

Knowledge and Attitudes of Psychiatrists About the Gun Rights of Persons With Mental Illness

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Individuals with mental illness have often been misperceived by the public to pose a higher risk of violence to others. Consequently, the United States government and many individual states have enacted laws barring firearm access for certain individuals with mental illness. Many of these laws allow for eventual restoration of firearm access (i.e., relief from firearm disability (RFD)). This study assesses the knowledge base and attitudes of psychiatrists practicing in South Carolina regarding these gun laws. Results of this study indicate that psychiatrists in South Carolina have significant knowledge deficits pertaining to gun laws that both restrict gun ownership and allow restoration of gun ownership rights for persons with mental illness; these deficits may apply to practitioners in other states as well. The only variable that predicted a greater knowledge about limitations on gun rights was whether a psychiatrist had a patient who was prohibited from gun ownership. South Carolina psychiatrists had more favorable attitudes about restricting gun access for persons with mental illness than about supporting the right of persons with mental illness to own a gun. Finally, if psychiatrists owned a firearm, they were more likely to support the right of persons with mental illness to own a firearm.

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Individuals with mental illness have often been perceived by the public to pose a higher risk of violence

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to themselves and to others. The link between mental illness and suicide is well established; as many as 90 to 95 percent of those who die from suicide have a diagnosable psychiatric disorder at the time of death.¹ Additionally, suicide accounts for approximately 65 percent of deaths due to firearms.² Individuals with serious mental illness, however, account for only three to five percent of all violent incidents against others in the United States, and only a small fraction of these incidents involve firearms.² An analysis of data from the MacArthur Violence Risk Assessment Study found that approximately two percent of individuals discharged from a psychiatric hospital committed a violent act involving a gun in the first year after discharge.^{3,4} In reality, most people who commit firearm-related violence do not have a significant mental illness. Despite these data, the common misconception that mental illness is

a major driver of gun violence against others presents significant obstacles to the discussion of effective interventions to address firearm-related violence against others in our society.

The federal government and many states have enacted laws barring firearm access for certain individuals with mental illness, i.e., persons who have been judicially committed for treatment, found not competent to stand trial, found not guilty by reason of insanity, or found guilty but mentally ill.⁵⁻¹¹ In 1993, Congress passed the Brady Handgun Violence Prevention Act, which established, among other items, the National Instant Criminal Background Check System (NICS).^{6,12} The NICS consists of three databases maintained by the Federal Bureau of Investigation (FBI) to which federal agencies are required to submit, and states may voluntarily submit, information about individuals who should be denied firearms ownership for various reasons.^{6,12,13} Because participation was voluntary and there were no repercussions for not participating, many states did not submit information to the NICS between 1993 and 2007.

In response to the mass shooting tragedy at Virginia Tech in April 2007, Congress passed the NICS Improvement Amendments Act (NIAA) of 2007.^{6,14} The goal of this Act was to increase state participation in complying with the NICS. It also included provisions requiring the establishment of federal and state programs to allow individuals to seek restoration of their gun rights if they were restricted for reasons of mental illness (i.e., relief from firearm disability (RFD)).⁶ As of September 2019, 33 states have federally approved RFD programs, including South Carolina.^{6,15}

In South Carolina, a person who is prohibited from possessing a firearm as a result of being “adjudicated as a mental defective” or “committed to a mental institution” may petition the court to remove this prohibition upon expiration of “any current [South Carolina] commitment order.”^{16,17}

‘Adjudicated as a mental defective’ means a determination by a court of competent jurisdiction that a person, as a result of marked subnormal intelligence, mental illness, mental incompetency, mental condition, or mental disease: (a) is a danger to himself or to others; or (b) lacks the mental capacity to contract or manage the person’s own affairs. The term includes: (a) a finding of insanity by a court in a criminal case; and (b) those persons found incompetent to stand trial or found not guilty by reason of lack of mental responsibility pursuant to Articles 50a and 72b of the Uniform Code of Military Justice, 10 U.S.C. Sections 850(a) and 876(b). . . .

‘Committed to a mental institution’ means a formal commitment of a person to a mental institution by a court of competent jurisdiction. The term includes a commitment to a mental institution involuntarily, and a commitment to a mental institution for mental defectiveness, mental illness, and other reasons, such as drug use. The term does not include a person in a mental institution for observation or a voluntary admission to a mental institution. . . .

