

April 2013

Grounded in Faith: Resources on Mental Health and Gun Violence

Prepared by the Interfaith Disability Advocacy Coalition (IDAC),
a program of the American Association of People with Disabilities (AAPD)



In January 2013, the Interfaith Disability Advocacy Coalition (IDAC) convened an Ongoing Dialogue Committee on mental health and gun violence. The following IDAC members participated in the drafting of this report for the benefit of the coalition and others interested in engaging these issues and concerns.

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April 2013

Dear Religious Leaders and Disability Advocates:

The mission of the Interfaith Disability Advocacy Coalition (IDAC) is to mobilize the religious community to take action on disability policy issues with Congress, the president and administration, and society at large. IDAC is a diverse, nonpartisan advocacy coalition of 32 national religious organizations, including representatives from the Christian, Jewish, Muslim, Hindu and Sikh traditions, whose core spiritual values affirm the rights and dignity of people with disabilities. IDAC is a program of the American Association of People with Disabilities (AAPD).

Although IDAC members come from many faith traditions, they are united by a common commitment to honor all people, especially children and adults with disabilities. That means treating all people with dignity and respect—especially people on the margins of society. That means seeing someone with a psychiatric disability as a person first—someone with a name, someone with dreams and goals, and someone who requires specific community services to achieve his or her potential and to contribute to the community. For IDAC, this means advocating for the services needed so that children and adults with long-term mental illness can live lives of meaning and hope.

In the wake of the horrific shootings in Newtown, Conn., there has been much discussion of the relationship between mental illness and violence, particularly mass violence. In an effort to respond to these concerns and to make a positive contribution to the conversation, IDAC formed a special committee in January that has been conducting an ongoing dialogue on issues of mental health and gun violence. IDAC's objective in issuing this report, which is the fruit of these discussions, is to aid its members and the larger faith community in their ongoing conversations about mental illness and violence.

“Grounded in Faith: Resources on Mental Health and Gun Violence” is more than a compendium of resources. It presents an opportunity for IDAC members and all religious organizations to become better informed and to take action consistent with our shared understanding of the inherent dignity and worth of men, women and children with mental illness. As people of faith we can do nothing less.

In hope and in sincerity,



Ginny Thornburgh, IDAC Convener
Director, AAPD Interfaith Initiative

Section One: Introduction to Grounded in Faith

Overview

“Grounded in Faith: Resources on Mental Health and Gun Violence” is a compendium of resources to be used by congregational leaders, disability advocates and other concerned persons who wish to ensure that the ongoing debate on gun control does not do great harm by stigmatizing people with mental illness or depriving them of their rights and freedoms. Immediately following this introduction are two sections prepared by the Interfaith Disability Advocacy Coalition (IDAC)—Section Two: Statistics and Perspectives on Mental Health and Gun Violence and Section Three: Positions and Policies of IDAC Members and Others on Mental Health Issues. The six appendices highlight the perspectives of experts and organizations in the field as well as summaries of legislative proposals and current state and federal laws.

The relationship of current discussions about mental illness and gun violence is of great concern to IDAC, which prepared this report. IDAC is a nonpartisan advocacy coalition of 32 national faith-based organizations, including representatives from the Christian, Jewish, Muslim, Hindu and Sikh traditions, whose core spiritual values affirm the rights and dignity of people with disabilities.

Why Are We Concerned?

In the wake of the horrific shootings in Newtown, as with other tragedies in Oak Creek, Aurora, Tucson and Blacksburg, there has been much discussion of the relationship between mental illness and violence, particularly mass violence. Our nation recoils in horror at these events. We also lament the toll of gun violence that takes the lives of 80 Americans each day and that tears at the fabric of families, congregations and communities across this great land.

We must find ways to prevent these tragedies from recurring. But, we must be careful not to overreact. We must avoid overly broad characterizations that stigmatize millions of Americans with mental illness by suggesting that they pose a threat of mass violence. Such characterizations may lead to demands for unwarranted limitations on the constitutional rights and freedoms of persons with mental illness, includ-

ing rights established under the *Olmstead* decision.¹ Equally important, these negative characterizations and the possible losses of rights and freedoms may discourage many from acknowledging their illness and seeking treatment.

Many IDAC members have recognized the hurtful danger of stigmatizing people with mental illness as referenced in statements, policies and study guides in Section Three. For example, in “Comfort My People: A Policy Statement on Serious Mental Illness with Study Guide,” the Presbyterian Church (U.S.A.) states: “Stigma takes the form of negative, inaccurate stereotypes, ostracism, and cruel, ignorant humor. Stigma prevents [mentally] ill persons from seeking treatment in a timely fashion. It diminishes public support for funding of necessary and appropriate services for the mentally ill. It prevents persons who are in recovery from finding meaningful and secure employment and acceptable housing.”²

We must also bear in mind that most violence is carried out by people who are not mentally ill. Moreover, we recognize that persons with mental illness and other disabilities are much more often the victims of violence than the perpetrators.

What Have We Learned?

In our research and discussions, we have tried to develop an understanding of available data and studies on the relationship between mental illness and violence. These issues affect large numbers of Americans; as many as 20 percent of our population now has some type of mental illness. Almost half of all Americans will experience symptoms of a mental health condition—mental illness and/or addiction—at some point in their lives.³

As previously stated, the consensus of experts is that most violence is not committed by people who are mentally ill and

¹ *Olmstead v. L.C. and E.W.* established that individuals with disabilities have a right to live in community rather than in institutions.

² “Comfort My People: A Policy Statement on Serious Mental Illness with Study Guide,” Advisory Committee on Social Witness Policy, Presbyterian Church (U.S.A.), 2008, p. 24.

³ See the testimony of Pamela S. Hyde, Administrator, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services beginning on page 8 in the section below, Summary of the Hearing of the Senate Committee on Health, Education, Labor, and Pensions on “Assessing the State of America’s Mental Health System,” Jan. 24, 2013.

that most mentally ill people are not violent. As will be referenced in Section Two, rigorous scientific studies on mental illness and violence demonstrate that demographic and socioeconomic factors are much more likely to contribute to violence than is mental illness. Of the 17,000 homicides committed in the United States each year, fewer than 5 percent involved mental illness.⁴ (Further information and links for the statistics in this report are found in the appendices.)

