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Consortium for Risk-Based Firearms Policy Recommends Evidence-Based Changes to State and Federal Gun Policies

The Consortium for Risk-Based Firearms Policy (“Consortium”) released its Reports, “Guns, Public Health and Mental Illness: An Evidence-Based Approach for State Policy,” (“State Report”)ⁱ and “Guns, Public Health and Mental Illness: An Evidence-Based Approach for Federal Policy,” (“Federal Report”)ⁱⁱ in December proposing evidence-based changes to both state and federal policy designed to reduce the risk of gun violence by individuals with mental health illness and other risk populations. Composed of the nation’s leading researchers,

practitioners, and advocates in gun violence prevention and mental health,ⁱⁱⁱ the Consortium proposes in its Reports a series of recommendations that include maintaining the mental health disqualification for purchasing and possessing firearms based on involuntary inpatient commitment, but expanding the disqualification to include involuntary outpatient commitment. The Consortium also proposes that states impose a temporary ban on those experiencing a short term involuntary psychiatric hospitalization.

The Consortium also recommends that federal funding for grants to the states be increased to assist them in developing the infrastructure necessary to fully transmit records of individuals prohibited from possessing or purchasing firearms to the National Instant Criminal Background Check System (“NICS) and to require as a condition of receipt of such funds that states develop a uniform restoration process for the mental health disqualifications that includes a requirement that a qualified clinician provide evidence that the individual is unlikely to relapse and present a danger to himself or others in the foreseeable future.

In addition, the Consortium recommends that Congress and the states enact new temporary firearm prohibitions banning other groups at heightened risk of violence from possessing firearms to include:

- Individuals convicted of a violent misdemeanor
- Individuals subject to a temporary domestic violence restraining order
- Individuals convicted of two or more DWIs or DUIs in a five-year period
- Individuals convicted of two or more misdemeanor crimes involving a controlled substance in a five-year period

The Consortium further proposes that states enact provisions authorizing law enforcement to remove guns from individuals, either with or without a warrant, whom they determine pose an immediate threat of harm to themselves or others. The Consortium also recommends that states create a new civil restraining order process similar to that used in domestic violence cases to allow family members and intimate partners to petition the court to authorize the removal of firearms and temporarily prohibit firearm possession and purchase based on risk of harm to self or others even when domestic violence is not an issue.

In both Reports, the Consortium points out that unless states consistently report all relevant firearms prohibitions to NICS and that all purchasers of firearms undergo a universal background check, implementation of any firearms prohibitions or expansion of state or federal law will be minimally successful in preventing or reducing gun violence.

Background

The recent spate of mass shootings has focused national attention on the relationship between mental illness and violence and what can be done to prevent individuals with mental illness from engaging in violent behavior. The Consortium’s Reports reflect the evidence that the vast majority of people with mental illness do not engage in violence against others and most

violence is caused by factors other than mental illness. Nonetheless, the Reports identify certain subgroups of individuals with serious mental illness that are at increased risk of violence. These include psychiatric inpatients and individuals experiencing first-episode psychosis. Notably, mental illnesses such as depression significantly increase the risk of suicide, accounting for more than half of all gun deaths in the United States each year.

Since enactment of the Gun Control Act of 1968, following the deaths of the Reverend Martin Luther King, Jr. and Robert F. Kennedy, civil commitment has formed the basis for the mental health firearm disqualifications under federal law. Currently federal law disqualifies individuals involuntarily committed to inpatient care, found incompetent to manage their own affairs, or found incompetent to stand trial or acquitted of a criminal act by reason of insanity. Some states have enacted additional prohibitions. In 1993, Congress passed the Brady Act creating the NICS system that requires federally licensed gun dealers to check the system to identify purchasers prohibited from possessing firearms. State reporting is voluntary, however, and many states fail to report mental health records because they lack the data systems necessary to collect and transmit mental health records. Some states also fail to report civil commitment records due to concerns about confidentiality. In 2007, following the tragedy at Virginia Tech, Congress enacted the NICS Improvement Amendments Act to provide grant funding to some states to create data systems to improve their ability to report disqualifications to the system. Notwithstanding these laws, there is no universal background check requirement and 40% of all gun purchases are made through unlicensed dealers for which no background checks are performed.

State and Federal Policy Recommendations

On December 2, 2013, the Consortium released its state policy proposals to expand state laws and policy designed to reduce gun violence at a widely-attended conference held at the University of Virginia. The Consortium followed on December 13, 2013, by issuing its recommendations for changes to federal firearms policies. Both Reports review the research that identifies several key factors in people both with and without mental illness that are associated with the risk of committing firearms violence. These factors include a history of violent crime, perpetration of domestic violence, alcohol abuse and drug abuse.

Involuntary Commitment

The Consortium's evidence reveals that although the vast majority of individuals with mental illness are not violent towards others, certain subgroups are at elevated risk of violence, including psychiatric inpatients and those experiencing first-episode psychosis. Suicide also accounts for more than half of gun deaths in the United States each year and mental illnesses such as depression significantly increase the risk of suicide. Suicide is the second leading cause of death among adults aged 25-35, and the 10th leading cause of death among all adults in America.

Research conducted by Jeffrey Swanson and others found that Connecticut's initiation of reporting gun-disqualifying mental health records to NICS resulted in a significant reduction in risk of arrest for violent crime among persons prohibited from possessing a gun due to mental

illness.^{iv} The Consortium notes, however, that only about 7% of people with serious mental illness receiving services from Connecticut's public behavioral healthcare system were disqualified from owning a gun due to civil commitment. In addition, almost all or 96% of violent crimes committed by people with serious mental illness did not have a firearms disqualification based upon mental illness, but based upon some other disqualifying factor. State policies and their rates of civil commitment also vary widely and Connecticut's rate is very low. Still, this research indicates that mental health background reporting and NICS checks can work in reducing somewhat the rate of violent behavior. As a result, the Consortium recommends that the current civil commitment disqualification be retained.

Involuntary Outpatient Commitment

Under involuntary outpatient commitment, a court determines that a person without treatment is likely to become a danger to self or others. Such a process provides mandatory treatment in the community for people with serious mental illness who are unlikely or unable to adhere to treatment on their own, and are therefore at risk of deteriorating to the point where they may require involuntary hospitalization. It is therefore logical to conclude that individuals who meet the criteria of dangerousness to self or others under outpatient commitment should also be prohibited from possessing a firearm. As a result, the Consortium recommends that the ban against persons involuntarily civilly committed be expanded to include those involuntarily ordered to outpatient treatment.

Short-Term Hospitalization Temporary Disqualification

Every state has a process in place whereby a mental health professional may determine that a person is a danger to self or others as a precursor to temporary hospitalization. Short term hospitalization is often initiated on an *ex parte* basis without a judicial or administrative hearing, permitting an individual to be transported for an evaluation and temporary hospitalization pending a hearing at a later date. As indicated above, the time period surrounding involuntary inpatient hospitalization and first-episodes of psychosis poses the highest risk among people with mental illness. People are often stabilized and discharged before a hearing can be held even though the person's risk of relapse and dangerousness is still high. Given that short-term involuntary hospitalization is a reliable predictor of dangerousness, the Consortium recommends that states enact temporary firearms prohibitions of five years following a person's admission to short-term involuntary hospitalization based upon a physician-certified emergency involuntary admission.