‘Mental institution’ includes mental health facilities, mental hospitals, sanitariums, psychiatric facilities, and other facilities that provide diagnoses by licensed professionals of mental retardation or mental illness, including a psychiatric ward in a general hospital.¹⁸

Based on these definitions, it is unclear whether court-mandated treatment at a local mental health center (i.e., outpatient commitment) would apply.

The petitioner requesting RFD is required to sign releases of information for the court to acquire the petitioner’s current and past medical records, including mental health records. Unless the court grants an extension upon the petitioner’s request, a closed hearing is held within 90 days. (The petitioner may request that the hearing be open to the public.) The court is required to consider the following:

- a) the circumstances regarding the firearm prohibition imposed by 18 USC §922(g)(4) and S.C. Code Ann. §23-21-1040; b) the petitioner’s criminal history and mental health records as well as other information the court deems relevant; c) evidence of the petitioner’s reputation developed through character witness statements, testimony, etc.; and d) a current evaluation presented by the petitioner conducted by the South Carolina Department of Mental Health or a physician licensed in South Carolina specializing in mental health addressing whether the petitioner poses a threat to the safety of the public or himself/herself due to “mental defectiveness or mental illness.”¹⁶

The court shall remove the firearm prohibition if the petitioner proves by a preponderance of the evidence that:

- a) the petitioner is no longer required to participate in court-ordered psychiatric treatment; b) the petitioner is determined by the South Carolina Department of Mental Health or by a physician licensed in South Carolina specializing in mental health to not likely act in a manner dangerous to public safety; and c) granting the petitioner relief will not be contrary to the public interest.”¹⁶

If denied relief, the petitioner can appeal to the court for *de novo* review.

There is no standard for conducting gun-restoration evaluations in South Carolina; in fact, there are no generally accepted standards for conducting such evaluations in the United States. In one survey of physicians concerning evaluation of competency to carry a concealed weapon, respondents had disparate

views on competency and little confidence in their decisions.¹⁹ Studies to date have not examined psychiatrists' knowledge about gun rights for persons with mental illness, although there have been a few studies that have examined psychiatrists' attitudes regarding gun rights for persons with mental illness. One such study, which specifically examined the perceptions of psychiatry residency training directors about gun ownership among persons with mental illness, revealed that approximately 24 percent of program directors believed access to firearms should not be prohibited for individuals with serious mental illness.²⁰

This study was designed to assess the knowledge base and attitudes that psychiatrists practicing in South Carolina have about gun laws that apply to persons with mental illness, as well as RFD for those individuals whose gun rights have been suspended. We believe this study is important because if psychiatrists are not knowledgeable about gun laws, they may be ill-equipped to engage in RFD evaluations. Additionally, because laws restricting gun ownership to certain groups of people (including certain persons with mental illness) can be politically and culturally charged subjects, it is important to see how psychiatrists as a profession feel about this topic. Finally, the American Psychiatric Association has suggested that psychiatrists' personal feelings about guns could impair their ability to perform an objective RFD assessment.²¹

Methods

This research project was granted exemption from the institutional review board (IRB) approval by the South Carolina Department of Mental Health IRB and the Palmetto Health Alliance (now Prisma Health) IRB, institutions that have academic affiliations with the University of South Carolina School of Medicine. Anonymous surveys designed to address the specific objectives of the study were mailed to a total of 613 psychiatrists, all of the psychiatrists on the South Carolina Board of Medical Examiners psychiatry mailing list. Surveys were mailed over a one-week period in April 2018 and were collected until July 1, 2018. Thirty-four of these surveys were marked as "return to sender" due to an incorrect mailing address. Of the remaining 579 surveys, there was a 33.2 percent return rate (i.e., 192 of the 579 psychiatrists who received the survey). Two of the surveys were returned after the end date for data

Table 1 Demographics

Male	92 (50.0)
Board-certified	161 (86.1)
Currently in training	19 (10.2)
Currently practicing	176 (94.6)
Have a concealed weapons permit	18 (9.6)
Own a firearm	54 (29.0)
Patient suicide by firearm	85 (45.7)
Patient violence by firearm	93 (50.3)
Patient prohibited from owning firearm	123 (68.7)
Length of practice, y	
<5	30 (16.0)
<10	25 (13.4)
<20	45 (24.1)
>20	87 (46.5)
Age, y	
<35	27 (14.4)
<45	48 (25.7)
<55	32 (17.1)
<65	39 (20.9)
≥65	41 (21.9)

Data are presented as n (%).

collection for this study had passed and therefore were not analyzed in the results, leaving 190 surveys for data analysis. The survey questions can be found in the Appendix.