It is inappropriate and harmful to make characterizations that cover the broad range of mental illnesses. Most forms of mental illness do not present a threat of violence. For example, a recent analysis by the National Bureau of Economic Research shows that there is little evidence that adolescent depression influences the likelihood of engaging in violent crime.⁵

IDAC's discussions have focused on measures that can be taken to reduce the risk of violence in the relatively small number of cases in which untreated mental illness does create such risks. Even in these cases, we must be extremely careful. Experts have little ability to predict which individuals are likely to commit violent acts.⁶

The problems of violence are of particular concern to advocates for the disability community because persons with disabilities are much more often the victims of violence than the perpetrators. Additionally, far and away, the most common form of violence attributable to mental illness is violence against oneself, or suicide. There are about 38,000 suicides a year, 90 percent of which involve mental illness.⁷

What Can We Do?

There are many options for dealing with the problem of violence without stigmatizing people with mental illness or depriving them of their rights. Many of these options are included in recent gun control and mental health proposals by the administration and in Congress, and some are outlined in the attached appendices.

Proposals addressing mental health include the following:

- enhanced training of those who work with young people to detect signs of illness and ensure appropriate treatment;
- enhanced availability of mental health service providers and facilities, particularly those designed to provide treatment in a home or community setting, thereby enabling treated individuals to live independent lives;
- better implementation in laws requiring parity between insurance coverage of mental health and physical health; and
- improvements in treatment and rehabilitation of incarcerated men and women with mental illness.

Although IDAC members come from many faith traditions, they are united by a common commitment to honor all people, especially children and adults with disabilities. That means treating all people with dignity and respect—especially people on the margins of society. That means seeing someone with a psychiatric disability as a person first—someone with a name, someone with dreams and goals, and someone who requires specific community services to achieve his or her potential and to contribute to the community. For IDAC, this means advocating for the services needed so that children and adults with long-term mental illness can live lives of meaning and hope.

In addition to treating all people with dignity and respect, IDAC members are united in a common call to justice. If we, as a nation, are to move forward in addressing violence and its causes, we must do so with proper respect for the individual rights of all people, including those with mental illnesses.

“Grounded in Faith: Resources on Mental Health and Gun Violence” is more than a compendium of resources. It presents an opportunity for IDAC members and all religious organizations to become better informed and to take action consistent with our shared understanding of the inherent dignity and worth of men, women and children with mental illness and our concern for their welfare.

⁴Testimony of Dr. Thomas Insel, Director of National Institute of Mental Health, beginning on page 8 in the section below, Summary of the Hearing of the Senate Committee on Health, Education, Labor, and Pensions on “Assessing the State of America’s Mental Health System,” Jan. 24, 2013.

⁵National Bureau of Economic Research Working Paper 18656 by D. Mark Anderson, Resul Cesur and Erdal Tekin, “Youth Depression and Future Criminal Behavior.” A link to this paper is on page 4 below.

⁶See comments of Dr. John Monahan, Professor University of Virginia and other materials cited on page 4 below and testimony of Dr. Thomas Insel, cited in footnote 4 above.

⁷Testimony of Dr. Thomas Insel, cited in footnote 4 above.

Section Two: Statistics and Perspectives on Mental Health and Gun Violence

According to the Substance Abuse and Mental Health Services Administration, approximately 20 percent of American adults reported some form of mental illness in 2011, and 5 percent reported a serious mental illness. (See [Huffington Post](#).) The following are statistics and perspectives from mental health experts on the association between violence and mental health (emphasis in quotes is added).

Correlations (or Lack Thereof) between Violence and Mental Illness:

“According to the MacArthur Study of Mental Disorder and Violence—the most rigorous scientific study conducted to date by the country’s leading experts on mental illness and violence—the **contribution to violence made by persons with mental illness is no larger than the contribution made by persons who do not have a mental illness** [Monahan et al., 2001], with other demographic and socioeconomic factors contributing much more than mental illness. The subgroup most at risk for committing violent acts is actually young and single working-class white males. Within behavioral health, broadly, active substance use does contribute to violence. But within mental health, schizophrenia [the condition most alluded to by people who characterize ‘mentally ill’ as violent] contributes least to violence among the major illnesses.” (See article by Larry Davidson, Ph.D., Appendix Four of this document.)

Most mass shootings are caused by workplace or family conflicts not related to mental illness.

(Paul Appelbaum, Columbia University College of Physicians and Surgeons’ Division of Law, Ethics and Psychiatry). (See [Huffington Post](#).)

Dr. Appelbaum has further stated that, “The relationship between mental disorders and violence is complex. **Among the variables that have been identified as increasing the risk of violence...are socioeconomic status and even the neighborhoods in which persons with mental disorders reside.** No single approach to reducing the risk is likely to be completely effective. And given the relatively modest contribution to overall risk of violence by persons with mental disorders, the likelihood and magnitude of adverse effects from any

intervention must be carefully considered before it is embodied in law.” (See [Psychiatryonline](#).)

“The tendency in our society is to label what happened, pack it in a box and tuck it away somewhere. It’s our collective defense mechanism. More often than not, the conversations quickly and unfairly turn to disability. These conversations usually lack depth and understanding, and they do nothing more than promote inaccurate and unfair stereotypes. Some reports suggested that the Connecticut shooter had a form of autism. There is **no more of a correlation between autism and violence** than there is between playing the piano and violence” (Michelle Uzeta, legal director of the Disability Rights Legal Center in Los Angeles). (See [LA Times](#).)

A recent study by the National Bureau of Economic Research was summarized in the [Washington Post](#) as concluding: “We find little evidence that adolescent depression influences the likelihood of engaging in violent crime or the selling of illicit drugs.”

