TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

House Select Committee on Mass Violence Prevention and Community Safety
Testimony by Joseph V. Penn, MD, CCHP, FAPA
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Good morning, Chairman Darby and committee members. My name is Dr. Joseph Penn, and I am here today representing the Texas Society of Psychiatric Physicians (TSPP). I appreciate the opportunity to speak to you today about the intersection of mass violence and mental health. Before I begin my testimony, let me share a little background about myself. I'm triple board certified in child and adolescent, general, and forensic psychiatry. I'm a clinical professor of psychiatry at The University of Texas Medical Branch (UTMB) at Galveston, and I'm also the mental health director for UTMB Correctional Managed Care. We provide medical, dental, and specialty care, including psychiatric and mental health care, for offender patients in the Texas Department of Criminal Justice.

[Disclaimer: My professional recommendations concerning guns are reflective of my professional association and not my position or employer, UTMB].

No. 1: Mental health is not a predictor – and not the major factor – in mass violence. If "we" take the approach or make assumptions that mental health issues are a leading factor, we only continue to stigmatize mental health.

Since it is difficult to imagine that a mentally healthy person would deliberately kill multiple individuals, it is commonly assumed that all perpetrators of mass violence must be mentally ill. And when mental illness becomes the etiology or accepted putative reason for mass violence, the conclusion follows that restricting the liberty of people with mental illnesses — even removing them from the community — or preventing them from owning guns is the solution.

The stereotype of an individual with a severe and persistent mental disorder such as schizophrenia, where schizophrenia is the sole factor contributing to mass violence, is unfounded. At the same time, studies suggest that perpetrators of mass violence, specifically, are more likely to suffer from mental illness (whether it has been diagnosed or not) and usually are receiving no or inadequate treatment.

The National Institute of Mental Health's Epidemiologic Catchment Area surveys found that the population's attributable risk of any violent behavior associated with serious mental illness (i.e., a Diagnostic and Statistical Manual of Mental Disorders [DSM] diagnosis of schizophrenia spectrum disorder, bipolar disorder, or major depression) alone is about 4%. This means that if we could eliminate the elevated risk of violence attributable directly to having schizophrenia, bipolar disorder, or major depression, the overall rate of violence in society would go down by only 4%; 96% of violent events would still occur because they are caused by factors other than mental illness. These other factors linked to violence include being young and male, living in poverty, having a history of childhood abuse, being exposed to abuse and violence in the social environment, having a history of antisocial behavior beginning in childhood or adolescence, and becoming involved with the criminal justice system. Substance use disorders account for 34% of the risk of committing violence towards others. They can exacerbate the effects of certain kinds of psychiatric symptoms, like excessive threat perception, and expose people to toxic social factors. **Overall, the best predictor of future violence is past violence.**

In a study of the pre-attack behaviors of 63 active shooters,[i] the FBI found that 16 (25%) had a confirmed diagnosis of mental illness, including mood disorder, anxiety, psychosis, personality disorder, and autism. The researchers were unable to determine a psychiatric history for 37% of their sample but concluded that "declarations that all active shooters must simply be mentally ill are misleading and unhelpful." In part, this is because if efforts at reducing mass violence are focused only on people with mental illness, they may miss those who are acutely distressed and perhaps more likely to commit violence. Many of those who are acutely distressed could be helped with mental health services.

Of the individuals who kill three or more people, it appears that about 60% have evidence of some sort of unspecified psychological distress, even if they do not meet formal DSM diagnostic criteria.[ii] Corner and Gill,[iii] and Gruenewald, Chermak, and Freilich[iv] found that mass casualty offenders/lone actor terrorists are significantly more likely to have a mental disorder than group actors. Thirty-two percent of lone actors have evidence of mental illness, compared with 3% of group actors. The greater the isolation of the individual in terms of co-offenders/social network, the greater the likelihood of mental illness. While individuals diagnosed with mental illness account for only 4% of all violent crime in the United States, a higher portion of perpetrators of mass homicides are mentally ill in comparison with perpetrators of other types of violence.[v]

According to a number of studies,[vi] in any given year, just 4% to 7% of people with mental illness alone were violent, and their risk of being violent accounts for only 4% to 5% of the total violence in the population. In contrast, those with only substance use are violent at a much higher rate – greater than 26%. This is because violence is much more prevalent among alcohol and drug users (as high as 20%) and because there are many more people with substance use problems in the community than there are with major mental illness only. Even those with dual diagnoses (mental illness and substance use) have relatively low attributable risks for violence (5% to 7%).

Blaming mental illness only serves to further stigmatize patients who have mental health issues as inherently dangerous. And it deflects attention from a real predictor of mass shootings: easy access

to guns. [Disclaimer: My professional recommendations concerning guns are reflective of my professional associations and not my position or employer, UTMB].