This recommendation is contingent upon 1) restoration of the person's rights within five years, absent another disqualifying event, 2) compliance with the state's statutory requirements for emergency evaluation and clinical findings by a physician upon admission that the commitment criteria are met; and 3) a fair and meaningful opportunity for restoration of the person's firearms rights are available after a one-year waiting period.

The Consortium also points out that civil commitment practices vary substantially among the states, which makes implementation of the civil commitment prohibition difficult. The Consortium therefore also proposes that the federal law prohibition be defined consistently

across the states as a judicial or administrative order of involuntary commitment to a facility based upon a finding of dangerousness to self or others. Because the policies and procedures for involuntary hospitalization vary so much from state to state, including the criteria to hold someone temporarily and the types of decision-makers that may order this, the Consortium does not recommend that the federal mental health disqualification contain a disqualification for temporary emergency hospitalization, but it encourages states to enact such a prohibition in state law.

Questions about the constitutionality of a firearms prohibition based upon a temporary hospitalization without a judicial review will inevitably arise. The State Report analyzes the 2008 Supreme Court decision in *District of Columbia v. Heller*, 554 U.S. 570 (2008), and the First Circuit Court of Appeals decision in *United States v. Rehlander*, 666 F.3d 45 (1st Cir. 2012). *Heller* confirmed a second amendment right of individuals to possess firearms, but stated in a footnote that the right is not absolute. The Supreme Court indicated that nothing should cast doubt on the long standing prohibitions against firearm possession for felons and people with mental illness. In *Rehlander*, a case decided after *Heller* challenging Maine's statutory firearms prohibition after emergency temporary hospitalization, that Court held that permanent disqualification without judicial process was unconstitutional. In so doing, the Court described important procedural differences between civil commitment and temporary inpatient hospitalization. The Court suggested, however, that the outcome in this case might have been different if the federal statutory prohibition in 18 U.S.C. § 922(g)(4) addressed *ex parte* hospitalizations requiring temporary suspensions of rights pending further proceedings.

The Consortium believes its temporary hospitalization disqualification recommendation meets constitutional concerns by 1) limiting the restriction to five years at which time the person's rights would be restored absent another disqualifying event; 2) requiring the five-year temporary restriction be based upon compliance with the state's statutory requirements for emergency evaluation and upon a clinical finding by a physician that the person meets the commitment criteria; and 3) providing a fair and meaningful opportunity for individuals to have their rights restored after a one-year waiting period.

Restoration of Rights Process

Currently, the NICS Improvement Amendments Act requires states that receive federal grant funds to implement a restoration process that provides a due process mechanism for people disqualified from purchasing or possessing a firearm to have their rights restored. Currently that language only requires a process for relief from the disqualification if "the person's record and reputation are such that the person will not be likely to act in a manner dangerous to public safety and the granting of the relief would not be contrary to the public interest."^v The states have enacted varying processes for rights restoration but these standards are not implemented consistently throughout the states or even within each state. As a condition of receipt of federal grant funds, the Consortium proposes that states be required to condition the restoration of firearms rights based upon a mental health disqualification on the opinion of a qualified clinician that the person is unlikely to relapse and present a danger to himself or others in the foreseeable future.

The Consortium Reports provide specific language related to the restoration process that would mandate that any petition seeking relief from the mental health firearms prohibition be accompanied by the opinion of a psychiatrist or licensed clinical psychologist. The opinion must state, among other things, that the person no longer manifests the symptoms of the mental disorder that resulted in the mental health prohibition or that otherwise elevated the risk of harm to self or others; that the person has adhered consistently to treatment for a substantial period and manifests a willingness to continue treatment; and adherence to ongoing treatment, if necessary, is likely to minimize the risk of the person's relapse. This opinion must be accompanied by records of the person's mental health and treatment history, including the person's history of suicide attempts and prior violence, history of the use of firearms and other weapons, history of use of alcohol and other drugs, and history of criminal justice involvement.

In addition, the burden of filing the petition and persuading the court rests upon the person. The person may not petition for restoration of these rights less than one year from entry of the involuntary commitment or outpatient commitment order. In addition to finding the person has consistently adhered to treatment and expressed a willingness to continue and that such adherence will minimize the risk of relapse so as to prevent the person from posing a danger to self or others, the court or administrative body must also find that restoration of the firearms rights would be compatible with the public interest, thus providing both clinical and judicial support for the decision.

New Prohibition Proposals

In addition to the mental health firearms prohibitions, the Gun Control Act also prohibits gun possession by other categories of individuals at high risk of violence, including felons; persons convicted of misdemeanor domestic violence crimes; persons subject to permanent domestic violence restraining orders; and unlawful users or those addicted to controlled substances. Evidence also indicates that individuals convicted of violent misdemeanors; subject to temporary domestic violence restraining orders; convicted of two or more DWIs or DUIs in a five-year period; and convicted of two or more misdemeanor crimes involving a controlled substance in a five-year period are also at elevated risk of committing violent acts.

Violent Misdemeanors

The Consortium's Reports review evidence that individuals convicted of violent misdemeanors are at increased risk of committing future violent crimes. California law^{vi} prohibits violent misdemeanants from owning firearms, which has resulted in reduced arrests for violent crime overall and gun crime specifically involving persons previously convicted of violent misdemeanors. Federal law does not currently prohibit individuals who have committed violent misdemeanors from purchasing and possessing firearms, except those convicted of domestic violence. Twenty-three states and the District of Columbia do prohibit firearms purchases by those convicted of at least one or more misdemeanors. The Consortium therefore recommends that Congress and all the states prohibit individuals convicted of misdemeanors involving the use of a deadly weapon, threat of force, or stalking from purchasing or possessing a gun for a period of ten years.

Temporary Domestic Violence Restraining Orders

Most victims of intimate partner homicides are killed with a gun. Research shows that there is an increased risk of intimate partner homicide when an abuser has a firearm. Moreover, approximately half of women killed by their partner had contact with the criminal justice system related to their abuse within the year preceding their murder. Cities in states with laws prohibiting firearms possession by respondents to domestic violence restraining orders had 25% fewer homicides, demonstrating that these abusers do not replace guns with other weapons to commit the same number of murders.

Temporary *ex-parte* orders are the first step in the domestic violence restraining order process. Given the immediate danger the domestic violence victims are in and the dangerousness associated with initiating separation in these situations, these orders are issued in the absence of the respondent. Hearings then follow issuance of temporary *ex-parte* orders, which can be dismissed if a court determines they are not warranted. Current federal law only prohibits gun purchases by those individuals subject to permanent restraining orders or those convicted of domestic violence misdemeanors. A number of states do prohibit firearms purchase and possession based upon *ex parte* restraining orders. Given the evidence concerning the extreme risk during this time period, the Consortium recommends that Congress and the states enact temporary prohibitions against the purchase and possession of firearms by those subject to temporary restraining orders. If the prohibition is not warranted, the court can quickly restore these rights during the hearing on the petition for the restraining order.

