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Article

Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness

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This Article examines the ways in which Connecticut and federal legislative efforts on gun control have affected persons with mental illness in the state and includes a brief history of that legislation in the context of tragic gun violence. There have been two major legislative and policy directions: (1) federal and state prohibitions on gun ownership related to several types of mental health adjudications; and (2) Connecticut's 1999 statute permitting gun seizures by law enforcement officers in situations of increased risk of harm to individuals—the first statute of its kind in the nation. We present available data about each of these two efforts, which show no support for the proposition that laws targeting persons diagnosed with mental illness will curb gun violence. The implications of these data are discussed, as well as the deleterious effects of stigma on the public health. The strengths of Connecticut's gun seizure law as an approach to reducing violence by people in distress are reviewed.

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MICHAEL A. NORKO[*] & MADELON BARANOSKI[**]

I. INTRODUCTION

In 1923, Connecticut enacted its first gun control legislation in the form of pistol and revolver permit requirements.[1] At that time, the only groups prohibited from obtaining permits were aliens and minors.[2] By 1947, the Connecticut General Statutes prohibited the issuance of a permit to anyone convicted of a felony and allowed the issuing authority to request the applicant's criminal record to "make an investigation concerning his suitability to carry any such weapons."[3]

Roughly two decades later, Connecticut's firearm permitting scheme was complemented by federal gun control measures. With the Gun Control Act of 1968,[4] Congress created several broad categories of persons prohibited from possessing firearms, including those who have "been adjudicated as a mental defective or . . . committed to any mental institution."[5] The term "adjudicated as a mental defective" is now defined in 27 C.F.R. § 478.11 to include a judicial determination that a person is a danger to himself or others or lacks the mental capacity to contract or manage his own affairs, or a finding of insanity or incompetence to stand trial by a criminal court.[6] This unfortunate language was not improved upon in the NICS Improvement Amendments Act of 2007[7] and has become the subject of advocacy.[8] The federal law remains unchanged, but the

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[1] Act of June 2, 1923, 1923 Conn. Pub. Acts 3707.

[2] *Id*. at 3708–09. Minors were defined to include anyone under the age of eighteen years old. *Id*. at 3709.

[3] CONN. GEN. STAT. § 715i (Supp. 1947) (current version at CONN. GEN. STAT. § 29-29(a) (2013)).

[4] Pub. L. No. 90-618, 82 Stat. 1213 (codified as amended at 18 U.S.C §§ 921–928 (2012)).

[5] § 102, 82 Stat. at 1220 (codified as amended at 18 U.S.C § 922(d)(4)).

[6] 27 C.F.R. § 478.11 (2013).

[7] Pub. L. No. 110-180, § 3, 121 Stat. 2559, 2561 (2008) (codified as amended at 18 U.S.C. § 922).

[8] *See, e.g*., Michael A. Norko & Victoria M. Dreisbach, *Letter to the Editor*, 36 J. AM. ACAD. PSYCHIATRY & L. 269, 269–70 (2008) (urging Congress to delete the phrase "adjudicated as mental

Federal Bureau of Investigation (FBI) agreed in 2008 to refer to these individuals using neutral terms in documents.[9] Unfortunately, however, as late as November 2011 the FBI referred to its "Mental Defective File" in testimony to the Senate Judiciary Committee, Subcommittee on Crime and Terrorism.[10] In Connecticut, these definitions apply to probate orders of civil commitment, appointments of a conservator of person or estate, and the two criminal court findings identified in the United States Code.[11]

The Brady Handgun Violence Prevention Act[12] was introduced to Congress in 1987 and enacted in 1993.[13] It required a five-day waiting period for gun purchases, but also stipulated that this term would sunset after five years.[14] The Brady Act further prompted the Attorney General to establish the National Instant Criminal Background Check System (NICS) within five years.[15] While NICS was under development, the Brady Act required state officers to conduct background checks—but the U.S. Supreme Court held that the directive was unconstitutional.[16] In 1998, NICS came into existence and the five-day waiting period lapsed, allowing for immediate gun purchases.[17]

With this preliminary regulatory framework now in place, Part II of this Article will proceed to discuss more contemporary developments in Connecticut's mental health-related firearm prohibitions. Notably, this will include a presentation of empirical data relating to warrants served for "imminent risk" gun seizures in Connecticut. Part III will explore Connecticut's experience with the NICS reporting scheme. Part IV will

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defective" and replace it with "the subject of a mental health adjudication"); *see also* Jana R. McCreary, *"Mentally Defective" Language in the Gun Control Act*, 45 CONN. L. REV. 813, 862–63 (2013) ("The use of *adjudicated as a mental defect* is not only outdated, but is (and always should have been deemed) pejorative. This language should be updated to reflect what most have understood it to be: a prohibition against a person who, because of a mental deficiency or intellectual disability, is unable to manage her affairs.").

[9] *See* Michael A. Norko, *Letter to the Editor*, 36 J. AM. ACAD. PSYCHIATRY & L. 428, 428 (2008) (informing readers that the FBI intended to rewrite their coding manuals and reports to no longer use the term "mental defective"); *see also National Instant Criminal Background Check System (NICS) Operations 2012*, FED. BUREAU INVESTIGATION, http://www.fbi.gov/about-us/cjis/nics/reports/2012-operations-report (last visited Apr. 15, 2014) (quoting the language of 18 U.S.C. § 922(g)(4), but elsewhere using the phrase "prohibiting mental health adjudications).

[10] *The Fix Gun Checks Act: Better State and Federal Compliance, Smarter Enforcement: Hearing Before the Subcomm. on Crime & Terrorism of the S. Comm. on the Judiciary*, 112th Cong. (2011) (statement of David Cuthbertson, Assistant Dir., Criminal Justice Information Services Division, Federal Bureau of Investigation).

[11] CONN. GEN. STAT. § 17a-495 (2013).

[12] Pub. L. No. 103-159, 107 Stat. 1536 (1993) (codified as amended at 18 U.S.C. §§ 921–922 (2012)).

[13] *Id.*; S. 466, 100th Cong. (1987); H.R. 975, 100th Cong. (1987).

[14] § 102, 107 Stat. at 1536–37.

[15] § 103, 107 Stat. at 1541.

[16] Printz v. United States, 521 U.S. 898, 923 (1997).

[17] *National Instant Criminal Background Criminal Background Check System*, FED. BUREAU INVESTIGATION, http://www.fbi.gov/about-us/cjis/nics (last visited Apr. 15, 2014).

describe Connecticut's most recent firearm legislation, which followed the tragedy at Sandy Hook Elementary School. Transitioning into a critical assessment of this entire regime of firearm prohibitions, Part V will identify lessons to be learned about risk factors for violence and regulatory efficacy. Part VI concludes with forward-looking recommendations.