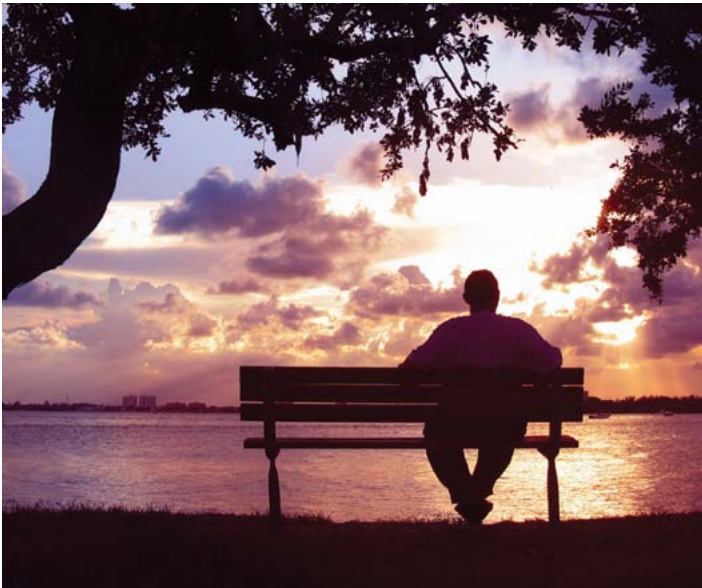
Predicting Violence in People with Mental Illness:

“Although mental-health professionals have become more skilled at predicting which patients may commit a violent act, the accuracy of such judgments is still ‘only slightly better than chance,’ said John Monahan, a professor at the University of Virginia whose work has focused on the science of violence prediction. Mental-health professionals who forecast violence are wrong two out of three times. [Imagine if another medical screening test was as poor—say, if mammograms showed false positives twice as often as real cancers.] Moreover, Monahan’s studies have involved violence such as simple battery—throwing a punch—not mass murder. “To predict something as rare as a mass shooting is like trying to find a very small needle in a very large haystack,” he says.” (See [National Journal](#).) “A [study of experienced psychiatrists](#) at a major urban psychiatric facility found that they were **wrong about which patients would become violent about 30 percent of the time.**” (See [NPR](#).)

Gun Violence and Suicide:

“The aggrieved advocates are right to call out this kind of broadside that sweeps up all kinds of people struggling with

mental illness who would never hurt another person. But the stigma fighters are missing something, too. The elephant in the room for a serious discussion of firearm injuries and mental illness is not homicide. It is suicide. When we bring suicide into the picture of gun violence, mental illness legitimately becomes a strong vector of concern; it should become an important component of effective policy to prevent firearm violence. **Suicides account for 61 percent of all firearm fatalities** in the U.S.—19,393 of the 31,672 gun deaths [recorded by the CDC in 2010](#). Suicide is the third leading cause of death in Americans aged 15 to 24, perhaps not coincidentally the age group when young people go off to college, join the military, and experience a first episode of major mental illness if it's bound to happen. The majority of suicide victims had identified mental health problems and a history of some treatment" (Jeffrey Swanson, Duke University School of Medicine). (See [Harvard Bill of Health blog](#).)



"To date, the only empirical evidence that gun restrictions on people with a history of mental illness might prevent firearm violence in the U.S. population comes from a national evaluation of the Brady Act [[Ludwig & Cook, 2000](#)]. That study found that **gun purchaser background checks and waiting periods had no significant effect on homicide rates, but did reduce the suicide rate by 6 percent in people over age 55**" (Jeffrey Swanson, Duke University School of Medicine). (See [Harvard Bill of Health blog](#).)

Addressing Mental Health Needs at an Early Stage:

In addition, Dr. Appelbaum has said, "It appears **risk for violence in psychotic illnesses is highest early in the course of illness**, frequently before people are identified as mentally ill and receive treatment" (Paul Appelbaum, Columbia University College of Physicians and Surgeons' Division of Law, Ethics and Psychiatry). (See [National Journal](#).)

"For years and years, we have had a shortage of child psychiatrists and people to work with the kids. We know that 20% of youth have mental illness that deserves treatment," reported Dr. Drell, who is also head of the Section on Infant, Child, and Adolescent Psychiatry at the Louisiana State University Health Science Center in New Orleans. He noted that "many of the mental health disturbances" that cause pain, economic problems, and family misery start by the age of 14 years; and 75% of these problems start by the age of 24 years. "**So child and adolescent psychiatrists need to be there from the beginning. It is our firm belief that if we do prevention and catch things early**, we might be able to alter the developmental course of these illnesses and not have disastrous results," said Dr. Drell. (See [Medscape](#).)

"Effective treatments are available, but sadly **there is an average delay of 8 to 10 years between the onset of symptoms and intervention**. The longer the lag time is between symptom onset and treatment, the more difficult and costly mental illness is to treat and the greater the burden becomes on our public health system" (The **American Academy of Child and Adolescent Psychiatry** [AACAP]). (Read specific policy recommendations at: http://www.aacap.org/galleries/default-file/AACAP_Letter_VicePresidentBiden.pdf.)

Alternative Program:

An alternative to Project AWARE (Advancing Wellness and Resilience in Education), a mental health first aid training for teachers, is Emotional CPR ([eCPR](#)). Developed by persons with lived experience of recovery who are members of the National Coalition for Mental Health Recovery, **eCPR is designed to teach anyone in the community to assist others through an emotional crisis**. This program is taught in layman's language, avoiding any mental health terms. In this manner it is very accessible, and not stigmatizing.

Cultural Factors Impacting Violent Behavior:

"In a sense, the easy part is creating reasonable gun control laws and more resources for helping those who are developing psychiatric problems. Those are good objectives, in themselves, and should be a part of life in a civilized society. But like the tree whose branches and trunk are easily visible, the rise of violence and killing in general has deeper, complex roots. And they're harder to see, understand, and deal with. They consist of some negative, destructive themes within our cultural attitudes about what we strive for in life. They're part of our shared values and norms of behavior towards others, which can be difficult to see.