DWI/DUI Convictions

Research demonstrates that alcohol abuse is associated with violence to self and others. The Consortium's Reports reference a 2011 study finding that gun owners were more likely to binge drink, drive under the influence of alcohol, and have at least 60 drinks per month.^{vii} Another study comparing individuals with one DUI arrest to those with multiple DUI arrests showed that those with multiple DUI arrests were more than three times as likely to be arrested for other misdemeanors and felony crimes.^{viii}

There is currently no federal firearm prohibition for alcohol abuse. A number of states have enacted laws prohibiting individuals who abuse alcohol from purchasing or possessing a firearm, but fail to precisely define who is disqualified, making enforcement of this prohibition difficult. Uniquely, Pennsylvania prohibits individuals who have been convicted of three or more drunk driving offenses in a five-year period from possessing a gun.^{ix} Given the overwhelming evidence correlating alcohol abuse and gun violence, the Consortium recommends that Congress and the states enact laws prohibiting individuals convicted of two or more DWI or DUI offenses in a five-year period from purchasing or possessing a firearm for at least five years.

Controlled Substance Convictions

The illegal use of controlled substances has consistently been shown to increase the risk of violence. Agitation, cognitive impairment, and impaired decision-making and communication skills heighten the risk of violent behavior. Involvement in the illegal drug trade is also

associated with violent crime. Federal law currently prohibits illegal users of controlled substances from purchasing a firearm, but this prohibition is poorly defined and states are confused as to what types of records should be reported. The Consortium therefore recommends that Congress and the states enact prohibitions against individuals who have been convicted of two or more misdemeanor crimes involving controlled substances in a five-year period from purchasing or possessing firearms for at least five years.

Law Enforcement Confiscation of Firearms

The Consortium proposes two mechanisms based on state laws in Connecticut, Indiana and Texas to authorize law enforcement officers to remove guns, both with and without a warrant, from individuals who pose a serious risk to self or others.

Connecticut. Following a shooting in 1998, Connecticut established a process authorizing two police officers or a state's attorney to file a complaint with the court alleging that an individual 1) poses a risk of imminent injury to self or others and 2) possesses one or more firearms. If the court finds sufficient probable cause, the court may then issue a warrant permitting law enforcement to search for and remove any and all firearms.^x Prior to seeking a warrant, law enforcement must first conduct an investigation to determine whether probable cause exists and whether there is any reasonable alternative to avert the risk. Criteria for assessing probable cause include recent threats or acts of violence towards self, others or animals. For assessing imminent risk, factors include reckless firearm behaviors, threatened or actual violence, prior involuntary commitment to a psychiatric hospital, and illegal use of controlled substances or alcohol.

Following the removal of the firearms, the court must schedule a hearing within 14 days. The state bears the burden of proving by clear and convincing evidence that the guns should be retained. If the state carries its burden, the court may then order that the guns be held for up to one year. The person whose guns have been confiscated may transfer them to an individual who is eligible to purchase and possess guns to prevent the state from retaining them.

During the first ten years of its enactment, at least 277 warrant requests were filed and 274 warrants were issued, resulting in the removal of more than 2000 guns from individuals who were deemed to pose an imminent risk of violence. Guns were confiscated from 96% of people named in the warrants.

Indiana. In 2004, Indiana enacted legislation authorizing law enforcement to remove guns from individuals they believed to be dangerous.^{xi} This law was enacted after one police officer and the shooter were killed, and four other officers were injured. The police were responding to a complaint about a man with a gun. Less than a year earlier they had removed firearms and ammunition from this same man after an encounter resulted in his inpatient hospitalization with a diagnosis of paranoid schizophrenia. Over the objections of law enforcement, the guns were returned to him.

The Indiana law defines a dangerous person as someone who 1) presents an imminent present risk or possible future risk and has not consistently taken medication to control a mental

illness that may be controlled by medication, or 2) has a history of or propensity for violent or emotionally unstable conduct. Police may remove guns from a person whom they identify as an immediate and substantial threat, but must complete a report justifying the gun removal within 48 hours. A hearing must then be held following the confiscation where the state must prove by clear and convincing evidence that the person poses an immediate threat to self or others. The removed guns may be held for up to one year by the state, an approved third party, or a licensed firearms dealer, or the person may sell the firearms. The person is also prohibited from purchasing additional firearms.

During the first two years following its enactment, one court in an Indianapolis county heard 133 cases involving firearms removal. In 9% of the cases, the judge ordered the guns returned to the owner. Sixty-five percent of those cases involved a response to a suicide threat. Ten percent were prompted by active psychosis. Most of those from whom guns were removed were transported for psychiatric evaluation. Recent data from 2010-2012 indicate, however, that the same Indianapolis county court that ordered guns be retained in more than 80% of cases, now was ordering guns returned in nearly 80% of cases. Firearms license suspensions that prohibit new gun purchases also declined precipitously after the first year the law was in effect, plus courts have faced difficulties in meeting the timeframes for conducting hearings.

Texas. Texas enacted a law in 2013 that authorizes law enforcement to confiscate guns from a person with mental illness whom he takes into custody who poses an imminent risk to himself or others.^{xii} This provision was enacted as part of a larger revision of the state's mental health system. The officer must provide the person with a receipt for the firearms confiscated and information concerning the process for reclaiming them. Within 15 days of the arrest, law enforcement must notify the person's closest family members about the procedure for returning the firearms. Within 30 days, law enforcement must request information from the court about the disposition of the person. Within 30 days of receiving information that the person is no longer in custody, law enforcement must notify the person that he or she may retain possession of the firearms upon determining following a background check that the person is not prohibited from possessing guns. If the individual received inpatient mental health treatment, law enforcement must notify the individual that he or she is no longer eligible to purchase or possess firearms.

Law enforcement officers regularly respond to crises, routinely assess whether people pose a threat, and employ strategies to minimize these threats. Based on the experience of law enforcement officers and the above state-law examples, the Consortium recommends that states enact Connecticut-style laws permitting law enforcement officers to remove firearms from dangerous individuals, either with or without a warrant. Following confiscation, law enforcement should file a report with the court within 48 hours of removal. The court should then schedule a hearing within two weeks at which the state bears the burden of proving by clear and convincing evidence that the person remains a risk to self or others. If the court determines the person remains a risk, the court may order the guns retained for up to one year by law enforcement or a licensed firearms dealer.

Civil Restraining Order

The Consortium also recommends that states enact a process permitting family members and intimate partners to initiate a court proceeding to order removal of firearms from dangerous individuals similar to the process for obtaining domestic violence restraining orders. This Gun Violence Restraining Order process would be similar to the process already in place in the fifty states that permit victims of domestic violence to seek an order to prevent further domestic violence, which sometimes also includes a firearms prohibition. Rather than addressing only domestic violence, this process would focus solely on firearms based upon a finding that a person poses a serious threat of harm to self or others for whatever reason. The process should include an *ex parte* temporary restraining order process followed by a hearing at which the court decides to issue or deny the restraining order. In assessing the threat of harm, the court should consider the petitioner's account of the threat; the respondent's history of threatening or dangerous behavior; history of or current use of controlled substances; history or current abuse of alcohol; and history of adherence to prescribed psychiatric medications. As part of the process, states should also include a mechanism for returning all removed guns at the conclusion of the temporary prohibition.

