence in the United States. An examination of violent crime statistics reveals that firearms feature prominently in both lethal and nonfatal violent crimes. A special report on firearm violence by the U.S. Department of Justice estimated 478,400 violent crimes were committed with a firearm in 2011. Despite an overall decrease in violent crimes over the past few decades, the proportion of crimes committed with a gun has remained stable for nearly 20 years (falling between 6% and 9% of all violent crimes). The extent of harm caused by firearm violence is substantial.

### Firearm Homicide

Firearms are easily the leading method for killing another human being, accounting for about 70% of all homicides. This holds true for nearly all types of homicide, including those involving intimate partners, teens and young adults, and law enforcement officers killed in the line of duty. Over the past 30 years, the use of firearms in homicides has increased in the context of gang-related homicides (73% to 92%) and murders committed during the commission of a felony (59% to 74%). These numbers suggest the use of guns in

homicides is not limited to certain settings. They play a key role in murder across contexts, including areas in which we might be surprised to see severe mental illness (e.g., gang conflicts). Although homicide represents the most lethal form of firearm violence, it accounts for merely 2.3% percent of all firearm-related crimes.

### Nonfatal Firearm Violence

Of nearly half a million incidents of firearm violence in 2011, more than 467,000 of those were attributable to nonfatal violent crimes. The crimes in which they are most likely to be used are robberies (25.7%) and aggravated assaults (30.6%). Since 2007, an average of 23% of these crimes resulted in physical injury to the victim. In sum, firearm violence presents a serious societal concern, as seen by the substantial and consistent use of guns in violent crimes and the considerable amount of harm that results.

### Is Mental Illness Related to Violence?

### Prevalence of Violence by Persons With Mental Illness

Despite public fears of dangerous mentally ill perpetrators, most individuals with mental illness do not engage in violence. Jeffrey Swanson and colleagues recently conducted a review of epidemiological studies on violence among national samples with a history of mental illness. They concluded what has long been understood by the mental health community: Persons with mental illness are *relatively* more likely to engage in violence, yet the majority of individuals with psychopathology never engage in vio-

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lent behavior. Thirty-three percent of persons with any history of mental illness will engage in violent behavior at some point in their lives, compared to 15% for the population without mental illness. The risk of

cited findings from the Duke Mental Health Study, which found that 16% of psychiatric inpatients had engaged in violence involving a weapon before being hospitalized. Of those incidents, only 20% (3% of all aggressive acts)

does not support categorical management of “dangerous” persons with mental illness. In 1998, James Bonta and colleagues analyzed 64 samples of offenders with mental disorders. Bonta found that risk factors for violence were comparable for those with and without a mental illness, which suggests that people with psychopathology do not represent a unique class of violent individuals.

Scholars have noted obstacles that may hinder our understanding of mental illness and violence. For instance, findings may be difficult to aggregate because studies are designed and conducted in very different ways. Clinicians do not always agree on diagnosis, which can result in inconsistent conclusions for specific diagnoses and their relationship to violence. Additionally, because mental illness is related to other behaviors that are themselves related to violence, such as poverty or substance abuse, making direct attributions is difficult.

### **Mental Illness as a Contributor to Firearm Violence**

Although there appears to be a modest relationship between mental illness and violence generally, research thus far suggests there may be no association, or perhaps a negative relationship, with firearm violence. A 2006 Bureau of Justice Statistics report prepared by Lauren E. Glaze and Doris J. James on mental health issues in correctional institutions noted that inmates with mental health problems were more likely to have engaged in repeated acts of violence, but they were just as likely to have used a firearm during their offense as those without mental health concerns. A recent study by Jason Matejkowski and colleagues explored the records of more than 500 convicted murders and found that severe mental illness was associated with a significantly *lower* likelihood to have used a firearm during the crime. These studies suggest that mental illness may not present a unique risk for firearm violence. This begs the question: If mentally ill persons rarely commit firearm violence, and psychopathology fails to increase risk for firearm violence, why are we debating the issue of firearm access for these individuals? Are current provisions targeting the right problems? To find the answers, we must first examine current solutions in place.