- Looking for self-worth and pleasure primarily through material consumption.

- Viewing people as objects or commodities to extract things from for one’s personal gain.
- Disregarding the impact on others or the larger social good when one’s self-interest is primary—especially through pursuing money, power, position; or by equating ‘success’ in life with those pursuits.
- Absence of empathy and a general disconnect from others’ emotional needs and realities.
- Disconnection from one’s own inner life, and from our interdependency throughout this world” (Douglas LaBier, [Psychology Today](#)).

Specific Legislative Commentary from Mental Health Advocates:

“The American Psychological Association [APA] expressed strong support for key components of President Obama’s plan to protect American children and communities by reducing gun violence. APA singled out for praise the president’s specific proposals to:

- increase access to mental health services;
- identify and refer youth and young adults in need of mental health treatment;
- train more psychologists and other mental health professionals;
- end the freeze on gun violence research;
- require criminal background checks for all gun sales; and
- ensure that health insurance plans offer mental health benefits at parity.”

Read more at: <http://www.apa.org/news/press/releases/2013/01/gun-violence.aspx>.

There are already federal laws which prevent people with mental illness from obtaining firearms. (See [ATF](#)).

[SECTION 3 NEXT PAGE]

Section Three: Positions and Policies of IDAC Members and Others on Mental Health Issues

American Baptist Home Mission Societies

The American Baptist Home Mission Societies [Public Witness Statement on Gun Violence](#), adopted Jan. 23, 2013, includes a call for “greater societal attention to issues of mental health and illness.” The [American Baptist Resolution on Mental Illness](#) calls upon American Baptists to respond in a variety of ways to the needs of persons with mental health issues in our society.

American Muslim Health Professionals

[Muslim Mental Health Resource Guide](#) compiled by American Muslim Health Professionals (AMHP). See also AMHP’s [Community Blog](#) post commenting on mental health in the wake of the Newtown killings.



Mental Health Ministries

[Mental Health Ministries](#) produces educational resources to help erase the stigma of mental illness in faith communities and to help congregations become caring congregations for persons living with mental illness and their families. Mental Health Ministries [Spring 2013 e-Spotlight](#) highlights resources on trauma and trauma recovery.

National Catholic Partnership on Disability

[National Catholic Partnership on Disability](#) offers content related to mental illness, including a theological framework, catechetical resources, a listing of other resources, events, links and foundational documents and concepts in disability ministry. [National Catholic Network on Mental Illness](#) offers additional resources and a monthly e-newsletter.

Pathways to Promise

[Pathways to Promise](#) is an interfaith cooperative of many faith groups, providing assistance and serving as a resource center that offers liturgical and educational materials, program models, and caring ministry with people experiencing a mental illness and their families. The resources are used by people at all levels of faith group structures, from local congregations to regional and national staff. See especially the Rev. Dr. Craig Rennebohm’s *Souls in the Hands of a Tender God*. Rennebohm encourages faith communities and others to “companion” with individuals with mental illness, as he has done for many years with homeless people in Seattle.

Presbyterian Church (U.S.A.)

Approved at its 218th General Assembly (2008) the [Policy Statement on Serious Mental Illness](#) uses the biblical theme of exile to describe the challenges and injustices experienced by persons living with a serious mental illness. Also focuses on appropriate ways congregations can minister with and to people with a serious mental illness. Includes study guide.

Union for Reform Judaism

Union for Reform Judaism offers a [Resource Page](#) for mental health with a wealth of resources compiled. See especially [Caring for the Soul](#), a mental health resource and study guide. For resources on gun control, visit the [Religious Action Center](#) (RAC) of Reform Judaism. You will also find helpful [prayers and readings](#) on the RAC site. At its 66th General Assembly (2001), Union for Reform Judaism adopted a [Resolution on Establishing a Comprehensive System of Care for Persons with Mental Illness](#). Additional policy pertaining to mental health issues can be found [here](#).

United Church of Christ

Since 1992, the [Mental Illness Network](#) has responded to the need for families and others to communicate among themselves about their experiences as families and in congregations. The network collaborates with [Disabilities Ministries](#) on various projects such as (twice a year) an insert in the UC News.

Appendix One:

Summary of the Hearing of the Senate Committee on Health, Education, Labor, and Pensions on “Assessing the State of America’s Mental Health System,” Jan. 24, 2013

In answer to senators’ questions at the Jan. 24, 2013, hearing, Dr. Thomas Insel, director of the National Institute of Mental Health, made the following points on the relationship of mental health to violence:

- Mental illness affects one in five Americans.
- “Serious mental illness,” in which a person is truly disabled, often by a psychotic illness, affects perhaps one in 20 Americans.
- Mental illness often begins early in life.
- Mental illnesses are treatable. But for many young people with schizophrenia, there are delays of one to two years between the time of recognizable symptoms and the beginning of treatment. This is regrettable, since the best outcomes come from early detection and treatment.
- Most violence has nothing to do with mental illness, and most mentally ill people aren’t violent.
- Mental illness and violence do intersect in the case of psychotic illnesses, such as schizophrenia, which start in early adolescence. People with these diseases who are not treated are at risk for violence, either because they’re paranoid and feel they’re under attack, or because they hear voices or hallucinations telling them to do something horrific.
- The most common form of violence by those suffering from mental illness is violence against themselves. There are about 38,000 suicides a year, 90 percent of which involve mental illness. There are about 17,000 homicides a year, and less than 5 percent involved mental illness.
- We’re not good at predicting which mentally ill people will become violent. It’s more of an art than a science.
- When adolescents with psychoses are treated, the risks of violence are 15 fold lower than before treatment.
- Moving forward, the National Institute of Mental Health aims to support research on earlier diagnosis and quicker delivery of appropriate treatment, be it behavioral or psychological.