General Policy Reforms

The Consortium recognizes that none of these recommendations will be fully effective unless states develop the necessary databases and report all relevant records to the NICS. Congress should also increase grant funding to the states to assist them in developing the needed infrastructure and data systems to make these reports to the NICS. As a condition of receipt of funds, Congress should also require the states to implement the Consortium's recommendations related to the involuntary outpatient prohibitions and develop a standard restoration process for individuals disqualified from possessing a firearm as a result of mental illness.

These recommendations will also be ineffective in reducing gun violence unless universal background checks are required for all gun purchases, and not just those from federally licensed dealers. Otherwise those prohibited from purchasing firearms will simply circumvent the process by purchasing from unlicensed owners as they now do 40% of the time.

What are your concerns or questions about state or federal mental health firearms disqualifications? What do you believe the policies should be? Post your comments [here](#).

DOJ/HHS Propose Regulatory Changes Clarifying Mental Health Firearms Prohibitions and Reporting Requirements

The United States Department of Justice issued proposed regulations on January 7, 2014 to clarify the Bureau of Alcohol, Tobacco, Firearms and Explosives regulations defining the terms "adjudicated as a mental defective" and "committed to a mental institution," the archaic terms contained in the Gun Control Act of 1968 that disqualify persons from purchasing and

possessing a firearm on the basis of mental illness. The proposed regulations clarify that these terms include persons committed to both involuntary inpatient and outpatient treatment. Mental institutions include mental health facilities and the auxiliary mental health services provided through these facilities. DOJ is also seeking comment on whether the term “committed to a mental institution” should include involuntary commitment that occurred when the person was under the age of 18. Comments must be submitted by April 7, 2014.^{xiii}

On the same day, the Department of Health and Human Services issued a proposed modification to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to expressly permit HIPAA covered entities to disclose to the National Instant Criminal Background Check System (“NICS”) the identities of individuals subject to the federal mental health firearms prohibition. Only covered entities with authority to make adjudications or commitment decisions, or that serve as repositories of the information for NICS reporting purposes would be permitted to disclose the information. The information that may be disclosed must also be restricted to demographic information and would be limited to the information minimally necessary to make the report. The information would not include medical records or mental health information beyond that information indicating the person is subject to the federal mental health disqualification. Comments must be submitted by March 10, 2014.^{xiv}

Illinois Department of Human Services Clarifies “Clear and Present Danger” Mental Health Reporting Requirements; All Individuals with Developmental Disabilities Must Be Reported

The Illinois Department of Human Services announced on January 13, 2014 new Firearms Owner Identification Mental Health Reporting System requirements for the expanded list of mental health professionals and mental health facilities mandated to report within 24 hours individuals they determine present a “clear and present danger” to self or others or have a developmental disability. The new law also expands the list of those banned from possessing a firearm to include anyone voluntarily or involuntarily receiving inpatient mental health treatment or involuntary outpatient treatment, and anyone determined to have an intellectual disability. These requirements were mandated by the Illinois Firearm Concealed Carry Act, PA 98-063, that amended the Firearms Ownership Identification Card Act, 430 ILCS 65/1, and became effective July 9, 2013.

In Illinois, gun owners must obtain a Firearms Owners Identification Card in order to legally possess a gun. The purpose of the card is to assist law enforcement in identifying those individuals who are prohibited under Illinois law from acquiring or possessing firearms. Anyone not otherwise disqualified from possessing a gun must have a card with them whenever a gun is in their possession. The State Police may refuse to issue or revoke a card for anyone not authorized to have one.

The new Act requires an expanded list of clinicians, including “qualified examiners,” to report any patients whom they believe pose a “clear and present danger” to themselves, another person, or the community to the Department of Human Services within 24 hours. The

Department must then review the information, and if in agreement, report to the Illinois Department of State Police. “Clear and present danger” is defined as “a person who:

- (1) Communicates a serious threat of physical violence against a reasonably identifiable victim or poses a clear and imminent risk of serious physical injury to himself, herself, or another person as determined by a physician, clinical psychologist, or qualified examiner; or
- (2) Demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions or other behavior, as determined by a physician, clinical psychologist, qualified examiner, school administrator, or law enforcement official.

430 ILCS 65/1.1.

Surprisingly, the Act also requires these same mental health professionals to report within 24 hours anyone they determine has a developmental disability. “Developmental disability” is defined as

a disability which is attributable to any other condition which results in impairment similar to that caused by an intellectual disability and which requires services similar to those required by intellectually disabled persons. The disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap.

430 ILCS 65/1.1. This definition is similar to and appears to encompass the definition contained in the Illinois Mental Health and Developmental Disabilities Code that includes cerebral palsy, epilepsy and autism when the impairment is similar to that of an intellectual disability or requires similar services. 405 ILCS 5/1-106.

In addition to physicians and clinical psychologists who are mandated to report, the list includes “qualified examiners.” “Qualified examiners” is defined in the Mental Health and Developmental Disabilities Code to include social workers, registered nurses, clinical professional counselors, and marriage and family therapists if any of these professionals have an additional three years of clinical experience involving evaluation and treatment of patients with mental illness. 405 ILCS 5/1-122.

Moreover, the Illinois General Assembly amended the Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/12(b), to require that all mental health facilities, as defined in the Firearm Owners Identification Card Act, to also report anyone determined to be a “clear and present danger” or developmentally disabled to the Department within 24 hours. The Firearms Owners Identification Card Act significantly expands the definition of “mental health facility” to include any public or private hospital, institution, clinic, evaluation facility, mental health center, college, university, long-term care facility, and nursing home, or parts thereof, which provide treatment of persons with mental illness regardless of whether that is their primary purpose. 430 ILCS 65/1.1.

In addition, all physicians, clinical psychologists and qualified examiners, and mental health facilities described above must also report others prohibited from possessing a firearm to the Department within seven days. These individuals include:

- A person who has been a patient of an inpatient mental health facility, either voluntarily or involuntarily, or outpatient facility involuntarily, within the past five years, or more than five years previously if he or she has not received a certification from a physician, clinical psychologist or qualified examiner that he or she does not pose a clear and present danger to himself, herself or others;
- A person who is intellectually disabled;
- A person who has been adjudicated as a mentally disabled person;
- A person involuntarily admitted into a mental health facility, either inpatient or outpatient; and
- A person disqualified under federal law, 18 U.S.C. 922(g) and (n), from purchasing or possessing a firearm.

740 ILCS 110/12(b); 430 ILCS 65/8. A person “adjudicated as a mentally disabled person” is defined as a person who has been determined by a court or other lawful authority to, among other things, present a clear and present danger to himself, herself, or others; lack capacity to manage his or her own affairs; be not guilty by reason of insanity, incompetent to stand trial, a sexually violent or sexually dangerous person; or involuntarily admitted to a mental health facility as either an inpatient or outpatient; or judicially admitted as a person with an intellectual disability. Specifically excluded from the mental health reporting requirements are those people hospitalized solely for treatment for an alcohol abuse disorder. 430 ILCS 65/1.1. In order to protect the person’s privacy, no information beyond that which would enable the State Police to determine whether a person is disqualified under State or federal law from purchasing a firearm may be reported. 740 ILCS 110/12(b).