II. CONNECTICUT'S MENTAL HEALTH-RELATED FIREARM PROHIBITIONS

Connecticut legislation related to mental health and gun regulations has taken two directions: (1) placing prohibitions on gun permits based on various mental health adjudications; and (2) creating a mechanism for the temporary seizure of legally owned guns from those deemed to pose a risk of imminent personal injury without arrest or criminal investigation. The first avenue of applying mental health prohibitions to gun ownership was initially an intra-state mechanism, but now it is consistent with federal law and based on the foundation of background checks for sales and permits. The second approach, however, was unique at its inception and remains a rare approach today, with only Indiana having subsequently enacted a similar law.

A. *Prohibition of Permits*

The Connecticut General Assembly first enacted mental health prohibitions for gun permits in 1994.[18] In their present-day form, these prohibitions prevent gun permits from being issued to anyone who has been discharged from custody within the last twenty years after being "found not guilty of a crime by reason of mental disease or defect," or who has been involuntarily committed to a psychiatric hospital within the last five years.[19] Possession of a pistol or revolver by such prohibited persons is a Class C felony.[20] The Department of Emergency Services and Public Protection (DESPP) is responsible for maintaining a database, which sellers or transferors of pistols or revolvers "may access" to determine whether a permit is valid, revoked, or suspended.[21] For some time following enactment, however, there was no system in place to monitor whether persons applying for gun permits were subject to mental health-

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[18] *See* Act of July 7, 1994, No. 94-1, § 3(a), 1994 Conn. Acts 1527, 1530 (Spec. Sess.) (codified as amended at CONN. GEN. STAT. § 29-28(b) (Supp. 2014)) (making mental health treatment history a potential element of criminal possession of a pistol or revolver).

[19] CONN. GEN. STAT. § 29-28(b).

[20] *Id*. § 53a-217. Prior to October 1, 2013, such possession was a Class D felony. In Public Act 13-3, the General Assembly changed the penalty to a Class C felony, "for which two years of the sentence imposed may not be suspended or reduced by the court." *See* Public A. 13-3, 2013 Gen. Assemb., Reg. Sess. § 45 (Conn. 2013), *available at* http://www.cga.ct.gov/2013/ACT/pa/pdf/2013PA-00003-R00SB-01160-PA.pdf.

[21] *Id*. § 29-36*l*(a).

related prohibitions.

On March 6, 1998, an accountant at the Connecticut Lottery Corporation killed four co-workers with a gun and knife before committing suicide.[22] He had been involved in a seven-month dispute over his salary and lack of promotion.[23] Notably, the perpetrator had a history of depression, had attempted suicide in the past, and was receiving treatment.[24] Less than three months after this tragedy, the Connecticut General Assembly passed Public Act 98-129, which, among other things, created a system for checking whether individuals had been subject to the gun prohibitions based on civil commitment.[25] This ended what had been essentially an honor system for persons applying for permits. Probate courts must now report commitment orders to the Department of Mental Health and Addiction Services (DMHAS) within three business days.[26] Further, DMHAS must report those commitment orders to DESPP "for a person who applies for or holds a permit or certificate."[27] In turn, DESPP must verify mental health commitment information prior to issuing a gun permit "in such a manner as to only receive a report on the commitment status of the person with respect to whom the inquiry is made."[28]

Prior to these enactments, the records of commitments in probate court, records of gun permits held by the DESPP, and psychiatric records held by DMHAS were all considered confidential. Public Act 98-129 called for exceptions to each of these confidentialities and for special handling of the releases of the relevant information to apply only to individual permit holders or applicants.[29] To accomplish the dual objectives of reporting and maintaining confidentiality, DESPP and DMHAS collaborated with the Department of Information Technology to create a "black box" computer system that would compare the databases held by each agency for matches and report only those matches to both

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[22] Jonathan Rabinovitz, *Rampage in Connecticut: The Overview; Connecticut Lottery Worker Kills 4 Bosses, Then Himself*, N.Y. TIMES (Mar. 7, 1998), http://www.nytimes.com/1998/03/07/nyregion/rampage-connecticut-overview-connecticut-lottery-worker-kills-4-bosses-then.html?pagewanted=all&src=pm; John Springer, *March 7, 1998: Worker Kills 4 Bosses, Self at Lottery Site*, HARTFORD COURANT (Mar. 7, 1998), http://articles.courant.com/1998-03-07/news/hc-lottery-shooting-newington-1998_1_lottery-president-otho-brown-connecticut-lottery-headquarters-matthew-e-beck.

[23] Rabinovitz, *supra* note 22.

[24] *Lottery Gunman's Parents: "We Love You Matt—but Why?,"* CNN (Mar. 8, 1998), http://www.cnn.com/US/9803/08/lottery.killings/index.html.

[25] Act of May 27, 1998, No. 98-129, §§ 17–19, 1998 Conn. Acts 516, 527–30 (Reg. Sess.) (codified as amended at CONN. GEN. STAT. §§ 17a-499, 17a-500(b), 29-38b).

[26] CONN. GEN. STAT. § 17a-499.

[27] *Id*. § 17a-500(b).

[28] *Id*. § 29-38b.

[29] §§ 17–19, 1998 Conn. Acts at 527–30.

agencies.[30] A match thus occurs when a permit holder is civilly committed or when a person who had been civilly committed applies for a permit. Neither agency can search the database of the other agency.

As of March 1, 2013, 6700 civil commitments were reported by the probate courts to DMHAS. Among those commitments, 71 unique matches were identified (an occurrence rate of 1%). Of those matches, all but one was for an individual who was committed sometime after being granted a gun permit. Put differently, only one person attempted to apply for a gun permit after having been civilly committed (an occurrence rate of 0.015%).

B. *Temporary Seizure of Legally Owned Guns*

On June 29, 1999, the Connecticut General Assembly passed Public Act 99-212.[31] As initially proposed, the bill would have made relatively minor changes to sections 29-28 through 29-32 of the Connecticut General Statutes.[32] But the final form of the Act, apparently influenced by the Connecticut Lottery shooting,[33] created a process for gun seizure.[34] As a result, after obtaining a warrant, law enforcement officers can now seize firearms from any person who is deemed to pose "a risk of imminent personal injury to himself or herself or to other individuals."[35]

Crucially, this process for gun seizure avoids stigmatizing persons with mental illness since the risk, as defined, could be related to a number of circumstances, including recent threats or acts of violence and recent acts of cruelty to animals.[36] In reviewing the warrant application, judges can consider the reckless use of a firearm, a history of the use or attempted or threatened use of force against others, illegal use of controlled substances, abuse of alcohol, and prior involuntary psychiatric hospitalization.[37] Thus, although mental health history might be a factor in assessing dangerousness in a given situation, it is only one of several factors that

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[30] The description of this computer system is based on the personal experience of one of the authors, who has worked extensively with DESPP. The civil commitment data in the ensuing paragraph is available to him in connection with his official duties at DMHAS.