Quotes excerpted from the written Statement of Pamela S. Hyde, J.D. Administrator Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

Prevalence of Behavioral Health Conditions and Treatment

In the wake of the Newtown tragedy, it is important to note that behavioral health research and practice over the last 20 years reveal that most people who are violent do not have a mental disorder, and most people with a mental disorder are not violent.¹ Studies indicate that people with mental illnesses are more likely to be the victims of violent attacks than the general population.² In fact, demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness.³ These facts are important because misconceptions about mental illness can cause discrimination and unfairly hamper the recovery of the nearly 20 percent of all adult Americans who experience a mental illness each year.

It is estimated that almost half of all Americans will experience symptoms of a mental health condition—mental illness or addiction—at some point in their lives. Yet, today, less than one in five children and adolescents with diagnosable mental health problems receive the treatment they need.⁴ And according to data from SAMHSA’s National Survey on Drug Use and Health (NSDUH), only 38% of adults with diagnosable mental health problems—and only 11% of those with diagnosable substance use disorders—receive needed treatment.⁵

¹ Monahan, J., Steadman, H., Silver, E., et al: *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence*. New York, Oxford University Press, 2001 and Swanson, 1994.

² Appleby, L., Mortensen, P. B., Dunn, G., & Hiroeh, U. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study. *The Lancet*, 358, 2110-2112.

³ Elbogen, E.B., Johnson S.C. *Arch Gen Psychiatry*. 2009 Feb;66(2):152-61. doi: 10.1001/archgenpsychiatry.2008.537. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions.

⁴ Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status Sheryl H. Kataoka, M.D., M.S.H.S.; Lily Zhang, M.S.; Kenneth B. Wells, M.D., M.P.H., *Am J Psychiatry* 2002;159:1548-1555. 10.1176/appi.ajp.159.9.1548

⁵ Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

With respect to the onset of behavioral health conditions, half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.⁶ When persons with mental health conditions or substance use disorders do not receive the proper treatment and supportive services they need, crisis situations can arise affecting individuals, families, schools, and communities. We need to do more to identify mental health and substance abuse issues early and help individuals get the treatment they need before these crisis situations develop. And we need to help communities understand and implement the prevention approaches we know can be effective in stopping issues from developing in the first place.

Reaching Youth and Young Adults

As noted earlier, three-quarters of mental illnesses appear by the age of 24, yet less than one in five children and adolescents with diagnosable mental health and substance use problems receive treatment. That is why last week, the president announced initiatives to ensure that students and young adults receive treatment for mental health issues. Specifically, SAMHSA will take a leadership role in initiatives that would:

- Reach 750,000 young people through programs to identify mental illness early and refer them to treatment: We need to train teachers and other adults who regularly interact with students to recognize young people who need help and ensure they are referred to mental health services. The administration is calling for a new initiative, Project AWARE (Advancing Wellness and Resilience in Education), to provide this training and set up systems to provide these referrals. This initiative has two parts:

Provide “Mental Health First Aid” training for teachers: Project AWARE proposes \$15 million for training for teachers and other adults who interact with youth to detect and respond to mental illness in children and young adults, including how to encourage adolescents and families experiencing these problems to seek treatment.

Make sure students with signs of mental illness get referred to treatment: Project AWARE also proposes \$40 million to help school districts work with law enforcement, mental health agencies and other local organizations to ensure that students with mental health issues or other behavioral issues are referred to and receive the services they need. This initiative builds on strategies that, for over a decade, have proven to improve mental health.

- Support individuals ages 16 to 25 at high risk for mental illness: Efforts to help youth and young adults cannot end when a student leaves high school. Individuals ages 16 to 25 are at high risk for mental illness, substance abuse and suicide, but they are among the least likely to seek help. Even those who received services as a child may fall through the cracks when they turn 18. The administration is proposing \$25 million for innovative state-based strategies supporting young people ages 16 to 25 with mental health or substance abuse issues.
- Train more than 5,000 additional mental health professionals to serve students and young adults. Experts often cite the shortage of mental health service providers as one reason it can be hard to access treatment. To help fill this gap, the administration is proposing \$50 million to train social workers, counselors, psychologists and other mental health professionals. This would provide stipends and tuition reimbursement to train more than 5,000 mental health professionals serving young people in our schools and communities.

National Dialogue

Finally, we know that it is time to change the conversation about mental illness and mental health in America. The U.S. Department of Health and Human Services is working to develop a national dialogue on the mental and emotional health of our young people, engaging parents, peers and teachers to reduce negative attitudes toward people with mental illness, to recognize the warning signs and to enhance access to treatment.

⁶ Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.

Appendix Two:

Summary of Reports from the Bazelon Center for Mental Health Law

- The root of the problem with mental health service systems is a shortage of community based services—including mobile crisis services, assertive community treatment, peer supports and supportive housing. This delays hospital discharges and results in mental health crises that could otherwise be prevented.
- A stronger commitment to vital community mental health services is long overdue and must be paired with improved gun laws to prevent future tragedies.
- No one who is dangerous—whether or not the individual has a mental illness—should have access to guns. In all instances, one’s capacity to handle a weapon responsibly should be determined individually, not based solely on a diagnostic label.
- Restrictions on access to guns should be applied equally to everyone rather than targeting people with mental illnesses.
- People with mental illnesses are no more violent than people without mental illnesses. Yet, these kind of tragic events unfairly and harmfully target people with mental illnesses as inherently dangerous. In fact, these Americans not only share the nation’s horror at these events but also bear the additional weight of false stereotypes and discrimination needlessly reinforced by these perceptions.

From the Bazelon Center [Statement on Sandy Hook Shooting](#). See also the Bazelon Center’s new report on [The Relationship Between the Availability of Psychiatric Hospital Beds, Murders Involving Firearms, and Incarceration Rates](#).

Appendix Three:

Remarks of Michael Fitzpatrick, Executive Director of the National Alliance on Mental Illness

In an interview with Michel Martin of National Public Radio, Michael Fitzpatrick, executive director of the National Alliance on Mental Illness, made the following remarks:

“There’s a pervasive stigma surrounding mental illness and mythology surrounding mental illness, and for some people a connection between violence—or some commentators use the word *evil*—so it is, for us, three steps forward as we talk about mental illness in the community—and organizations like mine have done that for years—but it’s four steps backwards when these tragedies happen. They do create a sense for America to have an opportunity to have a dialogue about this very broken, long broken mental health system, and to have the White House involved in that dialogue is a tremendous change.”