The mental health disqualifications and the reporting requirements for mental health professionals enacted under Illinois law are far more expansive than under any other state law. Under New York’s Secure Ammunition and Firearms Enforcement Act (SAFE Act), effective January 15, 2013, physicians, psychologists, registered nurses and licensed clinical social workers are required to report a person whom in their reasonable professional judgment is likely to engage in conduct that would result in serious harm to self or others as soon as practicable to the Director of Community Services, who in turn, if he or she agrees, must report to the Division of Criminal Justice Services. N.Y. MHY. Law § 9.46. This law when enacted was decried as discouraging individuals from seeking needed mental health treatment.

It is not clear that casting such a wide net as Illinois has done to disqualify all individuals with developmental and intellectual disabilities and anyone who has voluntarily sought treatment in an inpatient setting within the past five years from possessing a gun, will protect the public safety. Such expansive prohibitions that are not supported by the evidence only serve to further

stigmatize individuals with mental disabilities and discourage them from seeking needed treatment before they do become a clear and present danger.

By contrast, those individuals hospitalized solely for treatment for alcoholism are excluded from the reporting requirements and only those addicted to narcotics, not alcohol, are disqualified from possessing guns. Research has demonstrated that individuals who abuse alcohol are more likely to engage in violent behavior than those who do not.

The Consortium for Risk-Based Firearm Policy proposed in December 2013 recommendations for changes in state and federal policies based upon research and evidence, which legislators and researchers should heed. These reports, “Guns, Public Health, and Mental Illness: An Evidence-Based Approach for State Policy,” and “Guns, Public Health and Mental Illness: An Evidence-Based Approach for Federal Policy,” are available at <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/>.

Do you have comments or questions about the Illinois law? Post them [here](#).

Recently Decided and Pending Cases

Supreme Court Reinstates Death Penalty Holding Prosecution May Introduce Expert Psychological Opinion Rebutting Voluntary Intoxication Defense

In a unanimous opinion written by Justice Sonia Sotomayor, the United States Supreme Court held on December 11, 2013 that when a defense expert testifies that the defendant lacks the *mens rea*, or requisite mental state to commit a crime, the prosecution may offer evidence from a court-ordered psychological examination for the limited purpose of rebutting the defendant’s evidence. *Kansas v. Cheever*, _ U.S._ , 134 S.Ct. 596, 82 USLW 4032 (No. 12-609 Dec. 11, 2013) available at http://www.supremecourt.gov/opinions/13pdf/12-609_g314.pdf. In so doing, the Supreme Court reversed the decision of the Kansas Supreme Court that introduction of expert testimony from a court-ordered examination to which the defendant had not agreed violated his Fifth Amendment right against self-incrimination.

In January 2005, Scott Cheever shot and killed a county sheriff and shot at other law enforcement officers who were attempting to arrest him on an outstanding warrant. Several hours prior to the shooting, Cheever and his friends had cooked and smoked methamphetamine. One of Cheever’s friends warned him that officers were on the way to arrest him. He attempted to flee in his car but it had a flat tire. He returned inside and hid with a friend in an upstairs bedroom. Hearing footsteps on the stairs, Cheever stepped out and shot the sheriff climbing the stairs. He returned to the bedroom briefly, but went back to the stairs and shot the sheriff again. He also fired at other officers and members of the SWAT team that had arrived.

The State charged Cheever with capital murder, but shortly thereafter, the Kansas Supreme Court found in an unrelated case that the State’s death penalty scheme was

unconstitutional. Because the death penalty was no longer available, the state prosecutors dismissed the charges against Cheever and permitted federal prosecutors to indict him under the Federal Death Penalty Act.

Cheever filed a notice in the federal case that he intended to introduce evidence that his intoxication with methamphetamine prevented him from forming the specific intent to commit the crime. The federal district court ordered Cheever to submit to a psychiatric evaluation to assess how methamphetamine had affected him when he committed the crime. The federal court, however, suspended the proceedings during jury selection when defense counsel became unable to proceed, and then dismissed the case without prejudice. In the interim, the United States Supreme Court reversed the Kansas Supreme Court in the unrelated case, holding that the Kansas death penalty scheme was constitutional.

Kansas then refiled the state proceedings against Cheever at which he presented a voluntary intoxication defense, arguing that his methamphetamine use had made him incapable of premeditation. He presented evidence at trial from a psychiatric pharmacologist that long-term methamphetamine use had damaged his brain. The expert testified that Cheever was acutely intoxicated at the time of the shooting. The State then sought to present rebuttal testimony from the forensic psychiatrist who had examined Cheever under the federal court order. Cheever objected on the grounds that he had not voluntarily agreed to the examination and the expert's testimony would therefore violate his Fifth Amendment right against self-incrimination. The trial court admitted the testimony and the expert testified that Cheever shot the sheriff because of his antisocial personality and not because of his methamphetamine use. The jury convicted Cheever of murder and attempted murder, and recommended the death penalty, which the court imposed.

On appeal, the Kansas Supreme Court agreed that use of the rebuttal testimony from the expert in the federal proceeding violated Cheever's Fifth Amendment rights because he had neither initiated the examination nor put his mental capacity in issue at trial. In so deciding, the Kansas Supreme Court relied upon the United Supreme Court decision in *Estelle v. Smith*, 451 U.S. 454 (1981), holding that a court-ordered psychiatric examination violated the defendant's Fifth Amendment rights when the defendant had not initiated the examination or put his mental capacity in dispute at trial. The Court acknowledged the later-decided case of *Buchanan v. Kentucky*, 483 U.S. 402 (1987), which held that where a defense expert who has examined the defendant testifies that the defendant lacks the requisite mental state to commit an offense, the prosecution may present psychiatric evidence in rebuttal. But the Kansas Court found *Buchanan* did not apply because under Kansas law voluntary intoxication is not a "mental disease or defect." The State of Kansas then petitioned the United States Supreme Court for a writ of *certiorari*, which the Court granted.

The Supreme Court reversed distinguishing this case from *Estelle*, pointing out that the judge in *Estelle* had ordered a psychiatric examination to determine the defendant's competency to stand trial. The prosecution then used the defendant's statements from the examination during the sentencing phase of trial to demonstrate the defendant's future dangerousness. Instead, the Supreme Court relied on *Buchanan*, finding that "mental status" is a much broader term than "mental disease or defect." It held that mental status defenses include those based on expert opinion as to the defendant's *mens rea*, that is, his mental capacity to commit the crime or ability

to premeditate. The Court reasoned that to allow a defendant to present one-sided and potentially inaccurate evidence to the jury would undermine the adversarial process. On the other hand, permitting the prosecution to present rebuttal testimony harmonizes with the principle that when a defendant chooses to testify in a criminal case, the Fifth Amendment does not permit him to refuse to answer related questions on cross-examination.