[31] Act of June 29, 1999, No. 99-212, 1999 Conn. Acts 790 (Reg. Sess.) (codified as amended in scattered sections of CONN. GEN. STAT.).

[32] S.B. No. 1166, 1999 Gen. Assemb., Reg. Sess. (Conn. 1999).

[33] Adam Gorlick, *Gun-Seizure Law Targets the Unstable*, L.A. TIMES, Oct. 24, 1999, at 25. The legislative atmosphere may also have been influenced by the tragedy at Columbine, which occurred just two months prior to the passing of Public Act 99-212. On April 20, 1999, the nation was shocked by the Columbine shootings, in which two high school students killed thirteen people and injured twenty-four others at their school before taking their own lives. HON. WILLIAM H. ERICKSON, COLUMBINE REVIEW COMM'N, THE REPORT OF GOVERNOR BILL OWENS 139 (2001).

[34] § 18, 1999 Conn. Acts at 801–02.

[35] CONN. GEN. STAT. § 29-38c(a).

[36] *Id.*

[37] *Id.*

might lead to a court's finding of imminent risk that justifies gun seizure.

Courts must also consider the need for emergency mental health intervention. Should a court find that a person "poses a risk of imminent personal injury . . . it shall give notice to [DMHAS] which may take such action pursuant to chapter 319i as it deems appropriate."[38] Chapter 319I is entitled "Persons with Psychiatric Disabilities," and it includes provisions for psychiatric hospitalization and treatment within the least restrictive alternatives.[39]

Connecticut's "imminent risk" statute, which, as described, permits a law enforcement officer to instigate the seizure of a gun before its owner is taken into custody in connection with an act of violence, was considered the first of its kind.[40] In 2006, after an August 2004 incident left one police officer dead and four other officers wounded, Indiana passed a similar law that permits firearm seizure without an arrest—or even a warrant.[41] No other states have followed this line of legislation to date.

C. *Implementation and Use of the "Imminent Risk" Gun Seizure Statute in Connecticut*

From October 1, 1999, through July 31, 2013, 764 warrants for "imminent risk" gun seizures have been served in Connecticut, with 53% of them being served since 2010.[42] This increase in served warrants over time is a statistically significant increase compared to what would be expected due to random variation alone.

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[38] *Id*. § 29-38c(d).

[39] *Id*. ch. 319I.

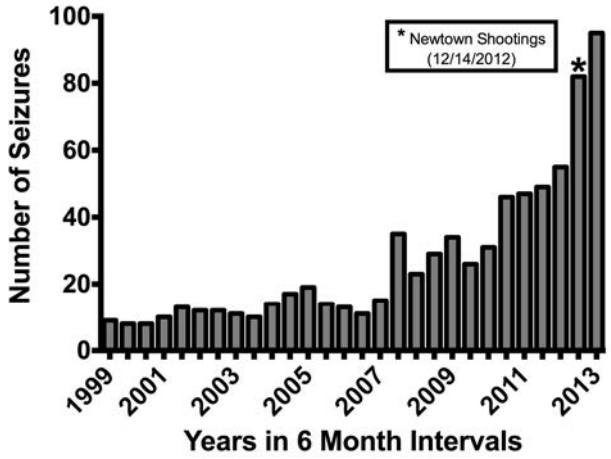
[40] Gorlick, *supra* note 33.

[41] 2006 Ind. Acts 445 (codified as amended at IND. CODE § 35-47-14-3 (2013)); *see One Officer Killed, Four Others Wounded in Southside Shootout: Suspect, Mother Also Dead*, WIBC (Aug. 18, 2004), http://www.wibc.com/news/story.aspx?id=31679 (providing local reporting on the shooting tragedy).

[42] The courts copy all warrant applications to DMHAS so that the Department "may take such action pursuant to chapter 319i as it deems appropriate." CONN. GEN. STAT. § 29-38c(d). The warrant applications are supplied in advance of the hearing so that jail diversion clinicians in the courts may be prepared to offer assistance to the individual at the time of the hearing. The related data analysis reported in this Article, and detailed especially within this Part II.C, is derived from the authors' private review of all of these 764 warrant applications.

FIGURE 1

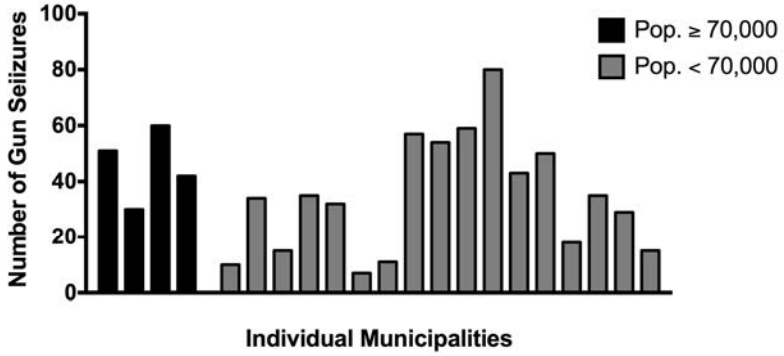
FREQUENCY OF GUN SEIZURES FROM 1999 THROUGH 2013



The extreme spike in the number of warrants served corresponds to the months after the Sandy Hook shootings. As reflected in Figure 1 above, however, the increase in seizures began in 2008 and trended upward again in mid-2010.

FIGURE 2

DISTRIBUTION OF TOTAL GUN SEIZURES ACROSS LARGE AND SMALL CONNECTICUT MUNICIPALITIES



Warrants were served in 164 of the 169 towns in Connecticut. As reflected in Figure 2 above, the resulting seizures occurred at a higher rate (based on number of seizures per population) in smaller towns (populations under 70,000) than in larger municipalities. Smaller towns comprise 31% of Connecticut's population but accounted for 76% of the gun seizure warrants; large municipalities account for 69% of the population but

contributed only 24% of the warrants.

Warrants were served to seven hundred men (91.5% of the total served warrants) and sixty-four women (8.5% of the total served warrants). The persons served with warrants ranged in age from 21 to 92 years, with an average age of 47.4 years.[43] The 64 women were between the ages of 30 and 84. The men ranged in age from 18 to 92, with 16% under the age of 30 and 0.6% over the age of 90. Twenty-seven percent of those served warrants were married. Five percent, all men, were veterans; eight of whom had been deployed to a war zone within the year before the warrant was served.

Review of the police reports indicated that for both men and women, the plurality of the calls were from family or friends of the gun owners. But, surprisingly, the second most frequent alerts came from people unrelated to the gun owners, including landlords, neighbors, and members of the public. Calls from clinicians and employers each accounted for about 5% of the reports. Six percent of the men and 2% of the women made the call reporting their own distress.

