Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters commenting on material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Refocusing Gun Policy

To the Editor: The article by McGinty and colleagues (1) in the January issue does a fine job of setting out a research agenda for gun laws applied to individuals with serious mental illness. However, it starts with the premise that we should consider such legislation as reasonable. I argue that the authors are looking down the wrong end of the barrel and furthering stigma.

Some have argued that the problem is gun control, but that approach has not been successful. One might as well advocate for making bullets illegal. In fact, some have suggested limiting the number of rounds sold at any one time. What actually kills? It's not guns. It's bullets. But that strategy is not likely to be any more effective than banning firearms.

What concerns me is focusing on policies that continue to make the spurious link between routine gun violence and mental illness. Suicide is the bigger problem. Mass shootings involving individuals with a history of mental illness fortunately are rare. Segregation of those with serious mental illness under yet another heading for purposes of separate treatment is little better than such separation was during the U.S. eugenics movement, the place where it all began back in the 1920s.

Jeffrey L. Geller, M.D., M.P.H.

Dr. Geller is facility medical director, Worcester Recovery Center and Hospital, and professor, Department of Psychiatry, University of Massachusetts Medical School, Worcester.

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In Reply: The two arguments raised by Dr. Geller play a central role in the ongoing national debate surrounding policy proposals to prevent persons with serious mental illness from having guns. Dr. Geller asserts that such policies—most of which have been proposed in response to mass shootings—are unlikely to prevent gun violence and likely to exacerbate public stigma toward persons with mental illness.

In the United States, an estimated 3%–5% of violence toward others is due to mental illness (1). Policies to prevent persons with serious mental illness from having guns are therefore unlikely to prevent the majority of gun violence in our society. This does not mean, however, that preventing firearm violence committed by persons with mental illness is not a worthy policy goal. A robust body of research shows that during high-risk periods—such as the time surrounding inpatient hospitalization or a first episode of psychosis—small subgroups of persons with serious mental illness are at heightened risk of committing violence toward others (2). Such violence is devastating to victims and perpetrators with mental illness alike, and recent research suggests that policies to prevent persons with serious mental illness from having guns can be effective. Under federal law, persons who have been involuntarily committed to inpatient psychiatric care or adjudicated mentally incompetent are prohibited from possessing firearms. Swanson and colleagues (1) found that implementation of this law in Connecticut was associated with a significant reduction in risk of arrest for violent crime among persons prohibited from having a gun because of mental illness.

In addition, mental illness is strongly associated with risk of firearm suicide. Firearm suicide accounts for 60% of gun deaths in the United States, and most fatal suicide attempts involve guns (1). Restricting access to lethal means is one of the only evidence-based strategies to prevent suicide (3), and implementation of means-restriction interventions is one of the core goals of the 2012 National Strategy for Suicide Prevention. However, little research exists to inform implementation of means-restriction interventions to prevent firearm suicide. Keeping firearms from persons at serious risk of suicide will require a combination of persuasive counseling by clinicians and, when necessary, effective policies that allow for removal of firearms during periods of high risk. Research related to the development, implementation, and evaluation of such policies is critically needed.

Pervasive public stigma toward persons with serious mental illness in the United States is associated with poor health and social outcomes in this vulnerable population (4). To date, however, no evidence exists to support the assertion that gun policies focused on mental illness exacerbate stigma. One national randomized study found that messages promoting policy to prevent "dangerous people" with serious mental illness from having guns did not heighten public stigma, compared with a control group (5). However, little is known about how persons with mental illness view such policies. Future studies should assess mental health care consumers' perspectives on existing or innovative policy mechanisms to prevent persons at risk of gun violence—particularly suicide—from having guns.

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Daniel W. Webster, Sc.D., M.P.H.
Colleen L. Barry, Ph.D., M.P.P.

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4. Pescosolido BA, Martin JK, Long JS, et al: "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. American Journal of Psychiatry 167:1321–1330, 2010

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Suicide Risk Assessment and Risk of Suicide in Schizophrenia

To the Editor: In the February issue, Pedersen and associates (1) reported that between 2005 and 2009, a steadily increasing proportion of patients with schizophrenia had received a suicide risk assessment at the point of discharge from Danish psychiatric hospitals. The authors also reported that 64 of 7,107 (.9%) discharged patients with schizophrenia died as a result of suicide during the following year. This second statistic suggests that patients with schizophrenia are approximately 80 times more likely to die by suicide than the general Danish population, for which the suicide rate is approximately 11.6 suicides per 100,000 per year (2). An understanding of the potential utility of risk assessment and the difference between absolute and relative risk suggests that the steady increase in risk assessment reported in Denmark represents the outcome of misguided policy.

A recent meta-analysis found that the odds of suicide among high-risk patients in the year after discharge from psychiatric hospitals were four times higher than among low-risk patients (3). This figure is dwarfed by the 80-fold increase, compared with the general population, in the likelihood of suicide among patients who are discharged with a diagnosis of schizophrenia. Irrespective of the patient's risk category, any patient discharged with schizophrenia is many times more likely than an individual in the general population to die by suicide. The low specificity of risk assessment means that few of the patients classified as high risk will actually die by suicide. Patients classified as low risk will still be at many times the risk of suicide as the general population.

Unless there is an intervention to reduce suicide that is suitable for "high-risk" patients that should not also be available to "low-risk" patients there is no point in further stratifying the population of patients discharged with schizophrenia by their assessed relative risk. There is no such intervention. Risk assessment of patients discharged with schizophrenia is pointless. All discharged patients should be offered individualized, optimized care to improve well-being and thereby reduce the likelihood of their taking their own lives.

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In Reply: On behalf of the author group, I thank Dr. Large and Dr. Ryan for their comments on our article. Screening for suicide risk among patients with schizophrenia cannot be done accurately, and when viewed as a diagnostic test, the currently used screening tools perform rather poorly. Thus it is natural to question the role of systematic suicide risk assessment in modern psychiatry.

However, systematic suicide risk assessment remains widely used across health care systems. This practice is rational if the systematic assessment is not used as a stand-alone diagnostic test with a dichotomous outcome. Instead, it should be considered a tool to supplement direct observation and interviews with the patient and his or her close relatives or friends. A systematic and structured approach is in our opinion a prerequisite for fulfilling the overall aim stated by Dr. Large and Dr. Ryan—that all patients "should be offered individualized, optimized care to improve well-being and thereby reduce the likelihood of their taking their own lives."

Charlotte Gjørup Pedersen, Ph.D., M.H.Sc.

Internet Use Among Veterans With Severe Mental Illness

To the Editor: Despite advances in Internet technologies, the extent to which adults with severe mental illness have access to and use these technologies remains unclear. The Internet has become an important portal for various activities and is becoming an integral part of health care. For example, the U.S. Department of Veterans Affairs (VA) has implemented an online health care record system for patients to access and interact with their health care providers. A national study found that veterans who use VA mental health services are not less likely to use the Internet than other VA service users or veterans who are users of non-VA services (1).

We conducted a study comparing the prevalence of Internet use in a local sample of 210 veterans with severe mental illness and in two other samples—a nationally representative