In this case, Cheever presented expert evidence of his voluntary intoxication to support his defense that he lacked the requisite intent to commit murder. The Supreme Court held that the prosecution may therefore offer evidence from a court-ordered psychological examination for the limited purpose of rebutting the defendant's evidence. The Court then reversed the Kansas Supreme Court decision, reinstated the death penalty and remanded the case for further proceedings.

Tenth Circuit Requires Treatment Plan with Medications and Maximum Dosages before Authorizing Involuntary Medication of Incompetent Defendant

The Tenth Circuit Court of Appeals overturned on November 13, 2013, the district court's order authorizing treatment of an incompetent defendant with antipsychotic medication over his objection. Following the precedent of three other circuits, the Tenth Circuit held that the government must submit a treatment plan containing the proposed medications and maximum dosages before the trial court can determine whether the second and fourth prongs required under *United States v. Sell*, 539 U.S. 166 (2003), have been met in order to justify an involuntary medication order. *United States v. Chavez*, 734 F.3d 1247 (10th Cir. 2013). In order to authorize medication of an incompetent defendant under *Sell*, the government must establish 1) that important governmental interests are at stake, 2) the involuntary medication will significantly further those interests, 3) the involuntary medication is necessary to further those interests, and 4) the administration of the medication is medically appropriate and in the defendant's best medical interests.

Reydecel Chavez, a Mexican citizen, was arrested in New Mexico and charged with being a felon in possession of a firearm, being an illegal alien in possession of a firearm, and reentry into the United States as a removed alien. Soon after he was charged, both his attorney and the government agreed that Chavez should be evaluated for his competency to stand trial. The district court committed him to the Bureau of Prisons medical center in Springfield, Missouri for a competency determination. The psychologist performing the evaluation reported that Chavez was diagnosed with paranoid schizophrenia and was not competent to stand trial. He also reported that Chavez was not a danger to himself or others while in custody and could likely be restored to competency with antipsychotic medication, which he was refusing.

At the competency hearing, the district court found Chavez incompetent to stand trial, and at the court's suggestion, the government filed a motion to require him to undergo treatment with medication over his objection. The same evaluator testified in general terms as to the treatment Chavez would likely receive, but the government presented no individualized treatment plan. The evaluator testified that an individualized treatment plan would be prepared for Chavez only after involuntary treatment was authorized by the court. He also testified that as

a psychologist he could not prescribe medication for Chavez, but that the “typical” treatment plan would involve injection with Haldol. Side effects could be addressed with a change in medication or administration of drugs specifically designed to treat them. He further testified that three-fourths of defendants treated with antipsychotic medications are successfully restored to competency. Following this testimony, and over Chavez’s objection, the district court found that a specific treatment plan was not necessary to meet the *Sell* requirements and ordered his treatment over objection, requiring only a status report in about six weeks.

On appeal, the Tenth Circuit found that the first two prongs of the *Sell* test were purely issues of law for the appellate court to decide *de novo*, but the third and fourth prongs were factual determinations that the appellate court would reverse only if they were clearly erroneous with no evidence in the record to support them. The Tenth Circuit then analyzed the evidence supporting the *Sell* requirements and agreed with Chavez’s arguments that without a specific treatment plan identifying which medications would be administered to him and at what doses, the district court had insufficient information to make the required findings. The Court of Appeals found that the need for a high level of detail is plainly contemplated by the *Sell* case. Without evidence in the record that a psychiatrist who will be prescribing the drugs solely to render him competent to stand trial, the court cannot ensure as a legal matter under the second *Sell* prong that the administration of the drugs will be substantially unlikely to produce side effects that will interfere with Chavez’s ability to assist his attorney in presenting a defense. Also, without knowing which drugs the government might administer and at what dosage, the court has no evidence upon which it can determine under the fourth prong whether the treatment will be medically appropriate for Chavez. In addition, the court’s order sets no meaningful limits on the government’s discretion in treating Chavez and is so open-ended that it would give treatment staff carte blanche to experiment with what might be dangerous drugs or dangerously high dosages of drugs.

In making these findings, the Tenth Circuit followed the decisions from three other circuits. The Ninth Circuit held in *United States v. Hernandez-Vasquez*, 513 F.3d 908 (9th Cir. 2007), that to pass muster under *Sell*, 1) the district court’s order must identify the specific medication or range of medications the physicians are permitted to use, 2) the maximum dosages, and 3) the duration of time the involuntary medication may continue before requiring a report back to the court. Similarly, the Fourth Circuit held in *United States v. Evans*, 404 F.3d 227 (4th Cir. 2005), that the government must set forth the particular medication, including the dosage. The Sixth Circuit in *United States v. Green*, 532 F.3d 538 (6th Cir. 2008), also upheld a specific treatment plan that set forth the specific medications, alternative means of injecting it, the specific dosage, and the potential side-effects.

In following these cases, the Tenth Circuit decided that a balance must be struck between the judicial oversight needed to protect the defendant’s constitutional rights and the need of medical staff to retain flexibility in providing effective treatment. The Court then held that a court may approve a treatment plan as long as all drugs that might be administered to a defendant and their maximum dosages are specified. In so doing, the Tenth Circuit found that the district court’s order lacked sufficient information to determine whether the second and fourth requirements under *Sell* were met, reversed the order and remanded the case for further proceedings.

DC Circuit Rejects Special Circumstances Argument of Potential Lengthy Civil Commitment in Upholding Involuntary Medication Order

The District of Columbia Circuit Court of Appeals upheld on December 24, 2013, the district court's order authorizing involuntary treatment with antipsychotic medication to restore the defendant's competency to stand trial. The Court found no merit in the defendant's argument under the first prong of *United States v. Sell*, 539 U.S. 166 (2003), that his potential civil commitment undermined the government's interest in prosecuting him for threatening the President of the United States. *United States v. Dillon*, 738 F.3d 284 (D.C.Cir. 2013).

The defendant Simon Dillon was indicted for threatening the President of the United States. Dillon, who had been repeatedly hospitalized for mental illness, sent an email to a Secret Service agent from a location three blocks from the White House, stating that he would not harm the President if the agent met with him and agreed to "meet the demands of God." If the agent did not, the President would get the worst Christmas present ever, would suffer for 30 days, and would wish for death that would not come to him. The Secret Service arrested Dillon the next day, and the D.C. Department of Mental Health sought his civil commitment. Following an administrative hearing in January 2012, the Mental Health Commission recommended his outpatient civil commitment. Dillon was then re-arrested and shortly thereafter, the district court ordered him committed for a competency evaluation.

Two government doctors first evaluated Dillon at the Metropolitan Correctional Center, and in a March 2012 report, diagnosed him with schizophrenia, paranoid type, but concluded he was competent to stand trial. Their opinion came with less than the usual degree of psychological certainty because they found Dillon was unable to rationally consider an insanity defense. As a result, both Dillon and the government requested a further psychiatric evaluation, and the court committed him to Butner Federal Medical Center. At Butner, he was diagnosed with delusional disorder, grandiose type, and the evaluator concluded he was incompetent to stand trial. Following a hearing, the district court found him incompetent to stand trial and committed him for a determination as to whether he could be restored to competency. Following a competency restoration study submitted to the court in February 2013, two evaluators diagnosed Dillon with schizoaffective disorder, bipolar type and concluded he could be restored to competency with antipsychotic medication. They based their conclusion on studies estimating the rate at which defendants are successfully restored to competency and on Dillon's medical history indicating he had responded favorably to psychotropic medication during prior hospitalizations. They also reported that Dillon was not a danger to himself or others while in custody.