Over 400 (53%) of the warrants concerned the risk of self-harm. However, the nature of the risk varied significantly by gender: 83% of women posed a risk to themselves with the firearm, compared to 51% of the men.[44] Reports for the men indicated that 24% posed a risk to others and an additional 9% were viewed as a risk to both themselves and others. For the women, only ten (15%) were viewed as risky to others and only two (3%) posed a risk to themselves and others.[45]

Notably, the majority of gun owners who were served warrants had no history of psychiatric treatment. Only 20% of the men and 30% of the women had been involuntarily hospitalized in the past. Even fewer—10% of the men and 20% of the women—had received services from DMHAS. At the time of the gun seizure, only 1% of the men and none of the women were in active treatment.

Also, police noted at the time of confiscation that about 30% of both men and women showed evidence of alcohol consumption, and less than 5% of the men were described as using street drugs (marijuana and cocaine). Moreover, police reports noted that 10% of both men and women indicated using prescribed pain medications.

In 596 (78%) of the cases, the police reports described events and circumstances associated with the increased risk of violence with a firearm. The two most frequently cited triggers were "conflict in the relationship with a significant other" and "depression." Grief secondary to the death of

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[43] The standard deviation was 14.7 years.

[44] This represented a statistically significant difference ($p = 0.029$).

[45] Not all of the warrant applications are contained in this data, so the figures do not add up to one-hundred percent.

a family member was described in 5% of the reports; health concerns and financial concerns each accounted for 5% as well. Problems with co-workers and neighbors were described in 4% of the cases.

The triggers did not vary by gender, but they did by age. For 53% of those 35 years and younger, relationship conflict was the primary stressor. For those 60 years and older (about 19% of the total population), the main sources of stress were death of a significant other (42%) and failing health (39%). All four of the men over 90 years of age had lost their spouse within the previous two years.

When the police served the warrant, the majority of the gun owners were sent to the emergency departments (ED) of the local hospital by the police: 60% of the men and 80% of the women required an emergency evaluation. Only 20% of the gun owners were arrested, while 16% (all of whom were men) were arrested *and* sent to the ED. Unfortunately, the results of the ED assessments were not reported to DMHAS. Future research will include a follow-up concerning the ED assessment after the gun seizure.

Another reporting gap in the law and associated policies is that the outcome of the mandatory hearing after the seizure (where judges decide whether the firearms can be returned) is not reported to DMHAS. In over 70% of the cases, the outcome of the hearings was unknown. For the cases with outcomes reported, the judges ruled that the weapons needed to be held by the state 68% of the time. Weapons were returned in only twenty of the reported cases. In fifteen other cases, guns were given to a family member; in thirty cases, the guns were destroyed.

III. NICS REPORTING

A. *Connecticut Legislation and Reported Data*

In 2005, the Connecticut General Assembly enacted legislation requiring that the state comply with provisions of the Brady Act and report relevant mental health adjudications within the state to NICS.[46] Thus, under Connecticut law, a gun permit may not be issued to any applicant who is prohibited from gun ownership under 18 U.S.C. § 922(g)(4)—in notable avoidance of the prejudicial language in the federal code that refers to adjudication as a "mental defective."[47] The resulting statute also prompted DESPP, DMHAS, and the Judicial Department to enter into a memorandum of understanding (MOU) with the FBI "for the purpose of

[46] Act of July 13, 2005, No. 05-283, 2005 Conn. Acts 1116 (Reg. Sess.) (codified as amended in scattered sections of CONN. GEN. STAT.).

[47] CONN. GEN. STAT. § 29-28(b).

implementing [NICS] in the state."[48] That MOU was finalized in November 2006, at which point the data system in place relating to civil commitments was used to forward information about those individuals as prohibited persons directly to NICS without DESPP seeing the records and without identifying mental health information.[49]

The legislation requiring such reporting affected tens of thousands of Connecticut residents without regard to whether they were seeking firearm licenses. From 2003 to 2012, the following mental health adjudications were tallied in Connecticut:

- Incompetent to stand trial: 2094 (approximately 200 per year).
- Civil commitment: 5014 (approximately 500 per year).
- Not guilty by reason of mental disease or defect: 51 (approximately 5 per year).
- Conservatorship: approximately 20,000 (approximately 2,000 per year).

The number of persons reported to NICS during this ten-year period contrasts sharply with the number of persons who sought and were denied gun permits. From 2005 to 2010, there were fourteen reported denials of gun permit applications.[50] If one allows for a rough comparison between these overlapping periods, based on the categories bulleted above the occurrence rate would be approximately 0.09%.

B. *NICS Improvement Amendments Act of 2007*

On April 16, 2007, a twenty-three-year-old senior at Virginia Tech used two semi-automatic handguns to kill thirty-two people and wound an additional seventeen before killing himself.[51] The young man had previously been declared mentally ill and dangerous to himself and was ordered to attend outpatient treatment.[52] This event strengthened the link in public opinion between mental illness and dangerousness[53] and spurred

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[48] *Id.* § 29-36*l*(d)(2).

[49] This account is based on the personal experience of one of the authors, who participated in the interagency work group. The data in the subsequent bullet list is made available to him in connection with that role.

[50] Office of Policy & Mgmt., State of Conn., NARIP Fiscal Year 2011 Grant Application, Attachment No. 2: NICS Record Improvement Plan 19–20 (2011) (on file with author).

[51] VA. TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH 5, 71, N-3 (2007), *available at* http://www.washingtonpost.com/wp-srv/metro/documents/vatechreport.pdf.

[52] *Id.* at 48.

[53] *See* Marilyn Price & Donna M. Norris, *National Instant Criminal Background Check Improvement Act: Implications for Persons with Mental Illness*, 36 J. AM. ACAD. PSYCHIATRY & L.

the NICS Improvement Amendments Act of 2007.[54] By making federal funds available to the states for participation and threatening loss of funds granted under the Omnibus Crime Control and Safe Streets Act of 1968 for failure to participate adequately, Congress aimed to encourage states' reporting to NICS.[55] However, because of severe limitations in states' ability to collect and report relevant records, the Department of Justice "has not administered [the Act's] reward and penalty provisions."[56] As of April 2014, thirty-six states had passed laws authorizing or requiring the submission of mental health records to NICS.[57] An additional seven states authorize or require the collection of mental health records in in-state databases only.[58]

Unfortunately, the passage of the NICS Improvement Amendments Act has been followed by further tragedies. The Fort Hood shootings occurred on November 5, 2009, leaving thirteen persons killed and thirty-two injured.[59] The Tucson shootings occurred on January 8, 2011, leaving six persons killed and thirteen wounded.[60] The Aurora shootings occurred on July 20, 2012, with twelve persons killed and fifty-eight others injured.[61] The Tucson shooter and the Aurora suspect have both been reported as having psychiatric illnesses.[62]

During the time of these tragedies, Connecticut responded to a provision in the NICS Improvement Amendments Act that induced states to create a system for providing relief from the federal firearms prohibition, i.e., a "firearms disability" program.[63] After a legislative

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123, 125 (2008) ("The new centerpiece of federal legislation affecting the purchase of firearms by persons with a history of mental illness . . . was introduced after the Virginia Tech tragedy . . . .").