“The other thing the president focused on was early intervention and early identification. Get in there early. We spend too much time in the mental health system in America looking at the back end, commitment laws, inpatient beds, jails and prisons. Let’s talk about getting in there early, and particularly with transitional youth, that 16- to 25-year-old age group where they’re transitioning from the children’s system—such as it is—into the adult system. They get lost. They’re not in school. They’re not working. They’re isolated. They can’t access care.”

“Within the social work, psychology and psychiatry professions, there’s not a whole lot of training on how do you identify someone when they’re dangerous? ... The state of the art is very limited on this. And so, it sounds like an easy fix. It’s kind of a political fix on identifying people who are dangerous, but who’s going to identify? How long do you stay on the list, and are you going to act as a barrier from people taking that first step to get treatment because they’re afraid they’re going to put on some government list?”

To listen to the full story, “How Would Better Mental Health Care Reduce Gun Violence?”, visit [NPR](#). Contact the National Alliance on Mental Illness at 888-999-6264 or visit [www.nami.org](#).

Appendix Four:

“One Response to One Reaction to the Newtown Tragedy” by Larry Davidson, Ph.D., Project Director, Recovery to Practice Institute, Substance Abuse and Mental Health Services Administration

While the country argues over stricter gun control legislation proposed by the president, mental health providers, along with persons with mental health conditions and their loved ones, continue to be in the position of having to respond to how some people in broader society have reacted to the tragedy in Newtown, Conn. Although much of the country has been compassionate and thoughtful, there have also been media reports, talk shows, op-eds, blogs and other media outlets replete with highly offensive and stigmatizing references to persons with mental illnesses—in which the mass shootings that unfortunately seem to be becoming a not-so-rare part of American culture are blamed (inexplicably) on “the mentally ill.” The use of terms such as “monsters,” “mental defects” and “madmen” is not only based on grave misunderstanding of mental illness and extremely hurtful to tens of millions of Americans who are working hard at their recovery, it also does nothing to explain the loss of 28 lives in Newtown on Dec. 14. More important, perhaps, it does nothing to prevent such horrors from occurring again in the future.

Many of us would like to simply dismiss such false and destructive myths and sever the erroneous connections made between mental illness and violence completely. But for those practitioners, persons in recovery and family members who feel they are in a position of having to respond to these damaging attitudes and beliefs, we offer the following facts and considerations.

Let’s start with the facts. According to the Institute of Medicine (IOM), “Although studies suggest a link between mental illnesses and violence, the contribution of people with mental illnesses to overall rates of violence is small, and further, the magnitude of the relationship is greatly exaggerated in the minds of the general population” (IOM, 2006). In fact, according to the MacArthur Study of Mental Disorder and Violence—the most rigorous scientific study conducted to date by the country’s leading experts on mental illness and violence—the contribution to violence made by persons with mental illness is no larger than the contribution made by persons who do not have a mental illness (Monahan et al., 2001), with other demographic and socioeconomic factors contributing much more than mental illness. The subgroup most at risk for committing violent acts is actually young and single working-class white males. Within behavioral health, broadly,

active substance use does contribute to violence. But within mental health, schizophrenia (the condition most alluded to by people who characterize “the mentally ill” as violent) contributes least to violence among the major illnesses. As summarized by Stuart (2003):

“The prevalence of violence among those with a major mental disorder who did not abuse substances was indistinguishable from their non-substance abusing neighborhood controls ... those with schizophrenia had the lowest occurrence of violence over the course of the year (14.8 percent), compared to those with a bipolar disorder (22.0 percent) or major depression (28.5 percent).”

Not only does mental illness contribute little to violence (estimated to be around 4 percent) but also persons with mental illnesses are generally much more at risk for being victims of violence than being perpetrators (Appleby, Mortensen, Dunn, & Hiroeh, 2001). Here the data are quite striking. Studies have consistently found that “people with severe mental illnesses... are 2 ½ times more likely to be attacked, raped, or mugged than the general population” (Hiday, 1999). In addition, “individuals with schizophrenia living in the community are at least 14 times more likely to be **victims** of a violent crime than to be arrested for one” (Brekke, Prindle, Bae, & Long, 2001). Despite the highly consistent findings that persons with mental illnesses are much likelier to be victimized by others than to hurt them, there have been 13 times as many articles on the violence presumably perpetrated by persons with mental illnesses as there have been on crime victimization among persons with mental illnesses.

In the face of the atrocity committed in Newtown, these facts unfortunately do little to persuade many people that mental illness is not the culprit. They want somebody and something to blame, and have a hard time believing a person could act in such a heinous way without being out of touch with reality. Confronted with so many deaths, especially of children, appealing to science may be seen as cold and heartless. What, then, should we do? Below are a few considerations—some based on research, others on experience—that may be useful in moving the discussion in a more constructive direction.

- Point out that mental illnesses are much more common than stereotypes suggest, with one in five Americans experiencing a mental health disorder during his or her lifetime. Were Congress to pass new laws that affect persons with mental illnesses, these would apply to one-fifth of the American population, or roughly 60,000,000 Americans. These laws would affect at least one in two American families.
- Personalize the issue by disclosing you have a mental illness (if you do) or know and care about people who have mental illnesses—whether they are loved ones, friends, coworkers or the people you serve. Point out visible examples of people who have, or have had, mental illnesses who have made important contributions to our society—from Abraham Lincoln to Beethoven and Mozart to Paul Wellstone, William Styron, Kate Jamison, Robin Williams, Billy Joel and Alma Powell, to more recent figures such as teen idol Demi Lovato, rapper DMX and soccer legend David Beckham. Although most people with mental illnesses will not become such public figures, **they are more likely to succeed in politics, write stirring music or fluid prose, or become an accomplished actor or athlete than they are to hurt anyone.**
- Educate people about the “real problem” associated with mental illness today—that so few people can or choose to access effective care for their condition, leading to unnecessary suffering on the part of the person and his or her loved ones (rarely on the part of the community) as well as lost productivity. Because mental health care has yet to be adequately funded in this country (the money never followed patients out of state hospitals, and our society has not viewed mental illnesses as illnesses for which effective treatments exist), very few people can access care. This travesty will hopefully be redressed through the combination of parity legislation passed in 2008 and provisions of the Affordable Care Act passed in 2010 (i.e., by mandating states include adequate coverage for behavioral health conditions in all benefits packages). At the present time, high-quality, effective mental health care remains difficult to access in most parts of the country, and impossible to access in some.