There were five multiple choice items that measured knowledge about laws restricting and restoring gun access among persons with mental illness; these items were scored as correct or incorrect. One question asked respondents if they have conducted an evaluation to restore gun ownership and, if not, to check the reason or reasons. There were 15 items that assessed psychiatrists' attitudes about persons with mental illness owning guns (e.g., persons with history of suicidal ideation, substance use disorders, active symptoms of psychosis, etc.) using a Likert scale. One item measured psychiatrists' attitudes about the need for special training prior to conducting evaluations to restore gun rights in persons with mental illness. The survey also collected demographic information such as gender, years of practice, ownership of guns, etc.

Results

Demographics

Table 1 displays the demographic characteristics of the psychiatrists who took part in this survey. There was an equal distribution between male and female psychiatrists. One hundred seventy-six (94.6%) of the psychiatrists were actively practicing,

Table 2 Respondents' Answers to the Five Knowledge Questions and the Question About Conducting an Evaluation to Restore Gun Rights

Question	Answer Selection						Did Not Answer	% Correct
	A	B	C	D	E	B&C		
1	1	6	117*	25	39	1	1	61.6
2	59	67*	30	24			10	35.3
3	0	8	155*	24			3	81.6
4	18	56	18	90*			8	47.4
5	93	2	6	82*			7	43.2
6	9	179					2	NA

Question 6 only had a "yes" (A) or "no" (B) choice and the response was neither correct nor incorrect.

* Indicates the correct answer.

NA = not applicable

with the majority of respondents practicing for 20 years or less. Eighteen (9.6%) of the psychiatrists had a concealed weapons permit, and 54 (29.0%) of the psychiatrists owned a firearm. Eighty-five psychiatrists (45.7%) had treated a patient who eventually died from suicide by a firearm, and 93 (50.3%) had a patient commit an act of violence with a firearm. One hundred twenty-three psychiatrists (68.7%) had a patient who was prohibited from owning a firearm.

Psychiatrists' Knowledge about Gun Rights

Table 2 shows how respondents answered each of the five knowledge questions (Questions 1 through 5), including the percentage answering each question correctly, and the question about conducting an evaluation to restore gun rights (Question 6). Seventy-three (38.4%) of the respondents were not aware that civil commitment by a probate judge for inpatient mental health treatment was the single most likely event that results in loss of the right to obtain a concealed weapons permit or to possess a gun legally. Only 67 (35.2%) of respondents knew that only a psychiatrist or a physician specializing in mental health can conduct a mental health evaluation for gun rights restoration. Ninety (47.3%) of the respondents knew that no time frame existed for when persons with mental illness could petition the court to have their gun rights restored after losing those rights; 82 (43.1%) of the respondents knew that there is no standard for conducting gun-restoration evaluations in South Carolina. A majority of the respondents (155, or 81.6%) were aware that gun-restoration evaluations must inquire about risk to self and others. The only variable that predicted a greater knowledge about limitations on gun rights was if a psychiatrist had a patient who was prohibited from gun ownership ($P = .017$).

Figure 1 displays the number of the knowledge questions answered correctly. Out of a total of five knowledge questions, the mean (standard deviation) number of correctly answered items was 2.7 (1.1). Approximately three percent of the respondents did not answer a single question correctly, while nearly four percent answered all of the questions correctly. More than 50 percent of respondents answered three of the knowledge questions incorrectly (Questions 2, 4, and 5).

The model used to investigate the predictors of the number of correctly answered knowledge items was prespecified (i.e., a prespecified set of predictors was regressed against the number of correctly answered knowledge items). Initially, Poisson regression was performed; however, this regression model showed under-dispersion, so generalized Poisson regression and linear regression were performed. Linear regression revealed that the only statistically significant predictor of correct responses was whether the respondent ever had a patient who was prohibited from gun ownership ($P = .017$). Respondents who had a prohibited patient correctly answered, on average, a half question more than those who had never had a patient prohibited from gun ownership. A generalized Poisson model with the same predictors yielded similar results ($P = .006$).