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violence for persons with mental illness is 3:1 relative to the general population.

Yet, these base rates vary considerably. This is likely because the category of “mentally ill” is itself quite variable. Consider the following complexities. A psychotic disorder, such as schizophrenia, presents very different functional difficulties than say major depressive disorder (i.e., perception of reality vs. mood regulation). Degree of impairment will fluctuate within a person with mental illness across the life span. For instance, outpatient treatment may suffice to alleviate symptoms at one time period but escalation can necessitate involuntary hospitalization at another. By contrast, the extent of dysfunction may be greatest for first time episodes, such as psychotic breaks, with adjustment improving over the life span. The critical point to be made is that most people with mental illness do not engage in violence, and even among those who have, this risk is not a static concern but can change over time. Additionally, just because a person with mental illness has engaged in violence does not necessarily mean the mental illness contributed to the aggressive behavior. Such persons may have perpetrated the crime during a period in which they were not experiencing active symptoms.

### **Prevalence of Firearm Violence by Those With Mental Illness**

Although violence occurs disproportionately among persons with mental illness, the same may not hold true for firearm violence specifically. Unfortunately, prevalence rates for this specific issue are not available. The previously mentioned epidemiological review

resulted in injury to the victim. The MacArthur Violence Risk Assessment Study, one of the largest and most rigorous research studies on violence and mental illness, reported weapon involvement (threat or use of a weapon) in 29.3% of violent incidents. Though not directly reported in the MacArthur study, one of the researchers, Paul Appelbaum, recently noted a personal correspondence revealing that only 2% to 3% of the sample had engaged in violence with a firearm.

In sum, the prevalence of firearm violence among persons with mental illness has not been well investigated. However, a review of existing research suggests that weapons are involved in only a third of violence among certain psychiatric populations, who themselves engage in few acts of violence. As a whole, firearm violence appears to occur rarely among such persons.

### **Mental Illness as a Contributor to Violence**

Early researchers debated whether mental illness increased one’s risk for violence. However, a plethora of research since the 1990s suggests that mental illness is a significant, but modest, predictor of violent behavior. Swanson and colleagues concluded that several disorders are associated with increased risk for violence across the life span, including schizophrenia, bipolar disorder, depression, and personality disorders. However, a small portion of this risk is uniquely attributable to severe mental illness (ranging from 2% to 10% across studies). More importantly, other risk factors account for a larger percentage of risk, such as substance abuse and history of violence. In addition to the relatively small role of mental illness in violence, the scientific literature

## Are Firearm Prohibitions for Persons With Mental Illness Useful?

The government employs various mechanisms for mitigating firearm violence, in-

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cluding: restrictions on the type of firearms that can be legally circulated; regulations on manufacturing, sale, and distribution of firearms; and prohibitions for who may possess a firearm and firearm ammunition. This latter category is the primary device for managing firearm violence perpetrated by persons with mental illness. As psychiatrist Joseph Simpson observed in his review of firearm statutes, federal and state laws vary in who qualifies for this restriction and the extent of firearm limitations. The federal standard, as stipulated in the 1968 Gun Control Act (GCA), disqualifies two categories of psychiatric persons from owning firearms or ammunition: (a) those adjudicated as mentally defective and (b) individuals involuntarily committed for psychiatric reasons. On a state level, restrictions may be very broad—applying to any weapon, with indefinite duration, or no provisions for restoring firearm rights. The criteria for prohibited status for mental health reasons are similarly wide-ranging, with some states defaulting to the federal standard and others extending restrictions to any individual diagnosed with a mental illness (e.g., Hawaii). Underlying these regulations are assumptions that may not be justified or sufficient to manage this issue.