Additionally, even when care is available, many people choose not to access that care, precisely because of the pervasive societal attitudes and beliefs about mental illness we criticized above. Many people choose not to access mental health care or follow through with outpatient care once discharged from a hospital because they do not see themselves as “mental defects” or “madmen”—nor do they want to. Rather than being a justified approach based on accurate information, societal responses that view persons with mental illnesses as dangerous and unpredictable accomplish exactly

the opposite of what they intend. They drive people in need away from the care that would be effective in addressing their concerns.

No one would willingly choose to adopt the label and identity of a “mental patient” or “crazy person.” This is why it requires considerable courage for people to seek mental health care in the first place. One recent consequence of these attitudes is the startling statistic mentioned in our Jan. 10 *RTP Highlight*: more American soldiers died from suicide in the previous year than from combat in Afghanistan. Painting misguided and offensive pictures of mental illness only fortifies the barriers that already exist and keep people from getting the care that is available. If we want to decrease the actual burden that mental illnesses impose on our country, we should disseminate accurate information to the public and offer fact-based education to our youths on as broad a scale as possible. We should make role models of recovery as visible and accessible to as many people as possible, infusing the mental health workforce—and general workforce—with persons who embody the reality of recovery. And we should invite, rather than coerce, people into care that is respectful and responsive to their needs, so they need not suffer in silence and alone, and so using mental health care need no longer be something to be ashamed of.

A final consideration has to do with the issue of “insight.” We addressed this issue at length in the Feb. 6 *Special Feature*. In the context of current debates about mental health policy, we would like to point out that there are many reasons why



some people with mental illnesses choose not to participate in care or take psychiatric medications. The stigma and stereotypes that surround mental health care are at least as prominent a reason for not accessing care or taking medications as the reason for lacking “insight” into having such an illness. No one is born knowing what mental illnesses are or how to know or recognize when one begins to experience symptoms associated with having one. How, then, can a person develop such “insight”? If the only things people are taught about mental illnesses are the negative and insulting stereotypes described above, we can assume many people will continue not to have “insight” when they begin to experience the symptoms of a

mental illness. From their perspective, they are not “crazy” or “insane” ... they are not “mental defects” or “madmen”—so they could not possibly have a mental illness. They are, after all, just like you and me (because they **are**, after all, you and me).

If we truly want people to recognize and gain insight into having a mental illness when they begin to experience the symptoms of one, we need to dispel these fallacious and off-putting myths. We need to educate the public and youths in particular about what mental illnesses are, including how common they are (e.g., one in five Americans will have one), that effective treatments are available, and, importantly, how possible it is to recover. Then we can turn our attention to the isolation, rejection, alienation, silent suffering, and culture of violence that truly underlie such atrocities.

Larry Davidson, Ph.D., is director of Recovery to Practice Initiative, Substance Abuse and Mental Health Services Administration. This article was originally published in the Feb. 1, 2013, Newsletter of the Recovery to Practice Institute. The views, opinions and content of this article are those of the author, and do not necessarily reflect the views, opinions or policies of SAMHSA or the U.S. Department of Health and Human Services.

References

Appleby, L., Mortensen, P.B., Dunn, G., & Hiroeh, U. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: A population-based study. *The Lancet*, 358, 2110–12.

Brekke, J.S., Prindle, C., Bae, S.W., & Long, J.D. (2001). Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services*, 52, 1358–66.

Hiday, V.A. (2006). Putting community risk in perspective: A look at correlations, causes and controls. *International Journal of Law and Psychiatry*, 29, 316–31.

Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, D.C.: Institute of Medicine.

Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Risk assessment: The MacArthur Study of Mental Disorder and Violence*. Oxford: Oxford University Press.

Stuart, H. (2003). Violence and mental illness: An overview. *World Psychiatry*, 2(2), 121–24.

[APPENDICES 5 & 6 NEXT PAGE]

Appendix Five:

Summary of Federal and State Laws on Gun Ownership and Mental Health

The National Conference of State Legislatures has prepared a useful [Summary of Federal and State laws](#) on mental health and gun ownership. In using this summary it is important to bear in mind that the laws sometimes use general terms and that there may be regulations interpreting these terms broadly or narrowly.

The screenshot shows the NCSL website with the following content:

- Navigation:** Home, FINES, Help & Member Services, Contact Us, Sign In, Create Account, Search, Home, Home & Overview, Press Room.
- Page Title:** Possession of a Firearm by the Mentally Ill
- Section: Federal Law**

Under 18 U.S.C. § 922(b), it is unlawful for any person to sell or otherwise dispose of any firearm or ammunition to any person knowing that person is prohibited from receiving such firearm or ammunition. A person who has been adjudicated as a mental defective or has been committed to any mental institution.
- Section: State Laws**