Reasons for Not Participating

Only nine (4.7%) of the respondents reported conducting an evaluation to restore gun ownership rights for persons with mental illness (Question 6 in Table 2). Psychiatrists could give more than one reason for not conducting this evaluation. The vast majority of respondents (86.3%) indicated that they were never asked to conduct an evaluation (see Table 3).

Psychiatrists and Gun Rights of Persons With Mental Illness

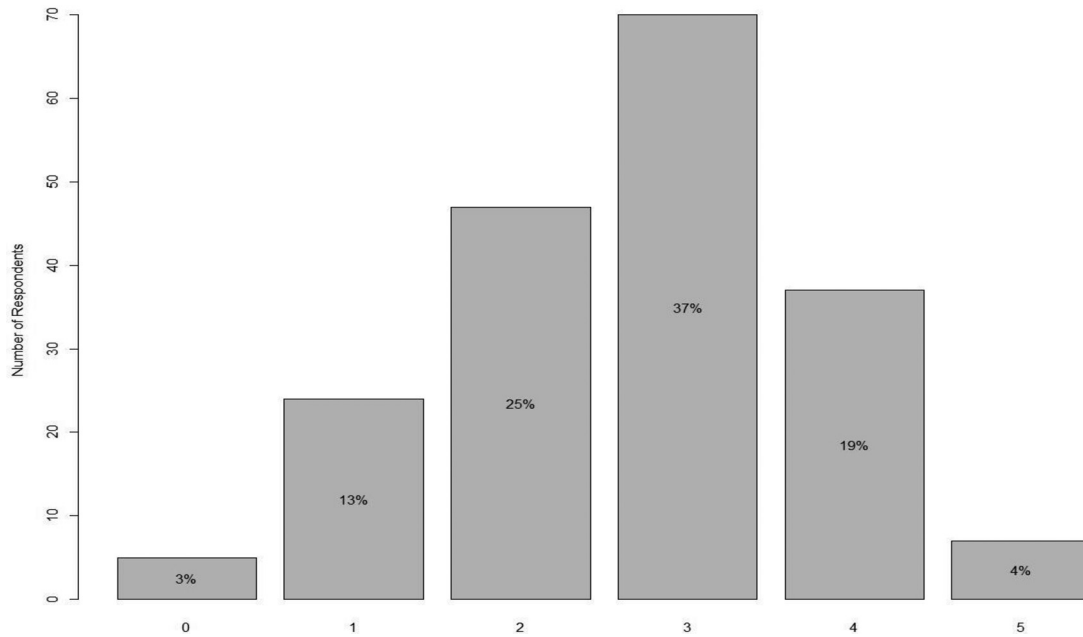


Figure 1. Number of knowledge questions answered correctly.

Table 3 Reasons for Not Participating in the Gun-Restoration Process

Never asked	86.3%
Lack of knowledge about the process	33.7%
Concerns about liability	22.6%
Lack of time to perform evaluations	9.5%

Note: Respondents had the option to select more than one answer.

Psychiatrists' Attitudes

Among the 15 attitude questions, higher Likert Scale scores indicated a favorable attitude toward restricting persons with mental illness from gun ownership, whereas lower scores indicated a favorable attitude toward allowing persons with mental illness to own guns. Table 4 presents all of the responses to the 15 attitude questions as well as responses to the question regarding the need for special training prior to conducting gun-restoration evaluations.

The mean (standard deviation) response score for all 15 items for the entire group of respondents was 3.31 (0.66). One hundred twenty-nine (67.9%) of the respondents believed that restrictions on persons with mental illness possessing a firearm should not be terminated after a specific time frame. One hundred thirty-seven (72.1%) of the respondents believed that persons with mental illness should be reevaluated at certain intervals after their gun rights have been restored to determine if they can still safely

possess a firearm. Sixty-seven (35.3%) of the respondents believed that a patient with a history of suicidal ideation that did not involve a firearm should not have access to a firearm, whereas 137 (72.1%) of the respondents believed that a patient with a history of suicidal ideation that did involve a firearm should not have access to a firearm. One hundred seventy-one (90.0%) of the respondents believed that a patient with a history of homicidal ideation and a history of violence should not have access to a firearm, whereas 100 (52.6%) of the respondents believed that a patient with a history of homicidal ideation without a history of violence should not have access to a firearm. Almost 95 percent of the respondents believed that special training should be involved prior to conducting evaluations to restore gun rights in persons with mental illness. Using a linear regression model, the only statistically significant demographic predictor was that psychiatrists who own a gun are more likely to look more favorably upon persons with mental illness possessing a gun ($P = .032$).

