



Severe mental illness and firearm access: Is violence really the danger?

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ABSTRACT

In response to a spate of mass shootings, national debate over the root of America's gun violence epidemic has centered on mental illness. Consequently, calls have been made to legislatively restrict firearm access among individuals with mental illness to reduce gun violence. While there is a link between mental illness and suicide, a dearth of empirical evidence exists to inform public policy on the link between firearm access and mental illness. The current study addresses this gap by exploring the nature of firearm-related risk among disordered individuals as compared to others from the same communities. We examined a subsample of the MacArthur Violence Risk Assessment Study, including 255 recently discharged psychiatric patients and 490 census-matched community residents. We conducted binomial logistic regressions to explore the impact of firearm access and patient status on violence and suicidality. In total, 15.3% reported firearm access, 23.5% violence, and 21.5% suicidality. Multivariate analyses revealed that, in the context of firearm access, patients were no more likely to perpetrate violence (OR = 0.588; 95% CI = 0.196–1.764) but were significantly more likely to report suicidality (OR = 4.690; 95% CI = 1.147–19.172). These results indicate that firearms constitute a serious risk factor for suicide, not violence, for disordered individuals. Thus, legislative efforts to reduce firearm-related risk among disordered individuals should focus on self-harm, not violence. Moreover, claims that mental illness is a principal cause of gun violence may reduce help-seeking among individuals at high risk for suicide. Researchers should devote further attention to addressing these claims empirically.

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1. Introduction

In the aftermath of each of an increasing number of mass shootings in the United States, debate over the link between mental illness and gun violence continues to dominate American public discourse (Coverdale, Coverdale, & Nairn, 2013; McGinty, Webster, & Barry, 2014; Metz & MacLeish, 2015; Rosenberg, 2014). In fact, some argue that stronger restrictions on firearm access by individuals with severe mental illness constitute effective and acceptable means of combatting America's gun violence epidemic that warrant more legislative focus (Kliff, 2012; Metz & MacLeish, 2015; Slack, Singer, & Kelly, 2015). Contrary to these claims, there is little evidence to suggest that mental illness contributes to >3–5% of all violent crime (Fazel & Grann, 2006), and there is even less evidence to suggest that mental illness is a primary cause of gun-involved crime, including homicide (Knoll & Annas, 2015; McGinty & Webster, 2015). On the other hand, mental illness is a major contributing factor to suicide (Li, Page, Martin, & Taylor, 2011), which in the United States most often involves the use of a firearm (Curtin, Warner, & Hedegaard, 2016; Webster & Wintemute, 2015).

Despite the attention mass shooting incidents garner, the role of mental illness in interpersonal gun violence remains ambiguous. While violence among the mentally disordered appears to be rare in the absence of specific symptom clusters or other general criminogenic risk factors (Elbogen & Johnson, 2009; Link, Andrews, & Cullen, 1992), it is unclear whether these factors or disordered status, alone, impart increased risk for interpersonal gun violence perpetration. This empirical vacuum is partially due to a lack of data available to identify similarities and differences between disordered individuals and non-disordered community-based comparison samples. Limited by a paucity of data to assess these questions empirically, the scholarly discourse has largely been editorial (e.g., Gold, 2013), descriptive (e.g., Steadman, Monahan, Pinals, Vesselinov, & Robbins, 2015), or indirect (e.g., Swanson, McGinty, Fazel, & Mays, 2015). That said, a slowly growing body of research is beginning to challenge the popular conception of the American gun violence epidemic as rooted in psychiatric problems.

This research indicates that gun violence perpetrated by the mentally ill is rare, is often associated with non-psychiatric risk factors, and is substantively different from gun violence perpetrated by the non-disordered (Matejkowski, Fairfax-Columbo, Cullen, Marcus, & Solomon, 2014; Steadman et al., 2015). For example, data from the MacArthur Violence Risk Assessment Study, a yearlong longitudinal analysis of individuals with severe mental illness recently discharged from inpatient

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psychiatric care facilities, revealed a 2% prevalence of violence involving the use of a firearm (Steadman et al., 2015). Furthermore, the researchers reported that gun violence against strangers was even more rare (1%), a finding contradictory to media portrayals of mental illness as the primary driving force behind mass shootings in America (Coverdale et al., 2013).

Overall, available research suggests that gun violence risk among individuals with severe mental illness, like their risk for violence more generally, is relatively concentrated among a small portion of the disordered population who exhibit various clinical and extra-clinical characteristics. Conversely, the greatest risk that individuals with severe mental illness who have firearm access face is suicide (Swanson et al., 2015). Indeed, evidence suggests that mental illness may imbue a lifetime, increased risk of suicide (Dutta et al., 2010); however, the effect of firearm access on disordered individuals outside the context of acute mental health crises is less understood.