### Assumptions of Firearm Prohibitions

At least two fundamental assumptions support the use of firearm prohibitions for categories of severely mentally ill persons. The first concerns a conceptual misunderstanding of the relationship between mental illness and violence, which we have previously addressed. The second regards a logistical assumption that “dangerous”

persons with mental illness have excessive access to firearms, which constitutes a critical bridge between aggressive intent and accomplished violence, and that acquisition can be effectively controlled. By

this reasoning, restricting ownership of firearms will deter such violence by intercepting the necessary means for completing the violent act. Unfortunately, this formula fails in conception and execution.

**Firearm access for persons with mental illness is too easy.** Evidence thus far suggests that persons with mental illness have comparable access to firearms as the rest of the population. Psychologist Mark Ilgen and colleagues analyzed data from the National Comorbidity Survey, a nationwide psychiatric survey with responses from more than 5,500 participants. Contrary to common belief, individuals reporting a mental illness at any point in their lives had just as much access to firearms as those without a history of psychopathology (34.1% vs. 36.3%, respectively). This held true across all diagnostic categories. The one exception was bipolar disorder, which was associated with *less* firearm access. There was also no association between mental illness and the decision to carry firearms or unsafe firearm storage practices. Thus, the presumption that firearm availability in itself exacerbates risk for persons with mental illness is debunked in light of ordinary access to guns that has yet to yield an onslaught of firearm violence by people with a psychiatric diagnosis.

**Firearms are purchased through one source.** An inspection of public mass shootings indicates a wide array of firearm and ammunition procurement. James Holmes, of the 2012 Aurora theater killings, purchased all of his materials through licensed firearm dealers, such as Bass Pro Shop. Seung-Hui Cho, perpetrator of the 2007 Virginia Tech shooting, purchased his weapons through licensed dealers

online and acquired many of the accessories through eBay. Adam Lanza, who was responsible for the murder of 26 individuals at Sandy Hook Elementary School, acquired his arsenal from his mother, a gun enthusiast who legally owned all of her firearms. These examples anecdotally demonstrate the multiple ways in which perpetrators with mental illness can acquire a firearm if the desire is present. It should be clear that there is no silver bullet solution to this issue. What, then, can be done to mitigate firearm violence?

### What Can We Do About Firearm Violence?

The problem of firearm violence is not monolithic. Therefore, to achieve real change, efforts to manage this crisis must be multisystemic. Government regulations are but one device for combating firearm violence. We propose revisions to current reforms and recommend action for clinicians.

### Government Solutions

**Prohibitions based upon dangerousness.** As reviewed, the prohibition of firearm ownership by persons with mental illness as a distinct category is unsophisticated, ill-informed, and ineffective. Firearm restrictions are not, however, inherently unreasonable. These provisions may indeed be very useful if refined in a number of ways to target those at greatest risk. First, restrictions should be aimed at individuals who are dangerous and not merely diagnosed with a mental illness. Legal restrictions should be tied to specific behaviors, not to status. Second, the present mechanism for regulating firearm transactions requires improved communication between parties who are aware of the disqualifying person and those agencies responsible for implementing these prohibitions. It is unfortunate that it took the crisis in Sandy Hook to inspire executive action aimed at addressing this issue. Third, effective regulation of firearm acquisition requires a realistic view that recognizes firearms involved in violence may be obtained through means beyond licensed dealers. Extending regulations to private transactions and Internet sales presents a number of privacy and communication concerns that exceed the scope of this commentary. However, they remain important areas for

discussion if this mechanism is to be pursued for managing firearm violence.

**Firearm removal.** When it comes to firearm access, acquisition is but one side

of the coin. Given the exorbitant amount of firearms already in the community (estimated to be over 300 million), it is necessary to devise methods for managing firearms that may already be owned by the person considered to be dangerous. The GCA does not stipulate a procedure for removing firearms from individuals who have been disqualified. A number of states have provisions that require voluntary disposal of firearms by individuals who become ineligible. Only four states have enacted laws to remove firearms from dangerous persons with mental illness. Yet, these statutes contain variations in the required time period for removal, acceptable methods of disposal, and ramifications for failing to surrender the firearm. For example, Texas Senate Bill 1189 authorizes law enforcement officers to temporarily confiscate any firearm from persons with mental illness who are taken into emergency custody as a result of their being considered dangerous.