As a result of this report, the court held a *Sell* hearing at which both the evaluating psychologist and psychiatrist testified. The district court found that the government had an important interest in bringing the defendant to trial that was not undermined by special circumstances, and that involuntary medication would significantly further that interest. On appeal, the D.C. Circuit first reviewed the Supreme Court decisions on involuntary medication, including the *Sell* decision. It then concluded that it should conduct a *de novo* review of the district court's holding under the first prong of *Sell* as to the importance of the governmental interest in prosecuting the case, and that it should review the remaining findings on the other

three prongs for clear error, following the approach of the majority of other circuits, except the Tenth Circuit.

Dillon first challenged the district court's finding under the first prong of *Sell* that important governmental interests were at stake. Dillon conceded that the crime with which he was charged was serious, but argued that special circumstances existed that lessened the importance of the government's interest, namely the prospect of lengthy civil commitment and his own purported non-dangerousness. Dillon, however, failed to argue the potential for his civil commitment before the district court, even though the government mentioned it in its brief and argument. The Court of Appeals therefore found he had waived his ability to raise this argument on appeal. The Court further found that the argument would not have succeeded in any event even though *Sell* raised the potential for lengthy civil commitment as a special circumstance that could undermine the government's interest in prosecution. The Court noted that Dillon was only civilly committed to outpatient treatment following his arrest on these charges, and given his second argument that he was not dangerous, it was unlikely he would have been committed to civil "confinement," the term used in *Sell* instead of civil "commitment."

Dillon also argued that he was not dangerous and this factor undermined the government's interest in prosecuting him. The Court found, however, that although the government has an interest in incapacitating someone who is a danger to the public, it is not the government's sole interest. The governmental interest also includes protecting the public by incapacitating the defendant, promoting respect for the law, and providing just punishment for an offense.

Dillon next argued under the second prong of the *Sell* test that the medication was not substantially likely to restore his competency. He stated that the schizoaffective diagnosis was inaccurate and he instead suffered from a delusional disorder. He argued the success rate for treating delusional disorders with antipsychotic medication was too low to warrant his forced medication. The Court pointed out, however, that the last two doctors who diagnosed Dillon with schizoaffective disorder had a much longer time to observe him and arrive at the correct diagnosis, plus his medical history reflected he had previously responded favorably to treatment with antipsychotic medication. The Court therefore found that the district court's determinations were not clearly erroneous and upheld its order to treat Dillon with medication over his objection to restore his competency to stand trial.

Tenth Circuit Holds Insanity Defense Precludes "Acceptance-of-Responsibility" Downward Adjustment to Sentencing Guidelines

The Tenth Circuit Court of Appeals upheld on January 14, 2014, the district court's refusal to give a defendant a reduction from the sentencing guidelines based on his acceptance of responsibility for his criminal acts because he raised an affirmative insanity defense. In refusing to approve a sentencing reduction, the Court of Appeals distinguished the insanity defense which the defendant must raise and prove by clear and convincing evidence from a *mens rea* challenge, which is an element of the offense the prosecution must prove beyond a reasonable doubt, and for which a court in its discretion may accord a sentence reduction. *United States v. Herriman*, 739 F.3d 1250 (10th Cir. 2014).

In August 2011, Daniel Herriman planted a bomb near a gas pipeline in Oklahoma. When he saw on the news that police had discovered the bomb, he called the police and told them he was responsible. When the police interviewed him, he provided details relating to the bomb, including what materials he used to make it and where they could be located in his house. After investigation and a search of his house, the government charged Herriman with attempting to destroy or damage property by means of an explosive and with illegally making a destructive device.

During pretrial proceedings, the district court became concerned about Herriman's competency to stand trial and ordered a mental evaluation. A forensic psychologist with the Bureau of Prisons examined him and found him competent to stand trial, a finding which the court accepted. Herriman then gave notice that he would raise an insanity defense. At trial, he did not challenge the prosecution's evidence that he had constructed and placed the explosive device. In support of his insanity defense, Herriman presented evidence that he had been diagnosed with manic depression, schizoaffective disorder, and post-traumatic stress disorder caused by sexual abuse he had experienced as a child. He had attempted suicide at age 13 and had been repeatedly hospitalized for psychotic episodes. Herriman had also been upset by the death of his mother by suicide and by the death of his sister, possibly by suicide. He also suffered from command hallucinations and was prescribed antipsychotic medications, which did not always work. At the time of the offenses charged, Herriman was taking antipsychotic medication and seeing a psychiatrist regularly. Herriman argued that his mental condition was aggravated at the time of the offenses due to the anniversary of his mother's death. Voices identifying themselves as al Qaeda urged him to plant the bomb and told him he would be turned over to the individuals who had sexually abused him if he disobeyed.

The prosecution strongly challenged Herriman's evidence eliciting testimony from his psychiatrist that he never mentioned auditory hallucinations to him during the time surrounding the events charged, nor did the psychiatrist notice any behavior indicating he was hearing voices. Testimony from his ex-wife and son indicated that his behavior at the time was cogent and lucid. The government also argued that Herriman clearly had the mental capacity to assemble a bomb. The jury rejected Herriman's insanity defense and found him guilty of both charges. At sentencing Herriman argued that the court should apply an acceptance-of-responsibility adjustment to the sentencing guidelines. The district court refused to do so and sentenced him to sixty-three months in prison on each count to be served concurrently, followed by three years of supervised release.

Under the sentencing guidelines, district courts are required to decrease the offense level of the crime by two levels if the defendant clearly demonstrates acceptance of responsibility for his offense. The Court of Appeals emphasized that Note 2 to the guidelines clarifies that an adjustment is not intended for a defendant who puts the government to the burden of proof at trial by denying the essential *factual* elements of guilt, is convicted and then admits guilt and expresses remorse. Such an adjustment to the guidelines is available only in rare circumstances when the defendant insists upon a trial only in order to preserve a *legal* defense to the charge.

In upholding the district court’s refusal to grant a downward adjustment, the Court of Appeals applied a clearly erroneous standard to the court’s decision. It then distinguished this case from *United States v. Gauvin*, 173 F.3d 798 (10th Cir. 1999), the only case in which the Court indicated it had ever approved a downward adjustment based upon acceptance of responsibility when the defendant required the prosecution to prove its case at trial. The defendant in *Gauvin* committed an assault while intoxicated. He acknowledged the conduct with which he was charged, but denied due to his voluntary intoxication that he was guilty of the crime charged. He denied he met the *mens rea* or the intent to harm or cause apprehension, which was a *legal* element of the crime. Although Herriman in this case acknowledged he committed the acts charged, he *factually* challenged whether he was criminally liable due to his insanity at the time of the offense, a fact which the government vigorously challenged.