[54] *See* Pub. L. No. 110-180, § 2, 121 Stat. 2559, 2560 (2008) (acknowledging that the Virginia Tech tragedy renewed the need for a more robust background check system).

[55] *Id*. § 104, 121 Stat. at 2569.

[56] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-684, GUN CONTROL: SHARING PROMISING PRACTICES AND ASSESSING INCENTIVES COULD BETTER POSITION JUSTICE TO ASSIST STATES IN PROVIDING RECORDS FOR BACKGROUND CHECKS 24 (2012).

[57] *Mental Health Reporting Policy Summary*, L. CENTER TO PREVENT GUN VIOLENCE, http://smartgunlaws.org/mental-health-reporting-policy-summary/ (last visited Apr. 15, 2014).

[58] *Id*.

[59] Billy Kenber, *Nidal Hasan Sentenced to Death for Fort Hood Shooting Rampage*, WASH. POST, (Aug. 28, 2013), http://www.washingtonpost.com/world/national-security/nidal-hasan-sentenced-to-death-for-fort-hood-shooting-rampage/2013/08/28/aad28de2-0ffa-11e3-bdf6-e4fc677d94a1_story.html.

[60] Alan R. Felthous, *The Involuntary Medication of Jared Loughner and Pretrial Jail Detainees in Nonmedical Correctional Facilities*, 40 J. AM. ACAD. PSYCHIATRY & L. 98, 98 (2012).

[61] Dan Frosch & Kirk Johnson, *Gunman Kills 12 at Colorado Theater; Scores Are Wounded, Reviving Debate*, N.Y. TIMES, July 21, 2012, at A1.

[62] *See* Felthous, *supra* note 60, at 98–99 (describing the Tucson shooter's psychiatric illness); Brady Dennis et al., *Suspect in Shooting Was Seeing Psychiatrist*, WASH. POST, July 28, 2012, at A1 (stating that the Aurora shooter was seeing a University of Colorado psychiatrist who studies schizophrenia).

[63] *See* Pub. L. No. 110-180, § 103(c), 121 Stat. 2559, 2568 (2008) (making a state's eligibility for certain grant monies contingent upon certification that it has established a firearms disability program).

attempt to comply with this requirement failed in 2010,[64] the Connecticut General Assembly adopted Public Act 11-134 on July 8, 2011.[65] This created a process whereby a person prohibited from firearms possession under 18 U.S.C. §§ 922(d)(4) and 922(g)(4) based upon an adjudication in Connecticut can petition the probate court for relief from the federal firearms disability.[66] The applicant bears the burden of proving by clear and convincing evidence that he or she "is not likely to act in a manner that is dangerous to public safety, and . . . granting relief from the federal firearms disability is not contrary to the public interest."[67] The applicant must make criminal, medical, mental health, and other records available to the court.[68] As of this writing, a relief hearing as created in Public Act 11-134 has not occurred.[69]

IV. THE SANDY HOOK TRAGEDY AND PUBLIC ACT 13-3

It is a still-painful memory that on December 14, 2012, a twenty-year-old gunman took the lives of twenty young school children and six teachers at the Sandy Hook Elementary School, as well as his mother, before killing himself.[70] The final report of the State's Attorney, released on November 25, 2013, states:

> [T]he shooter had significant mental health issues that affected his ability to live a normal life and to interact with others, even those to whom he should have been close. As an adult he did not recognize or help himself deal with those issues. What contribution this made to the shootings, if any, is unknown as those mental health professionals who saw

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This inducement was only linked to providing relief from federal firearms prohibitions; the NICS Improvement Amendments Act did not similarly induce states to create a relief mechanism for their own prohibiting statutes. *See id*. § 105, 121 Stat. at 2569–70 (outlining the requirements of a qualifying firearms disability program, which is only identified as one that serves persons affected by 18 U.S.C. §§ 922(d)(4), (g)(4)).

[64] S.B. No. 458, 2010 Gen. Assemb., Reg. Sess. (Conn. 2010).

[65] Act of July 8, 2011, No. 11-134, 2011 Conn. Acts 1670 (Reg. Sess.) (codified as amended at CONN. GEN. STAT. § 45a-100 (2013)).

[66] CONN. GEN. STAT. § 45a-100(a). Connecticut's system only provides relief in connection with the federal firearms prohibitions under 18 U.S.C. §§ 922(d)(4) and 922(g)(4), and does not extend to state mental health prohibitions articulated in section 29-28 of the Connecticut General Statutes. *Id*.

[67] *Id*.

[68] *Id*.

[69] This information is available to one of the authors in connection with his participation in an interagency work group.

[70] STEPHEN J. SEDENSKY III, OFFICE OF THE STATE'S ATT'Y, JUDICIAL DISTRICT OF DANBURY, REPORT OF THE STATE'S ATTORNEY FOR THE JUDICIAL DISTRICT OF DANBURY ON THE SHOOTINGS AT SANDY HOOK ELEMENTARY SCHOOL AND 36 YOGANANDA STREET, NEWTOWN, CONNECTICUT ON DECEMBER 14, 2012, at 1–2 (2013) [hereinafter SANDY HOOK REPORT], *available at* http://www.ct.gov/csao/lib/csao/Sandy_Hook_Final_Report.pdf.

> him did not see anything that would have predicted his future behavior. He had a familiarity with and access to firearms and ammunition and an obsession with mass murders, in particular the April 1999 shootings at Columbine High School in Colorado. Investigators however, have not discovered any evidence that the shooter voiced or gave any indication to others that he intended to commit such a crime himself.[71]

The Connecticut General Assembly's sweeping response to the Sandy Hook tragedy took form in Public Act 13-3, which was approved on April 4, 2013, more than seven months before the final report was available.[72] There are three sections of the Act that are particularly relevant to the purposes of this Article. Section 8 raised the state prohibition on permits and gun possession from twelve to sixty months following an individual's release from civil commitment.[73] Given that the federal prohibitions under NICS are indefinite, this change would only be relevant in the event that a person who was civilly committed is able to successfully gain relief through the probate court from the federal firearms prohibition.[74] At that point, then, the new state prohibition of sixty months would remain in effect.

The most significant change for persons with mental illness is found in sections 10 and 11 of the Act, which create a firearms prohibition of six months from the date of a voluntary psychiatric admission.[75] This is an interesting development under state law in that no due process procedures exist in relation to voluntary admission, yet this clinical process deprives an individual of Second Amendment rights via state prohibition, without involvement of NICS reporting.[76] As was the case with civil commitment

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[71] *Id*. at 3.