South Carolina psychiatrists had more favorable attitudes toward restricting gun access for persons with mental illness rather than supporting the right of persons with mental illness to own a gun. One hundred twenty-nine (67.9%) of the respondents believed that restrictions on persons with mental illness possessing a firearm should not be terminated

Table 4 Psychiatrists' Views on Gun Ownership by Persons With Mental Illness

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
Restrictions on persons with mental illness from possessing a firearm should be terminated after a specific time frame.	54 (28.4)	75 (39.5)	26 (13.7)	25 (13.2)	8 (4.2)	2 (1.1)
A person with mental illness should be reevaluated at certain intervals after their gun rights have been restored to determine if they can still safely possess a firearm.	10 (5.3)	26 (13.7)	16 (8.4)	67 (35.3)	70 (36.8)	1 (0.5)
A patient with a history of suicidal ideation that DID NOT involve a firearm should NOT have access to a firearm.	23 (12.1)	63 (33.2)	34 (17.9)	41 (21.6)	26 (13.7)	3 (1.6)
A patient with a history of suicidal ideation that DID involve a firearm should NOT have access to a firearm.	7 (3.7)	24 (12.6)	19 (10.0)	59 (31.1)	78 (41.1)	3 (1.6)
A patient with a history of antisocial personality disorder should NOT have access to a firearm.	9 (4.7)	42 (22.1)	40 (21.1)	46 (24.2)	51 (26.8)	2 (1.1)
A patient with a history of homicidal ideation with a history of violence should NOT have access to a firearm.	1 (0.5)	4 (2.1)	12 (6.3)	56 (29.5)	115 (60.5)	2 (1.1)
A patient with a history of homicidal ideation WITHOUT a history of violence should NOT have access to a firearm.	7 (3.7)	37 (19.5)	44 (23.2)	60 (31.6)	40 (21.1)	2 (1.1)
A patient with active psychotic symptoms (hallucinations and/or delusions and/or disorganized thinking) should NOT have access to a firearm.	0 (0.0)	7 (3.7)	11 (5.8)	58 (30.5)	112 (58.9)	2 (1.1)
A patient with a successfully treated psychotic disorder (e.g., schizophrenia) should NOT have access to a firearm.	15 (7.9)	69 (36.3)	46 (24.2)	39 (20.5)	19 (10.0)	2 (1.1)
A patient with a history of recurrent depression should NOT have access to a firearm.	23 (12.1)	80 (42.1)	44 (23.2)	27 (14.2)	12 (6.3)	4 (2.1)
A patient with a history of a single episode of major depression that is currently in remission should NOT have access to a firearm.	52 (27.4)	99 (52.1)	25 (13.1)	5 (2.6)	6 (3.2)	3 (1.6)
A patient with successfully treated bipolar I disorder should NOT have access to a firearm.	33 (17.4)	91 (47.9)	41 (21.6)	10 (5.2)	11 (5.8)	4 (2.1)
A psychiatrist who believes their patient should NOT have a concealed weapon permit should report that concern to South Carolina Law Enforcement Division (SLED).	11 (5.8)	12 (6.3)	31 (16.3)	80 (42.1)	53 (27.9)	3 (1.6)
A patient with a current substance use disorder should NOT have access to a firearm.	11 (5.8)	46 (24.2)	51 (26.8)	46 (24.2)	33 (17.4)	3 (1.6)
A patient with a substance use disorder that is in sustained remission should NOT have access to a firearm.	37 (19.5)	97 (51.1)	41 (21.6)	7 (3.7)	4 (2.1)	4 (2.1)
I believe there should be special training involved prior to conducting an evaluation to restore gun rights in persons with mental illness.	1 (0.5)	0 (0.0)	7 (3.7)	49 (25.8)	131 (68.9)	2 (1.1)

Data are presented as *n* (%).

after a specific time frame. One hundred thirty-seven (72.1%) of the respondents believed that a patient with a history of suicidal ideation involving a firearm should not have access to a firearm, and 171 (90.0%) of the respondents believed that a patient with a history of homicidal ideation with a history of violence should not have access to a firearm. A majority of the respondents (170, or 89.5%) believed that individuals with active symptoms of psychosis should not have access to a firearm; in addition, 58 (30.5%) respondents believed that individuals with a successfully treated psychotic disorder should not have access to firearms. One hundred fifty-one (79.5%) of

the respondents disagreed with restricting the gun rights of individuals with a single episode of major depression that is currently in remission. One hundred twenty-four (65.3%) respondents disagreed with restricting the gun rights of individuals with successfully treated bipolar I disorder. If psychiatrists owned a firearm, they were more likely to support the gun ownership rights of individuals with mental illness ($P = .032$).