According to the American Psychiatric Association, "It is important to note that the overwhelming majority of people with mental illness are not violent and are far more likely to be *victims* of violent crime than *perpetrators* of violence".[vii] "Rhetoric that argues otherwise will further stigmatize and interfere with people accessing needed treatment." Patients with psychiatric disorders actually account for a quarter of crime victims in any given year.[viii] And although mental illness has been shown to play a role in more mass shootings than other forms of large-scale homicides, the attributable risk of violence remains low, at just 4%.[ix]

Factors like antisocial personality traits or other behavioral patterns are more closely tied to criminal recidivism than mental illness, according to a National Council on Behavioral Health report.[v]

Specifically, most prior shooters have experienced childhood trauma and had a crisis in the weeks predating the shootings, according to The Violence Project,[x] an ongoing database cataloguing more than 100 mass shootings over the past 20 years. Bullying victimhood is often cited as a feature of many shooter' pasts.

No. 2: There is no one-size-fits-all assessment tool we can mass-generate to help identify the next individual(s) who will commit mass violence.

During my time at Brown University/Medical School when I routinely consulted for the Rhode Island Family Court, I was often asked to give testimony and comment on a "profile" of a school shooter or who might be a perpetrator of mass violence. Unfortunately, there is no current "profile," or reliable test/diagnostic process to readily determine such an individual. Certainly, if an individual verbalizes a threat of harm to self or others or both, this should be considered an emergency, and this individual should be referred immediately for an emergency/priority mental health evaluation by a qualified mental health professional and detained if clinically warranted/indicated under applicable Texas mental health laws.

Often, individuals who are angry or disaffected may need referrals to mental health treatment. Frequently, there are "markers" or building blocks that build upon one another, that take place over time, and that suggest a person may be predisposed towards violence. Sometimes these people have a manifest antipathy towards certain circumstances (like the Odessa and Sutherland Springs shooters) or an obsession with a particular culture (such as the shooters in El Paso and Charleston, S.C.).

FBI special agent Katherine Schweit was appointed to represent her agency on a presidential panel aimed at curbing gun violence. She also co-authored a detailed FBI study[xi] of 160 active shooter incidents in the U.S. According to her, the FBI is "not looking for somebody who's got mental health problems, and we're not looking for somebody who's a loner. We're looking for atypical behavior. When someone is moving on this trajectory towards violence, they often have a

grievance that's real or perceived. They feel shunned by a boss or spouse or spurned by someone they're interested in, and they begin to get more obsessive about it."

"What people can also watch for is the person planning, preparing. Purchasing weapons, ammunition, clothing, ballistics vests. If they're someone who shoots with a gun – which is very common – are they shooting more than they usually do? Are they buying additional weapons that they normally wouldn't? Are they talking about violence? Are they showing you violent videos? Are they talking about other shootings to you or to somebody else? Are they stopping medications they're taking? Have they changed their behavior or their appearance? Have they given away their personal belongings?"

"These behaviors are the kind that need to be reported, and they need to be reported right away."

No. 3: Workforce: There is a critical need for a well-trained psychiatric and other physician and mental health professional workforce. Texas has a priority need for more forensic psychiatrists.

TSPP is exploring the proposed expansion and funding of additional fellowship programs and positions to help build up this particular sector of the psychiatry/physician community. TSPP, through TMA, submitted to the Texas Health and Human Services Commission a request for additional funding for fellowships to be included in the agency's Legislative Appropriations Request. Workforce issues also expand into continuing medical education in the physician and mental health professional community on violence risk assessment, management and reporting requirements, and professional ethics.

Privacy/confidentiality/sharing of information between agencies and health care facilities is something to be further worked out and typically an obstacle.

No. 4: Psychotropic medications do not cause individual or mass violence.

It is true that the use of psychiatric medications in this country has increased significantly since the 1980s. Between 1987 and 1996, the use of psychostimulants such as Ritalin increased nearly four-fold, and the use of antidepressants by adolescents aged 15 to 18 increased more than four-fold. Similarly, there was a 75% increase in the use of antidepressants from 1996 to 2005.[xii]

There is no question that the use of psychiatric medications has grown substantially in the past 25 years. The problem with the argument blaming psychotropic medications for murder, however, is that though there has been a significant increase in the use of psychiatric medications, there has not been a corresponding increase in violence. In fact, just the opposite has occurred. Violent crime has decreased dramatically.

The violent crime rate declined 47% from 1991 through 2010. The homicide rate across all ages decreased 51% from 1991 through 2010. Most strikingly, youths between the ages 10 and 24, the population that includes the children and adolescents who had four-fold increases in particular

psychiatric medications, had a 40% decrease in the male homicide rate and a 51% decrease in the female homicide rate.

Thus, the dramatic increase in psychiatric medications coincided with a dramatic decrease in homicide and other violent crimes. Perhaps the medications resulted in decreased violence; perhaps there is no connection between the medications and decreased violence. Either way, the claim of epidemic violence as a result of the increased use of psychiatric medications simply is not supported by the data.