[72] Act of April 4, 2013, No. 13-3, 2013 Conn. Acts 27 (Reg. Sess.).

[73] § 8, 2013 Conn. Acts at 54–55 (codified as amended at CONN. GEN. STAT. § 29-28(b) (Supp. 2014).

[74] *See* 28 C.F.R. § 25.9(a) (2013) (noting that NICS will indefinitely retain "records that indicate that receipt of a firearm by the individual to whom the records pertain would violate Federal or state law . . . unless they are cancelled by the originating agency"); *see also* 18 U.S.C. § 922(d)(4), (g)(4) (2012) (prohibiting individuals who have been "committed to any mental institution" from buying, transporting, or possessing a firearm); CONN. GEN. STAT. § 45a-100 (allowing individuals to petition for relief from a federal firearms disability and noting that successful petitions will result in the cancellation of the individual's record in NICS).

[75] §§ 10–11, 2013 Conn. Acts at 55–57 (codified as amended at CONN. GEN. STAT. § 29-28(b)).

[76] In 2012, the U.S. Court of Appeals for the First Circuit noted in dicta that such temporary prohibitions might be constitutionally permissible. United States v. Rehlander, 666 F.3d 45, 49–50 (1st Cir. 2012) ("Congress might well be able to impose a temporary ban on firearms possession . . . if procedures existed for later restoring gun rights."). Given that the state prohibition for voluntary psychiatric hospitalization expires automatically in six months, without the need for further procedures, the requirements proposed in *Rehlander* may well be satisfied.

prohibitions in 1999, there was no mechanism in place to effectuate this new prohibition, as there was no database of voluntary admissions in the state. As a result, DMHAS and DESPP created the Voluntary Admission Tracking System ("VATS"), an entirely new data system with similar "black box" protocols to the system created for civil commitments.[77] Private psychiatric hospitals can now upload data about new voluntary admissions to this confidential database that has an automated matching process with the DESPP database of permits and eligibility certificates. That system became operational on October 1, 2013.

As of December 2, 2013, thirty of the states' thirty-two hospitals with psychiatric admission units had reported data to VATS, covering a total of 2619 admissions. Of those admissions, seventy-three matched with individuals holding active permits or possessing guns (an occurrence rate of 2.8%). None of the matched individuals were in the DMHAS system.

Anecdotal reports from the hospitals have focused on two different concerns. The first is for people like armed security guards and law enforcement officers who would be unable to work for at least six months following a voluntary admission, with the potential for more long-lasting consequences. Some of these patients may be advised to seek hospitalization in neighboring states in order to receive appropriate psychiatric care without jeopardizing their livelihoods—an undesirable response to the dilemma. The other concern has been related to individuals who are well-known and do not want the fact of their hospitalization to be released to anyone outside of the hospital to which they have turned for help.

V. CRITICAL LESSONS

A. *Gun Seizure Data Do Not Support Psychiatric Diagnoses as a Risk Factor for Gun Violence*

Fourteen years of implemented gun seizure legislation in Connecticut provide empirical results that indicate several important patterns and critical lessons:

- The risk from firearms was not significantly related to mental disease diagnoses. Nearly 80% of those who had a firearm confiscated had no history of diagnosed mental illness and less than 1% were in treatment at the time of confiscation.
- The profile that emerges from Connecticut's experience is

[77] The description of VATS is based on the personal experience of one of the authors. The data in the following paragraph is available to him in connection with his official duties at DMHAS.

> that of people in crises. The triggers varied across the ages but represented common life struggles—relationship breakups, health problems, death in the family, and financial burdens. Family members and friends recognized the crises and the risk. Most often, the risk was of suicide and self-harm.
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> - The majority of persons subject to gun seizure due to an "imminent risk" required further evaluation at a hospital.
> - The most common profile is that of men from a town rather than a city, thirty to sixty years of age, facing a variety of stressors. Although that represents the majority, both genders and all ages—including those over ninety years of age—were represented.

So what can we learn from the data? Collectively, the results indicate that the risk factors are the circumstances—not the person and not a diagnosis. As circumstances converge and coping strategies and supports are overwhelmed, the risk for self-harm increases; a person's function, thought processes, judgment, and problem-solving are affected. The decline in function does not necessarily mean that a person is mentally ill or that the persons meet diagnostic criteria for a mental illness. A decline in function does, however, mean that in the presence of a potentially dangerous device, risk in general increases. For example, when someone is upset, they likely do not drive a car as carefully as they would under normal circumstances.

Although persons with diagnoses of depression and other mental disorders may be at increased risk for violence, including suicide,[78] when such persons are treated their risk for violence to others[79] and themselves

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[78] *See* Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 764–65 (1990) (finding that 10–13% of respondents with major mental disorders reported violence in the previous year, compared to 2% of respondents with no disorder).

[79] *See* Olav Nielssen et al., *Homicide of Strangers by People with a Psychotic Illness*, 37 SCHIZOPHRENIA BULL. 572, 577 (2011) (finding that stranger homicide by psychotic persons is extremely rare and is even rarer among patients receiving pharmacological treatment); *see also* AM. PSYCHIATRIC ASS'N, RESOURCE DOCUMENT ON ACCESS TO FIREARMS BY PEOPLE WITH MENTAL ILLNESS (2009), *available at* http://www.psych.org/File%20Library/Learn/Archives/rd2009_Firearms.pdf (noting the research literature supporting the finding that individuals with mental illness who are in regular treatment are much less likely to commit violent acts); Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 400 (1998) (finding that among mentally ill patients who were not using substances, violence in the year after hospitalization was not statistically significantly higher than for the community sample without mental illness or substance abuse).

decreases.[80] In fact, following treatment such persons pose a risk of violence that is no greater than that of the general population.[81] Further, among treated individuals mental health status is a poor predictor of violence by comparison to other non-mental-health factors.[82] Connection with treatment provides therapy and medication, but also—and importantly—a safety net and monitoring not available to many persons without mental illness who fall on hard times.

There is another consideration. In the presence of decreased function, heightened negative emotion, helplessness, and despair, and in the presence of crises, the availability of guns does impact the immediacy and severity of risk. The means available for self-harm or for harm to others are a relevant factor in determining the severity and probability of harm. Guns are in the class of lethal means. Like jumping from a tall building or hanging, guns deprive an individual of the opportunity to reverse the harm done from an impulsive act. With lethal means, the opportunity for intervention by others and the effects of reconsideration, ambivalence, and second thoughts are greatly diminished. A law or policy that removes guns during periods of crises has the potential to reduce the severity and immediacy of risk.