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California's Welfare and Institutions Code § 8102 requires the seizure of firearms or any dangerous weapon from anyone who has been detained or apprehended for examination of a mental condition.

Little data is available on the number of surrendered and/or seized firearms from individuals with mental disorders. At least two program evaluations have addressed gun seizure laws and reasons for removal. Veronica Rose and Meghan Reilly conducted a review of Connecticut's gun seizure law from the period of 1999 to 2008. This law enables police officers to acquire warrants for seizing firearms from anyone believed to pose an imminent risk of harm to self or others after establishing probable cause and eliminating reasonable alternatives. The is-

suing judge may consider prior involuntary psychiatric commitment as a reason for determining imminent risk. Over the course of 9 years, police applied for 222 warrants and seized over 1,700 firearms. Of these, only 27

warrant applications (12%) were for "mental issues." The leading purpose of firearm seizures were suicide threats (40%). The court upheld most (81%) of the firearm seizures. Unfortunately, more than half of these cases lacked mental health history information, which prevented analyses on this issue.

George Parker evaluated an Indiana law that permits police officers to seize firearms from individuals who are believed to have a mental illness and to be dangerous. He identified 155 cases in the Indianapolis area in a period of 2 years. Psychosis was listed as a reason for confiscation in only 9% to 11% of cases, with the leading cause of seizure being suicide risk and substance abuse. Unlike Connecticut, very few firearms were retained by court (29% in 2006, 8% in 2007).

### **Clinical Interventions**

**Risk assessment.** The data detailed in this commentary suggest some implications for risk assessment issues confronted by clinicians on a frequent basis. For example, substantial data exists indicating that firearms are a prominent method for suicide attempts. In addition to recognizing the substantial availability of weapons when assessing suicide risk, clinicians need to evaluate the link between suicide and risk of harm to others. It should be clear, however, that the

risk of violence by persons suffering from mental illness should not be exaggerated despite the attention drawn from infamous workplace violence and school shooting cases. As noted by epidemiological data cited within *The Lancet*, there has been a myth perpetuated toward the relationship among mental illness, suicide, and crime. The stigmatization of those with mental health disorders is alive and well despite the fact that those with mental illnesses are far more likely to be a danger to themselves than to others, with the risk of suicide being far greater than the risk of homicide. Keeping this cautionary note in mind, research is emerging linking the relationship between suicidal and homicidal behavior. F. Stephen Bridges recently noted that homicide-suicides occurred predominantly in the family unit and, in particular, involved female spouses with handguns and other firearms as the weapon of choice. Data from psychologist David Lester and colleagues, in an analysis of 105 incidents of workplace violence in the United States from 1982 to 2002, noted that murderers who killed themselves after the incident tended to kill more victims than those who had been arrested. Given the availability of firearms through legal and illegal means, clinicians would be prudent to consider risk to others, even within suicide risk assessments.

### **Therapeutic communication.**

Media attention regarding multiple shootings by persons suffering from mental illness has highlighted the issue of how much coercion should be considered as reasonable when clinicians are contemplating hospitalization or other treatment options for clients contemplating violent action. The role of therapeutic alliance between clinician and clientele has consistently emerged as predictive of level of treatment success. Respecting patient autonomy and decreasing perceived coercion are frequently cited goals in mental health care. Research suggests that the therapeutic relationship and patients' experiences of coercion may be associated—especially when level of treatment setting (e.g., hospitalization) is considered. Investigation within British hospitals performed by Kathleen Ann Sheehan and Tom Burns in 2011 indicated that high levels of coercion were experienced by 48% of voluntarily and 89% of involuntarily admitted patients. High levels of perceived coercion were significantly associated with involuntary ad-



mission and a poor rating of the therapeutic relationship. Although involuntary hospitalization may be viewed as necessary by both clinician and client alike in certain circumstances, how such placement decisions occur may impact perceived coercion and treatment success. Such a balancing act is also influenced by public safety concerns when clinicians may feel pressure to utilize hospitalization or emergency protective custody to mitigate threatening activity. Whenever the media is inundated with coverage of another multicasualty event, questions arise as to why the alleged individual with mental illness was not subjected to involuntary care.