State	Law	Provisions
Arizona	ARS 13-3006, ARS 13-3007, CA 13-302	No person in possession of a firearm by any person who: <ul style="list-style-type: none"> Has been found to constitute a danger to himself or herself or others pursuant to court order under section 13-3005, and whose right to possess a firearm has not been restored pursuant to section 13-3005.
Illinois	65, Code 10-22.5(i)	No person shall possess or own any firearm if he or she has been: <ul style="list-style-type: none"> Adjudicated mentally ill or Committed involuntarily to any mental institution.
California	CA, Welfare and Inst. Code 50 1302, 8 208	A person is barred from possessing, purchasing, receiving, attempting to purchase or receive, or having control or custody of any firearm if the person: <ul style="list-style-type: none"> Has been admitted to a facility and is receiving inpatient treatment for a mental illness and the attending mental health professional assesses that the person is a danger to self or others. This prohibition applies even if the person has consented to the treatment, although the prohibition ends as soon as the person is discharged from the facility. Has been adjudicated to be a danger to others as a result of a mental disorder or mental illness or has been adjudicated to be a mentally disordered law offender. This prohibition does not apply, however, if the court of adjudication orders, upon the individual's release from treatment or at a later date, a certificate stating that the person may possess a firearm without endangering others. Has been found not guilty by reason of insanity of a crime involving the use of a firearm. A person who is found not guilty by reason of insanity of other crimes is barred from possessing firearms unless a court finds that the person has recovered from the insanity. Has been found mentally incompetent to stand trial, unless there is a subsequent finding that the person has become competent. Is currently under a court-ordered career calendar because he or she is a previously disabled as a result of a mental disorder or injured by a violent act. <p>A person shall not have in his or her possession or under his or her custody or control, or purchase or receive, or attempt to purchase or receive, any firearm (including an air firearm) or other deadly weapon for a...</p>

Appendix Six:

Proposals for Legislative and Administrative Actions on Gun Control

White House

Visit the [White House](#) to review “Now is the Time: The President’s plan to protect our children and our communities by reducing gun violence.”

U.S. House of Representatives

“It’s Time to Act: A Comprehensive Plan to Reduce Gun Violence and Respect the 2nd Amendment Rights of Law-Abiding Americans.” [Report](#) of the Gun Violence Prevention Task Force, Feb. 7, 2013. Congressman Mike Thompson (CA-05), chair.

U.S. Senate

- The [Mental Health First Aid Bill](#) has been introduced by Sen. Michael Bennett (D-CO) and is cosponsored by a bipartisan group of senators, including Reed (D-RI), Stabenow (D-MI), Shaheen (D-NH), Blumenthal (D-CT), Blunt (R-MO), Rubio (R-FL) and Ayotte (R-NH).
- The [Excellence in Mental Health Act](#) has been introduced by Sen. Debbie Stabenow (D-MI) and is cosponsored by a bipartisan group of senators, including Reed (D-RI), Boxer (D-CA), Collins (R-ME) and Rubio (R-FL).
- The [Mental Health in Schools Act](#) has been introduced by Sen. Franken (D-WI). Provisions of this legislation have also been included in the [Mental Health Awareness and Improvement Act of 2013](#) introduced by Sen. Tom Harkin (D-IA), and cosponsored by a bipartisan group of senators, including Alexander (R-TN) and Franken (D-WI).

Appendix Seven: Nine Relevant Questions

1. What is *Grounded in Faith: Resources on Mental Health and Gun Violence*? It is a compendium of resources for congregational leaders, disability advocates, and other concerned persons who wish to ensure that the on-going debate around gun violence does not stigmatize people with mental illnesses, and deprive them of their rights and freedoms.

2. What is the Interfaith Disability Advocacy Coalition (IDAC)? The mission of IDAC is to mobilize the religious community to take action on disability policy issues with Congress, the President and Administration, and society at large. IDAC is a diverse, nonpartisan advocacy coalition of 32 national religious organizations, including representatives from the Christian, Jewish, Muslim, Hindu, and Sikh traditions whose core spiritual values affirm the rights and dignity of people with disabilities.

3. What does this report have to do with “faith”? Although the 32 members of IDAC come from many faith traditions, they are united by a common commitment to honor all people, especially children and adults with disabilities. This report reflects their shared understanding of the inherent dignity and worth of men, women and children with mental health conditions.

4. How can communities of faith use this report? This compendium of resources can be used to initiate conversations among students, parents, neighbors and colleagues with conflicting views; to provide guidance to study groups and workshops; to support advocacy to protect the rights and dignity of people with disabilities; and to inform national organizations, state and federal policy makers and officials about this complex subject. *Grounded in Faith* can nurture a new dialogue about the nation’s insufficient mental health system and serve as a springboard for action across religious and secular communities. At every opportunity, the voices of people dealing with mental health issues should be welcomed and valued.

5. Is there a correlation between mental illness and violence? “According to the MacArthur Study of Mental Disorder and Violence—the most rigorous scientific study conducted to date by the country’s leading experts on mental illness and violence—the contribution to violence made by persons with mental illness is no larger than the contribution

made by persons who do not have mental illness (Monahan et al., 2001), with other demographic and socioeconomic factors contributing much more than mental illness.” See *Grounded in Faith* Appendix 4.

6. Who carries out acts of violence? The research is inconclusive as to who carries out acts of violence. The consensus of experts is that most violence is not committed by people who are mentally ill and that most mentally ill people are not violent. Moreover, people with mental illnesses and other disabilities are much more often the victims of violence than the perpetrators.

7. What harm is caused by the media’s indiscriminate blaming of “the mentally ill” when gun violence occurs? By the suggestion that they pose a threat of violence, millions of Americans with mental illnesses who pose no threat are stigmatized by the media, talk show hosts, humorists, bloggers, and uninformed citizens.

8. When millions of Americans with mental illnesses are thoughtlessly stigmatized, what other negatives occur? There can be demands for unwarranted limitations on their rights and freedoms, including rights established under the Supreme Court’s *Olmstead* decision. Equally important, these negative characterizations and the possible loss of rights and freedoms may discourage many from acknowledging their illness and seeking treatment.

9. Who wrote *Grounded in Faith*? The members of IDAC’s Ongoing Dialogue Committee who researched and wrote this report are not trained mental health researchers, psychologists or psychiatrists. As disability advocates and people of faith, they focused on identifying already existing resources from a wide variety of experts and sources. Many conclusions of mental health experts are quoted or referenced in *Grounded in Faith*. The report also includes in the appendices examples of recent gun control and mental health proposals by the Administration and in the Congress.

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