The results of the gun seizure law have relevance to policy development and legislation. As evident in these data, the public used the available access to help. People recognized the risk and the need for intervention over seven hundred times.[83] Police across the state used the statute and policy to intervene legally and safely.[84] The results suggest that laws and policies that increase access to resources and solutions during

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[80] *See* Olav B. Nielssen & Matthew M. Large, *Untreated Psychotic Illness in the Survivors of Violent Suicide Attempts*, 3 EARLY INTERVENTION IN PSYCHIATRY 116, 121 (2009) (finding an "odds ratio of about 20 to one toward an increased risk of violent suicide in first episode psychosis when compared to the annual risk after treatment").

[81] *See* Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 290 (1992) (explaining that if a patient is not having a psychotic episode, or his or her problems do not include psychotic symptoms, "then he or she is no more likely than the average person to be involved in violent/illegal behavior"); Steadman et al., *supra* note 79, at 400 (explaining that "public fears of violence on the street by discharged patients who are strangers to them is misdirected").

[82] *See* Link et al., *supra* note 81, at 290 (asserting that "the excess risk of violence posed by mental patients is modest compared to the effects of other factors"); Dale E. McNeil et al., *Utility of Decision Support Tools for Assessing Acute Risk of Violence*, 71 J. CONSULTING & CLINICAL PSYCHOL. 945, 949 (2003) (suggesting that clinical factors are only predictive of violent behavior during periods of acute illness, and that other factors explain violence after periods of treatment and recovery); Michael A. Norko & Madelon V. Baranoski, *The State of Contemporary Risk Assessment Research*, 50 CAN. J. PSYCHIATRY 18, 21 (2005) (describing violence as being "significantly correlated with various socio-demographic and environmental factors, while the contribution of mental illness is relatively small"); Swanson et al., *supra* note 78, at 764 (reporting that 16% of eighteen- to twenty-four-year-old males of the lowest socioeconomic status group reported violence in the previous year).

[83] *See supra* text accompanying note 42.

[84] *See supra* Part II.B.

crises and times of increased risk can work to reduce violence. It is impossible to tell how much violence was averted and how many deaths and injuries the legislation has prevented. We cannot prove for any individual case that the law made a difference—i.e., the individual, despite a risky situation, might not have committed a violent act with firearms. The gun seizure law was not employed in the Sandy Hook shootings; the Sandy Hook Final Report does not indicate that anyone noted the increased risk and notified authorities before the event began.[85] We do know, however, that when the seizure law was implemented, the risk of violence was reduced by removing lethal means of violence and, in most cases, bringing the individual for professional evaluation.

B. *Low Rates of Permit Matches for Mental Health Factors Indicate Minimal Effectiveness of Prohibiting Laws*

As noted above, the rate of matches between the DESPP database of permits and individuals previously subjected to civil commitment is exceedingly low at 0.015%.[86] A somewhat higher, but still low, matching rate of 2.8% was found in the first two months of voluntary admission data across the state.[87] This latter number may change as more data are gathered over a longer period of time. Also very low is the rate of denials of Connecticut gun permit applications based on mental health adjudications reported to NICS (approximately 0.09%).[88] The national rate of denials based on mental health adjudications in NICS records as of March 2010 was 0.7%.[89]

These figures are consistent with data about the rates of serious violence committed by individuals with psychosis recently reported in a meta-analysis of seven research studies from Western countries.[90] Stranger homicides by offenders with psychosis were identified as extremely rare—one in 14.3 million is victimized per year.[91] If the rate of schizophrenia in the population is considered to be 1% (which is the measured rate in the United States),[92] the risk of people with schizophrenia committing a stranger homicide is estimated to be about one in 140,000 patients per

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[85] *See* SANDY HOOK REPORT, *supra* note 70, at 9–10, 32–35 (describing the details of the incident with no mention of increased risk or notification to officials).

[86] *See supra* note p. 1615.

[87] *See supra* note p. 1624.

[88] *See supra* p. 1620.

[89] Paul S. Appelbaum & Jeffrey W. Swanson, *Gun Laws and Mental Illness: How Sensible Are the Current Restrictions?*, 61 PSYCHIATRIC SERVICES 652, 653 (2010).

[90] Nielssen et al., *supra* note 79, at 575.

[91] *Id*.

[92] *See Schizophrenia*, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml (last visited Mar. 3, 2014) (noting that about one percent of Americans suffer from schizophrenia).

year.[93] Notably, 64% of the homicide offenders had never been treated with antipsychotic medications before, often despite years of symptoms and dysfunction.[94] Only 12% of the homicide offenders were in active treatment—a differential of treated and not-treated groups similar to the results of our gun seizure data noted above.[95] There were no studies available for the meta-analysis from the United States, where the rate of homicide in general and the rate of psychosis might be higher than the countries that were studied. Still, as one researcher has noted, these data tell us that for every person with schizophrenia who demonstrates risk factors identified in the meta-analysis and who commits a stranger homicide, there are tens of thousands with the same risk profile who will not.[96]

Studies in the United States and Sweden demonstrate that about 5% of all violence is attributable to persons with mental illness, most of which is not committed with guns.[97] While the NRA has supported efforts to target people with mental illness in gun control efforts,[98] there is little evidence to support the effectiveness of such prohibitions in controlling gun violence.[99] The available data indicate the impossibility of differentiating between individuals with mental illness who might become perpetrators of gun violence and the vast majority of such individuals who will not be violent.[100]

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[93] Nielssen et al., *supra* note 79, at 575.

[94] *Id*. at 576.

[95] *Id*.; *see supra* Part II.C.

[96] Jeffrey W. Swanson, *Explaining Rare Acts of Violence: The Limits of Evidence from Population Research*, 62 PSYCHIATRIC SERVICES 1369, 1371 (2011).

[97] Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, *in* VIOLENCE AND MENTAL DISORDER 101, 118 (Henry J. Steadman & John Monahan eds., 1994); Appelbaum & Swanson, *supra* note 89, at 653; Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 AM. J. PSYCHIATRY 1397, 1399 (2006).

[98] *See* Marilyn Price & Donna M. Norris, *National Instant Criminal Background Check Improvement Act: Implications for Persons with Mental Illness*, 36 J. AM. ACAD. PSYCHIATRY & L. 123, 127 (2008) (noting the NRA's support in passing the NICS Improvement Amendments Act).

[99] *See, e.g.*, Jeffrey W. Swanson et al., *Preventing Gun Violence Involving People with Serious Mental Illness*, *in* REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 33, 36–37 (Daniel W. Webster & Jon S. Vernick eds., 2013) ("[T]here is no evidence to suggest that merely filling the NICS with more records of people with gun disqualifying mental health histories would have any measurable impact on reducing firearm violence . . . ."); Liza H. Gold, *Gun Violence: Psychiatry, Risk Assessment, and Social Policy*, 41 J. AM. ACAD. PSYCHIATRY & L. 337, 340 (2013) ("[T]here is little evidence of any kind to suggest that gun restriction policies for the seriously mentally ill actually prevent the small subgroup of dangerous individuals with mental illness from committing acts of violence."); Emma Elizabeth McGinty et al., *Gun Policy and Serious Mental Illness: Priorities for Future Research and Policy*, 65 PSYCHIATRIC SERVICES 50, 53 (2014) (discussing the lack of evidence and consensus among experts of the effectiveness of gun restrictions policies on the mentally ill).