The Court of Appeals acknowledged that the same evidence would be relevant both to challenge the *mens rea* element of an offense and to assert an insanity defense. But the Court stated that the process for raising the defenses is completely different. The *mens rea* is the mental element of the crime charged, which the government must prove beyond a reasonable doubt. By contrast, insanity is an affirmative defense which a defendant must raise and prove by clear and convincing evidence. In *Gauvin*, the defendant admitted he committed the acts in question, but was legally not guilty of all the elements of the crime charged. Here, Herriman acknowledged he committed the acts, but could not be held criminally liable due to his mental state, a fact the prosecution strongly contested. The Court of Appeals therefore upheld the district court’s refusal to grant a downward adjustment to the sentencing guidelines because, unlike Gauvin who only forced the government to proceed to trial to preserve a legal issue unrelated to his factual guilt, Herriman required the government to rebut the factual evidence of his insanity at trial.

Do you have questions or comments concerning any of the above cases? Please post them [here](#).

ⁱ The State Report is available at <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/GPHMI-State.pdf>.

ⁱⁱ The Federal Policy Report is available at <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/GPHMI-Federal.pdf>.

ⁱⁱⁱ Additional information concerning the Consortium for Risk-Based Firearm Policy may be obtained at <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/>.

^{iv} Swanson, J.W., Robertson A.G., Frisman L.K., Norko M.A., Lin H.J., Swartz M.S. Cook P.J. (2013). Preventing Gun Violence Involving People with Serious Mental Illness. *Reducing Gun Violence in America: Informing Policy with Evidence and Analysis*, 33-51.

^v 121 STAT. 2559, NICS Improvement Amendments Act of 2007.

^{vi} Cal. Welf. & Inst. Code § 8103.

^{vii} Wintemute, G.J. (2011). Association between firearm ownership, firearm-related risk and risk reduction behaviors and alcohol-related risk behaviors. *Injury prevention*, 17(6), 422-427.

^{viii} McMillen, D.L., Adams, M.S., Wells-Parker, E., Pang, M.G., & Anderson, B.J. (1992). Personality traits and behaviors of alcohol-impaired drivers; a comparison of first and multiple offenders. *Addictive behaviors*, 17(5), 407-414.

^{ix} 18 Pa. C.S.A. § 6105.

^x Conn. Gen. Stat. § 29-38c.

^{xi} Ind. Code Ann. § 5-47-14.

^{xii} Texas Health and Safety Code Title 7, subtitle C, § 573.001.

^{xiii}79 Fed. Reg. 774 (January 7, 2014)(to be codified at 27 CFR § 478.11). The proposed regulation is available in the Federal Register at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-07/pdf/2014-00039.pdf>.

^{xiv}79 Fed. Reg. 784 (January 7, 2014)(to be codified at 45 CFR § 164.512(k)(7). The proposed regulation is available in the Federal Register at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-07/pdf/2014-00055.pdf>.

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Full-day Conference on Juvenile Justice

February 27, 2014, Charlottesville, VA: This full-day conference on juvenile justice engages participants in state-of-the-art discussions of three issues of contemporary concern: Pathways of Desistance to Crime in Juveniles, with Edward Mulvey, Ph.D; How Juveniles Understand and Use Their Miranda Rights, with Heather Zelle J.D., Ph.D; and Wrongful Conviction of Juvenile Offenders, with Gregg McCrary, SSA Retired (FBI). Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$50. Others: \$135. Group discounts to other agencies may be available: please contact els2e@virginia.edu.

Assessing Individuals Charged with Sexual Crimes

February 27-28, 2014, Charlottesville, VA: This program focuses on the assessment and evaluation of sexual offenders, including 19.2-300 pre-sentencing evaluations and 37.2-904 assessment of Sexually Violent Predators (SVPs). The program addresses the legal background relevant to sex-offender evaluation as well as the clinical background including topics such as paraphilias and base rates of reoffending. The program provides training in well-researched sex-offender risk assessment instruments. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$100. Others: \$190. Group discounts to other agencies may be available.

Advanced Seminar: Dynamic Risk Factors: Implications for Assessing Treatment Progress and Recidivism Risk

March 3, 2014, Charlottesville, VA: Rebecca Jackson, Ph.D, will present a full-day advanced seminar on Dynamic Risk Factors: Implications for Assessing Treatment Progress and Recidivism Risk. This program may meet needs of providers for renewal of SOTP certification in Virginia. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$50. Others: \$135. Group discounts to other agencies may be available: please contact els2e@virginia.edu.

Conducting Mental Health Evaluations for Capital Sentencing Proceedings

April 21-22, 2014, Charlottesville, VA: This two-day program prepares experienced forensic mental health professionals to meet the demands of a capital sentencing case, in which the accused faces the possibility of the death penalty. Attorneys and others are welcome. The agenda includes statutory guidelines for conducting these evaluations, the nature of the mitigation inquiry, the increased relevance of mental retardation, the process of consulting with both the defense and the prosecution, and ethics in forensic practice. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$100. Others: \$190. Group discounts to other agencies may be available: please contact els2e@virginia.edu.

Juvenile Forensic Evaluation: Principles and Practice

May 5-9, 2014, Charlottesville, VA: This five-day program provides basic legal, clinical, and evidence-based training in the principles and practices of forensic evaluation appropriate for juvenile forensic evaluators. The format combines lectures, clinical case material, and practice case examples for evaluation of juveniles. Ethics of professional practice is explored. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$250. Others: \$750.

Evaluation Update: Applying Forensic Skills to Juveniles

May 5,6,7, 2014, Charlottesville, VA: This three-day program is for experienced adult forensic evaluators - who have already completed the five-day "Basic Forensic Evaluation" program (regarding evaluation of adults) and accomplished all relevant qualifications for performing adult forensic evaluation - and wish to become qualified to perform juvenile forensic evaluations. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$100. Others: \$190.

Advanced Seminar: Mock Trial and Discussion

May 21, 2014, Charlottesville, VA: This program provides a full-day exploration of trial preparation, courtroom dynamics and expert testifying through a mock trial and preparatory and follow-up discussions. The program is planned to be held in a courtroom of the University of Virginia's School of Law. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$50. Others: \$135. Group discounts to other agencies may be available: please contact els2e@virginia.edu.

Advanced Case Presentation: Juvenile Adjudicative Competence

Date TBD, Charlottesville, VA: Advanced Case Presentation is a follow-up training for all evaluators who have successfully completed the Juvenile Forensic Evaluation training or Evaluation Update training and who wish to complete the training requirements approved by the VA DBHDS Commissioner for individuals authorized to conduct juvenile competence evaluations. Registration fees: Employees of VA DBHDS facilities and Community Services Boards: \$50. Others: \$135. Group discounts to other agencies may be available: please contact els2e@virginia.edu.

In Planning:

April 11, 2014, Charlottesville, VA: A day of learning and discussion is being planned regarding juvenile mental health. Overview presentations would include depression, anxiety, psychosis, trauma, and malingering, with special consideration given to issues of intellectual disability and gender differences. Presentation and discussion of exemplary cases are expected as part of the day-long program. Please visit the Institute's website where the program's webpage will be posted when full information is available.