Despite the lack of evidence upon which to base legislative responses to the problem of gun violence in America, several laws and executive orders have been implemented that directly impact firearm access among individuals with severe mental illness. Most notably, the federal *Gun Control Act of 1968* (GCA) prohibits access to firearms by specific classes of individuals, including those who have been adjudicated mentally unfit or who have been involuntarily committed to mental institutions. These restrictions are enforced, at least in theory, through the reporting and sale restriction mechanisms of the *Brady Handgun Violence Prevention Act of 1993*, which explicitly prohibits the sale or transfer of firearms by federally licensed dealers to disqualified persons and establishes a federal database of individuals who meet the disqualifying criteria outlined in the GCA. While many state and federal rules require a person to be adjudicated as “dangerous” to be disqualified from firearm access, federal rules under the Obama administration expanded disqualification criteria to include any individuals receiving Social Security benefits for mental health problems, so long as they required financial management assistance (Eilperin & Nakamura, 2016). The U.S. Congress has since overturned this rule, sparking renewed debate over the appropriateness of firearm access among individuals with severe mental illness, irrespective of dangerousness (Vitali, 2017).

In summary, limitations on gun violence research have largely stymied the development of empirical research devoted to clarifying the role of mental illness in gun violence perpetration. That said, recent studies indicate that interpersonal gun violence is exceptionally rare (Steadman et al., 2015; Swanson et al., 2016), while suicide risk is disproportionately high (Dutta et al., 2010; Hiroeh, Appleby, Mortensen, & Dunn, 2001), among this population. Still, questions remain regarding how firearm access impacts this population as compared to others. In the face of this empirical uncertainty, state and federal lawmakers continue to pass legislation and implement guidelines that directly impact the ability of individuals with severe mental illness to access firearms in the United States. Without more robust research, stakeholders will be unable to effectively inform the legislative process. Thus, this study's aim is to assess: (a) whether firearm access increases the odds of interpersonal violence and/or suicidality among a sample of individuals with severe mental illness living in the community; and (b) whether the increased risk, if any, is disproportionate compared to a comparison group of non-disordered individuals from the same neighborhoods.

2. Methods

The current study uses data from the first follow-up wave of the MacArthur Violence Risk Assessment Study (MacRisk). This study provides data on numerous clinical, social, and behavioral characteristics of interest here, including firearm access, symptomatology, disorder-related functioning, violence perpetration, and suicidality. The inclusion of a census tract-matched, non-disordered community comparison sample at one site during the first follow-up period allows us to address

the main question of interest here: does firearm access present a *greater* risk of violence perpetration and/or suicidality for disordered individuals than for others?

2.1. Samples

Using a stratified random sampling technique, eligible MacRisk study participants were recruited from the inpatient admissions rosters of mental health facilities in three cities, including Pittsburgh, Pennsylvania, between 1992 and 1994 (Steadman et al., 1998). Patients were considered eligible for study inclusion if they (a) were between the ages of 18 and 40 years old; (b) spoke English; (c) were White or Black; (d) were civilly admitted; and (e) had received primary diagnoses of schizophrenia, schizoaffective or schizophreniform disorders, major depressive disorders, mania, psychotic or delusional disorders, substance use disorders or dependence, or personality disorders. A detailed description of the study design and methods may be found elsewhere (Monahan et al., 2001; Steadman et al., 1998).

At the Pittsburgh site, researchers recruited a community comparison group that provided data during the first follow-up period. This sample was matched to the Pittsburgh patient sample by distribution of census tracts. Like the patient sample, eligible subjects were between 18 and 40 years old and were either Black or White. Unlike the patient sample, community respondents who had been treated in psychiatric facilities in the prior ten weeks were excluded. The community comparison group received several of the same clinical instruments and questionnaires as the patient sample, making it possible to compare risk factors for violence across the two groups.

Thus, analyses in the current study were limited to data collected from the Pittsburgh participants during the first follow-up. Restricting data analysis by time and location allowed us to directly compare the impact of firearm access on both disordered and non-disordered individuals from the same community during the same time period. Of the 829 cases that provided data on the dependent variables of interest, 84 were missing data on one or more of the independent variables assessed in the analyses. To maintain a constant *n* across each of the analyses, subjects with missing data for any of the variables of interest were excluded, leaving 745 subjects (community sample, *n* = 490; patient sample, *n* = 255). Subsequent analyses did not reveal any significant differences on either of the outcome variables between the missing cases and the cases included in this study.

2.2. Measures

2.2.1. Interpersonal violence

MacRisk utilized the Conflict Tactics Scale (Gelles & Straus, 1988) to determine whether and to what extent participants had engaged in a number of violent and aggressive acts (e.g., biting, choking, kicking) over the previous ten weeks. For the current study, we created a dichotomous indicator of any violent or aggressive behavior over the prior 10 weeks.

2.2.2. Suicidality

Suicidality was assessed using a number of questions about suicidal thoughts or behaviors over the prior ten weeks. A substantial body of research indicates that firearm access increases risk for completed suicide (Miller, Swanson, & Azrael, 2016); however, data limitations prevented us from examining either completed or attempted suicides involving firearms. Thus, we restrict our analysis to the following question: “[Over the last 10 weeks] have you ever thought of hurting yourself?”

2.2.3. Firearm access

Respondents were asked a series of questions to determine their access to various weapons. If a respondent indicated access to a weapon, whether through ownership or availability, researchers probed to

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