As previously mentioned, 50.3 percent of the respondents reported that they had a patient who had committed an act of violence with a firearm. This high rate is likely due to the broad wording of the question: Have you had a patient commit an act

of violence with a firearm? The term “violence” was not narrowly defined, thus it was not limited to homicide or serious injury and could be interpreted as any act involving a firearm.

Discussion

Although state laws may mandate the involvement of a psychiatrist in the evaluation of a patient for the purpose of restoring gun rights, psychiatrists may be ill-prepared to do so. Currently, the Accreditation Council for Graduate Medical Education’s Program Requirements for Graduate Medical Education in Psychiatry and their Program Requirements for Graduate Medical Education in Forensic Psychiatry do not require training during general psychiatry residency or forensic psychiatry fellowship on gun laws as they relate to persons with mental illness (i.e., restricting and restoring access to firearms).^{22,23} Additionally, the education of practicing psychiatrists would likely require continuing medical education seminars and, perhaps, involvement of professional organizations (e.g., American Psychiatric Association, American Academy of Psychiatry and the Law, etc.) in the creation of resource documents or practice guidelines for conducting these types of assessments.

While principles of violence risk assessment should be utilized as an integral part of these evaluations, specific risk factors for mental illness and gun violence are less well known, largely because persons with mental illness who are not abusing substances are not a large contributor to the gun violence problem. This lack of clarity creates difficulties in developing an evidence-based RFD evaluation regarding gun violence risk. Many states also require consideration of harm to self as an element of RFD. Because suicide risk factors are well known, incorporating suicide risk assessment as a part of an RFD evaluation is less problematic.

The RFD process varies by state. Oregon has one of the most stringent evidentiary requirements.²⁴ The Oregon model requires the review of all mental health records pertaining to the mental health disqualification, all court records for the individual, and a National Crime Information Center (NCIC) history (including juvenile convictions).²⁵ Furthermore, the evaluation must be an “independent forensic mental health assessment” (Ref. 25, subpara (3)(d)) that cannot be performed by a current or former mental health provider, with the petitioner demonstrating by clear and convincing evidence that the petitioner does not pose a threat to the safety of the public or the

petitioner.^{25,26} Many states, including New York, do not require that the evaluator be independent of the treating psychiatrist.²⁷ Finally, not all states require a mental health evaluation outside of the record review.²⁸

From this study, a consensus regarding which clinical factors should limit access to firearms could not be determined. Many psychiatrists, in general, believe that RFD should never occur in persons who have had mental health disqualification from gun ownership. There was a tendency for respondents to restrict access in numerous clinical scenarios. Based on our data, these scenarios include gun ownership among persons with a history of suicidal ideation involving a gun, persons with a history of homicidal ideation and violence, and persons with active psychotic symptoms. For other clinical scenarios, especially successfully treated disorders, clinicians were in favor of restoring gun rights. These results may represent sampling bias as persons with strong views opposing or supporting gun ownership may have been more likely to complete the survey. Finally, the significant difference in attitudes between those psychiatrists who were gun owners and those who were not gun owners may lead to persons who are seeking RFD to gravitate to psychiatric evaluators who favor gun rights, assuming such reputations became known publicly.

Conclusions

Psychiatrists in South Carolina, and perhaps other states, have significant knowledge deficits pertaining to gun laws restricting and restoring gun ownership for persons with mental illness. In addition, they are potentially more concerned about protecting individuals and society from firearm violence by persons with mental illness than about supporting the right of persons with mental illness to own a gun. These results show that there is a need for further education regarding this topic during general psychiatry residency and forensic psychiatry fellowship training and with continuing medical education activities for practicing psychiatrists. Finally, professional organizations may want to consider the development of resource documents or practice guidelines to assist psychiatrists in conducting RFD evaluations.