**Threat assessment and management.** On a promising note, law enforcement and mental health practitioners are increasingly collaborating via threat assessment strategies to address the risk of targeted violence across a range of educational, workplace, and governmental settings. Threat assessment considers contextual, target- and individual-specific, and behavioral factors to determine the risk of violence. Different from profile-based techniques focused primarily on an individual's characteristics, models of this approach deal more with the interaction of the perpetrator's behavior, the target's vulnerability, and related factors. As a prevention-oriented strategy, threat assessment strives to accurately identify risks and to implement appropriate measures designed to minimize the *potential* for violence. In addition to promoting values of respect and community engagement, which are consistent with policing and mental health outreach, threat assessment strategies have been noted by Dewey Cornell in this special section as an effective means of violence prevention that promotes the least intrusive response to concerning behaviors. Further, this approach is behaviorally driven, avoiding the perception and practice of focus upon potential perpetrator profiles or characteristics.

## Conclusions

Firearms continue to feature prominently in violence, both fatal and nonlethal. Legislation has targeted persons with mental illness in an effort to manage this form of harm since the 1960s. In the wake of high-profile mass shootings by individuals with mental illness, recent reforms have proposed

## Suggestions for Further Reading

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a tightening on these restrictions. Yet, an examination of the research reveals that the base rate for violence among this population is low and that mental illness explains a small share of violence relative to other risk factors. Prevalence rates specific to firearm violence among psychiatric samples are scarce, but preliminary evidence suggests it may be rare and calls into question whether mental illness presents a unique risk for this form of violence.

The predominant legislative response to firearm violence has been regulations that prohibit certain groups of persons with men-

tal illness from owning firearms or otherwise dangerous weapons. However, this strategy is undermined in light of evidence that those with psychopathology report no difficulties acquiring firearms compared to the rest of the population, and instances of mass shootings indicate persons with mental illness who are considered dangerous obtain weapons from sources not monitored by the government. Statutes and regulations for the removal of firearms are sparse and their effectiveness has yet to be demonstrated. Yet, not all is bleak. There are many strategies, some of which are presently available

but underutilized, that may assist in reducing firearm violence.

Additionally, mental health professionals should be taking a more active role in the management of potentially violent individuals. This includes integration of violence risk assessment into suicide risk protocols, enhancing clinician-to-client communication regarding emergency interventions, and engaging in threat assessment and management activities. From a legislative vantage point, lawmakers should reform statutes in depth (refining what currently exists) and

breadth (expanding current efforts). In terms of depth, prohibitions would be most useful if they focused on *dangerousness* as a disqualifying criteria rather than mental illness, involuntary commitment, or adjudication per se. By breadth, it is helpful to first recognize that prohibiting the purchase of firearms is both unrealistic and insufficient as the sole Band-Aid to this problem. This issue requires a multisystem resolution. Management efforts aimed at firearm removal require more investigation before their effectiveness can be understood. Beyond strat-

egies aimed at firearm possession, policy should be focused on increasing access to treatment that can address risk issues for violence to those who need it. Lastly, every strategy that is implemented must be monitored for fidelity and evaluated for effectiveness. If we are to reject the false wisdom of “Guns don’t kill people—crazy people kill people,” then we are obliged to embrace more enlightened solutions for change.

**Keywords:** mental illness; firearms; firearm violence; threat assessment