How many school shooters were on psychiatric medications – or coming off them – at the time of their attacks? Out of 24 secondary school shooters, only two were taking medication at the time of their attacks, and one had stopped taking his medications prior to the attack. So, 12.5% of the sample was taking medications. Put differently, more than 87% of the secondary school shooters were not on psychiatric medications at the time of their attacks.

The numbers are essentially the same for the college and adult shooters. Of the 24 in these two groups (13 college and 11 adult), two were taking psychiatric medications at the time of their attacks, and another only recently stopped taking his medication. Thus, 12.5% of the college and adult shooters were on medication at the time of their attacks. There is no evidence that psychiatric medications made them manic, agitated, or violent.

Taken all together, only six out of 48 shooters (12.5%) were on medication at the time of their attacks. Even if we were to accept that psychiatric drugs caused these attacks, this still leaves more than 87% of the incidents unaccounted for. The overwhelming majority of school shooters were not medicated or going through withdrawal at the time of their attacks. The belief that psychiatric medications cause school shootings is not supported at either the societal or the individual level.

With regard to possible adverse effects of the psychostimulants on brain development, while the issue has not be studied exhaustively, the analysis to date suggests that the medication does not inhibit normal brain development, even after terminating treatment. For example, one study found that prior psychostimulant treatment in children with attention deficit-hyperactivity disorder (ADHD) was associated with greater brain volumes relative to those of children with ADHD who were untreated.[xiii] In fact, volumes in the medication-treated group were also closer to the range of those in typically developing children, suggesting a neuroprotective effect by psychostimulants. In another study, a group of patients who were treated with psychostimulants was compared with similar patients who were not.[xiv] The findings showed no evidence that psychostimulants were associated with slowing of overall brain growth.

Meanwhile, the benefits of treatment seem undeniable. Use of psychostimulants to treat ADHD is not associated with future substance use and may in fact have a protective effect against substance use. One study of more than 2.9 million health care claims from 2005 to 2014 found that relative to periods off medication, male patients had 35% lower odds of substance-related events, while female patients had 31% lower odds.[xv]

Additionally, stimulants have not been associated with acts of violence when taken at therapeutic doses used to treat ADHD. One study indicates that when adults with ADHD are on medication,

males have a 32% lower crime rates relative to when they are off medication, and among women, crime rates decline by 41%.[xvi]

Research has indicated that while on medication, drivers with ADHD have fewer accidents relative to when they are off medication – a 38% lower rate for men while on medication, and a 45% lower rate for women.[xvii] Further, another study supports the conclusion that this class of medication reduces suicidality – as high as a 59% suicide attempt risk reduction among ADHD youths prescribed between 90 and 180 days, and a 72% risk reduction in those prescribed for more than 180 days.[xviii]

No. 5: Downstream issues – impact on communities as a whole. Following a mass shooting, there is a ripple effect with mental health sequalae. This can impact first responders, law enforcement, bystanders, victims, and their families. Following a mass shooting, people may develop acute stress or subsequent post-traumatic stress disorder, which is a set of symptoms that can result from experiencing, witnessing, or participating in an overwhelmingly traumatic (frightening) event.

No. 6: Recommendations

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Several studies (see summary) link prevalence of firearms to homicide and suicide rates.

Specific research on gun violence by the Consortium on Risk-Based Firearm Policy,[xix] which includes some of the nation's leading researchers into gun violence and mental health, has led to specific recommendations the state might consider. These include:

1. Strengthen state law to temporarily restrict individuals from purchasing or possessing firearms after involuntary hospitalization, coupled with clarifying and improving the process for restoring firearms rights. The removal of weapons should be predicated on a clinical finding of danger to self or others, and restoration of rights should be based on an evaluation by a qualified clinician that the petitioner is unlikely to relapse.

2. Consider restrictions on the ability to purchase or possess firearms that reflect evidence-based risk of dangers. These include conviction of violent misdemeanors, two or more DWIs in a period of five years, or two or more convictions of crimes involving a controlled substance within a five-year period.

TSPP supports the following recommendations by the consortium:

3. Develop a mechanism to authorize law enforcement personnel to remove firearms when they identify someone who poses an immediate threat of harm, as well as a means to request a warrant for gun removal when the threat of harm is credible but not imminent. Lastly, family members and partners should have a means to petition the court to authorize removal of firearms, based on a credible risk of physical harm to self or others. Any such mechanisms

should include due process protections for affected individuals, including the opportunity to participate in a hearing after gun removal and to ensure processes are in place to return all removed guns at the conclusion of the temporary prohibition.

4. Clarify Texas law on disclosing patient information for safety. We need to ensure the ability of professionals such as physicians to disclose confidential patient information to medical or law enforcement personnel if the professional determines there is a probability of imminent physical injury by the patient to the patient or others or if there is a probability of immediate mental or emotional injury to the patient. I know last session a bill was filed related to this; however, it did not pass (House Bill 3519).

Again, thank you for allowing me to be here today. I am available to the committee if you have any questions or need additional information. I am happy to take any questions.

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