[100] *See* Nielssen et al., *supra* note 79, at 577–78 ("[T]he extreme rarity of stranger homicides among untreated patients who are in contact with health services and by previously treated patients

VII. CONCLUSION

A. *Future Directions*

The initial evaluations of the gun seizure data indicate the need for further research. Follow-up of ED evaluations after gun seizures and of the outcomes of the hearings are critical to understanding the full effect of the law. The experience with prohibitions based on voluntary admissions is too short at the time of this writing to make any predictions about the law's potential effects; continued monitoring of these data is warranted.

The low rates of gun permit and sale denials based on mental health adjudication reports in NICS do not inspire confidence that these processes will lead to decreased violent crime among people with mental illness.[101] Moreover, a recent study of more than 23,000 persons with serious mental illness in Connecticut found that since NICS reporting began, 96% of the crimes committed by this group were not committed by persons who had a NICS-qualifying mental health adjudication in their history.[102]

Beyond specific legislation, we also need to explore other avenues for public access to mental health and supportive interventions. For example, providing "special interventions in ordinary places" is an approach in early stages of consideration. Public places, schools, churches, libraries, and other gathering places are points at which information on risk factors, signs of distress, and how to access help can be disseminated without stigma. Efforts to de-stigmatize psychiatric conditions and their treatment are underway by the National Alliance on Mental Illness (NAMI) and other organizations.[103] Evaluation of the effectiveness of such efforts has not been conducted. The Affordable Care Act and centralized care centers can be vehicles for reaching persons who would benefit from psychiatric and mental health interventions during critical times. Incorporation of new technologies can also benefit the dissemination of services. All of these innovations are risk management strategies targeting the impairment and suffering of persons in crises without unfairly associating people with

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means that identification of individual patients who might kill a stranger is not possible."); Swanson, *supra* note 96, at 1370 ("For every homicide perpetrator with schizophrenia who fits the profile of risk factors, there are tens of thousands of people with the same risk factors who will never commit a homicide.").

[101] *See* Appelbaum & Swanson, *supra* note 89, at 653 (noting that by December 2006, records citing "mental defect" constituted only 0.4% of all NICS denials).

[102] Swanson et al., *supra* note 99, at 35, 48.

[103] *See, e.g.*, *Fight Stigma*, NAMI, http://www.nami.org/template.cfm?section=fight_stigma (last visited Apr. 15, 2014), (promoting "StigmaBusters," an advocacy group that "seek[s] to fight inaccurate and hurtful representations of mental illness"); *National Anti Stigma Campaign Launched*, NAMI (Dec. 4, 2006), http://www.nami.org/Template.cfm?Section=top_story&template=/ContentManagement/ContentDisplay.cfm&ContentID=52424 (describing NAMI's partnership with the federal government to produce "a sustained national PSA campaign to reduce stigma and encourage support of people with mental illnesses").

mental illness with violence.

B. *The Danger of Stigma*

The consequences of stigmatizing psychiatric disorders have been well described for those with these diagnoses and their families. Stigma creates a barrier to access to treatment.[104] The labels are hurtful and demeaning and reduce a person to a diagnosis.

Less described are the counter-productive results that stigma and labels create. An approach that creates a simple explanation for violence and identifies a group to blame for tragic and unpredictable acts is appealing. It is also wrong. The data do not, in general, support a predictable link between mental illness and serious violence. The effort to use mental illness to predict mass killings with firearms is useless due to the infrequency of such incidents (despite the trauma they cause and the attention they garner).[105] Therefore, targeting persons diagnosed with mental illness as a means of reducing gun violence will be futile.

Such thinking is also dangerous to the safety of the public. Assuming that a diagnosis appropriately and accurately identifies the risky person could lead to mistreatment of those with psychiatric diagnoses and also misdirect our attention to and appreciation for risk. In our gun seizure data, "labeled" people were not the ones who presented risks with firearms.[106] Risks came from ordinary people in problem circumstances.

To maximize the safety of the public and to prevent gun violence, our attention must focus on signs that people are struggling and are in distress. With or without a diagnosis, the presence of mental distress, social isolation, pain, suffering, and decreased function and problem solving ability is evidence that people need help. By helping such people with available and effective services, we will reduce risk and avert violence.

There is a further risk to stigma and labeling. After a tragic, violent event, and in the wake of the extraordinary suffering experienced by families and communities, the perpetrator is often described in highly charged language. Yet, condemnation of the perpetrator—without further examination of the person's life—is an inadequate approach to prevention of future tragedies. When the actor is labeled as evil, we miss the opportunity to explore the trajectory that ended in the violence. Even more troubling is that the label prevents other families from accessing help for a

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[104] S. Clement et al., *What Is the Impact of Mental Health Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies*, PSYCHOL. MED., Feb. 26, 2014, at 1, 7.

[105] *See* Swanson, *supra* note 96, at 1369 (noting that mass shootings are extremely rare, and mental health researchers do not possess epidemiological data or risk assessment instruments to reliably predict such events).

[106] *See supra* Part VI (noting that nearly 80% of gun seizures were from people with no history of mental illness or treatment and less than 1% were in treatment at the time of the firearm confiscation).

troubled loved one; such labeling decreases the chances of early detection and intervention. Those individuals behind recent violent attacks had past histories marked by isolation and distress, not criminal activity. Appreciating the acts of violence as acts of desperation is not an expression of charity; rather, it is a utilitarian analysis that can lead to strategies for intervention and prevention.

Such interest and exploration are not as easy as labeling and blaming, but will be more effective. We know that such an approach works because our country faced a similar crisis in the past. When AIDS and its transmission were first identified, some commentators called for the overt labeling—even tattooing—of persons diagnosed with the disease.[107] The idea was that the public would know who carried the disease and protect themselves from them. With further thought, we recognized that only universal precautions would help treat everyone with the same caution and care. The universal precaution with violence is this: crises and conflict are often overwhelming; when people need help, it is risky to all of us not to provide it.

Connecticut's gun seizure law is a good example of the application of applying universal precautions and universal access. The law allows families and the public to access intervention when the risk of harm increases. The law provides immediate but temporary relief during crisis without relying on diagnosis. At the same time it provides due process and preserves Second Amendment rights.

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[107] *See* William F. Buckley, Jr., *Crucial Steps in Combating the AIDS Epidemic: Identify All the Carriers*, N.Y. TIMES, Mar. 18, 1986, at A27 ("Everyone detected with AIDS should be tattooed in the upper forearm and on the buttocks . . . .").