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APPENDIX

KNOWLEDGE QUESTIONS ABOUT GUN RIGHTS AMONG PERSONS WITH MENTAL ILLNESS

(* = Correct Answer)

1. Which of the following persons is legally barred from purchasing a gun or getting a concealed weapons permit?
 - a. A person with a history of a suicide attempt
 - b. A person who has ever been detained on emergency psychiatric hospitalization papers
 - c. A person who has ever been committed to a mental hospital by a probate judge*
 - d. All of the above
 - e. None of the above

2. In order to have gun rights restored, an individual must undergo a mental evaluation with which of the following?
 - a. Any physician licensed in South Carolina
 - b. A psychiatrist or physician specializing in mental health treatment*
 - c. A psychiatrist or psychologist
 - d. A psychiatrist, psychologist, or a mental health social worker

3. What does an evaluation in South Carolina to restore gun rights consider?
 - a. Risk to self
 - b. Risk to others

- c. Risk to self and others*
 - d. Unsure
 4. When can someone in South Carolina petition to have their gun rights restored after losing their right to bear arms?
 - a. 6 months
 - b. 1 years
 - c. 5 years
 - d. No time frame exists*
 5. Where does the standard for gun restoration evaluations in South Carolina originate?
 - a. State legislative statute
 - b. State Medical Board
 - c. American Academy of Psychiatry and the Law
 - d. No standard exists*

Question regarding conducting an evaluation to restore gun ownership

6. Have you ever conducted an evaluation to restore gun ownership?
 - a. Yes
 - b. NoIf you answered *no*, please check the following factors that apply.
 - Not enough time due to other clinical duties
 - Lack of knowledge on the process
 - Liability concern
 - I have never been asked

Questions

For questions 7 to 22, participants were asked to respond along a continuum of Strongly Agree to Strongly Disagree

7. Restrictions on persons with mental possessing a firearm should be terminated after a specific time frame.
8. A person with mental illness should be reevaluated at certain intervals after their gun rights have been restored to determine if they can still safely possess a firearm.
9. A patient with a history of suicidal ideation that DID NOT involve a firearm should NOT have access to a firearm
10. A patient with a history of suicidal ideation that DID involve a firearm should NOT have access to a firearm.
11. A patient with history of antisocial personality disorder should NOT have access to a firearm.
12. A patient with history of homicidal ideation with a history of violence should NOT have access to a firearm.
13. A patient with history of homicidal ideation WITHOUT a history of violence should NOT have access to a firearm.
14. A patient with active psychotic symptoms (hallucinations and/or delusions and/or disorganized thinking) should NOT have access to a firearm.
15. A patient with a successfully treated psychotic disorder (e.g., schizophrenia) should NOT have access to a firearm.
16. A patient with a history of recurrent depression should NOT have access to a firearm.
17. A patient with a history of a single episode of major depression that is currently in remission should NOT have access to a firearm.
18. A patient with successfully treated bipolar I disorder should NOT have access to a firearm.
19. A psychiatrist who believes their patient should NOT have a concealed weapon permit should report that concern to South Carolina Law Enforcement Division (SLED).
20. A patient with a current substance use disorder should NOT have access to a firearm.
21. A patient with a substance use disorder that is in sustained remission should NOT have access to a firearm.
22. I believe there should be special training involved prior to conducting an evaluation to restore gun rights in persons with mental illness.

Please answer your demographic characteristics

- | | | |
|---|------|--------|
| 23. What is your gender? | Male | Female |
| 24. Are you currently board-certified? | Yes | No |
| 25. Are you currently in your psychiatry residency training or fellowship training? | Yes | No |
| 26. Are you currently practicing psychiatry? | Yes | No |

For questions 27 and 28, "Prefer not to answer" was another option

- | | | |
|--|---|----|
| 27. Do you have a concealed weapons permit? | Yes | No |
| 28. Do you own a firearm? | Yes | No |
| 29. Have you ever had a patient die from suicide by firearm? | Yes | No |
| 30. Have you had a patient commit an act of violence with a firearm? | Yes | No |
| 31. Have you ever had a patient who was prohibited from gun ownership? | Yes | No |
| 32. How long have you been practicing psychiatry (in years)? | (<5, <10, <20, >20) | |
| 33. What is the setting of your practice? | (Mental health center, Private practice, Academic setting, Public hospital, Private hospital) | |
| 34. Where did you do your psychiatric training? | (Northeast, Southeast, Midwest, Northwest, Southwest) | |
| 35. What is your age? | (<35, <45, <55, <65, ≥ 65) | |
| 36. In which county of the state is your primary practice? | | |