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POLICY SERIES

Preventing Suicide Through Better Firearm Safety Policy in the United States

Jeffrey W. Swanson, Ph.D.

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Dear Reader,

Now is the time to solve the growing behavioral health needs in our country by advancing public policies that transform the delivery of mental health and substance use disorder services and address outdated funding mechanisms.

This paper is part of Think Bigger Do Good, a series of papers launched in 2017 through the support and leadership of the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation. While the paper topics continue to evolve, our goal to develop a policy agenda to improve health outcomes for all remains constant.

In partnership with national experts in behavioral health, including our editors, Howard Goldman and Constance Gartner, we identified seven critical topics for this third series of papers. Each paper identifies the problem and provides clear, actionable solutions.

We hope you join us in advocating for stronger behavioral health policies by sharing this paper with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters. To learn more about Think Bigger Do Good and to access the other papers in the series, visit **www.thinkbiggerdogood.org**

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Preventing Suicide Through Better Firearm Safety Policy in the United States

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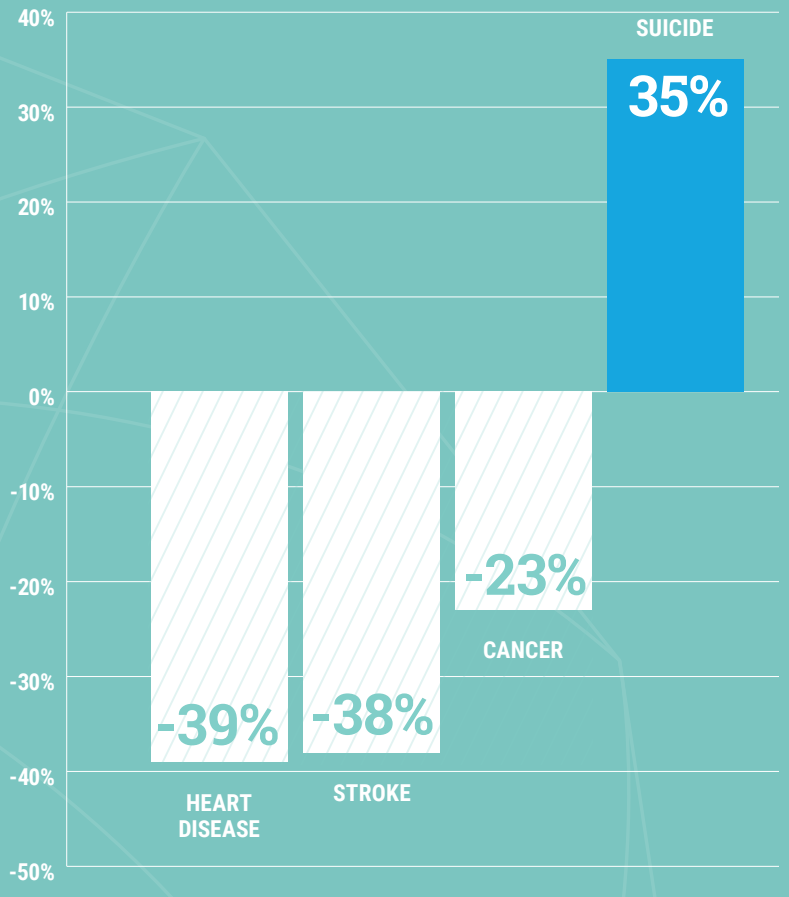
The suicide death rate in the United States has increased by 35% over the past two decades (1), despite federal investment in research to "understand the neurobiological underpinnings of suicide and [develop] suicide risk screening tools for use in medical settings" (2). During the same period, medical and public health advances have brought steep declines in mortality from heart disease (down 39%), cancer (down 23%), and stroke (down 38%) (3, 4). What makes suicide different as a public health problem, and what should be done differently to address it?

Change in mortality rates from selected causes in the U.S. | 1999-2017



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Vital Statistics Reports 68:6 and 49:11

1 Thinking Differently About Suicide as a Socially Determined Public Health Problem

The traditional approach to suicide prevention has tended to view suicidal behavior as symptomatic of an insufficiently treated mental health condition. In support of this model, epidemiological research has found that people with serious psychiatric illnesses and substance use disorders have an eightfold relative risk of suicide (5, 6) and that suicide rates are lower in populations with greater access to mental health care (7). Such studies imply that suicide prevention should focus on finding at-risk individuals with behavioral health disorders and improving their access to effective treatment, including timely hospitalization when needed. Examples of this approach include suicide screening and risk assessment protocols in clinical settings, public education on how to recognize suicide warning signs and "get help," and the proliferation of crisis line telephone services (8).

The mental health–focused model is not necessarily wrong, as far as it goes, but it comes up short in preventing a large number of suicides. Available mental health treatment is not always effective in ameliorating suicidal symptoms (9). About one in five suicide decedents were currently being treated for a mental health problem when they died (10), and recently discharged psychiatric hospital patients have a suicide rate 100 times higher than the rate in the general population (11). Also, many important risk factors for suicide are unrelated to having a mental illness or an addiction disorder and fall outside the scope of standard behavioral health care interventions. On average across studies, the proportion of suicide risk that is attributable to behavioral health disorders is approximately 57% in the male population and 77% among females; the rest is attributable to social, economic, circumstantial and other factors with little or no connection to psychopathology (12). Access to lethal means is perhaps the most important circumstantial driver of suicide mortality in the United States and is amenable to policy interventions that have untapped potential to prevent a large number of suicide deaths (13).

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An estimated 1.4 million people in the United States survived a suicide attempt in 2017 (14), and about 47,000 died (1). Clearly, the overwhelming majority of people who try to end their own life get a second chance. However, case-fatality rates vary dramatically by the method of intentional self-harm. People who use a firearm to attempt suicide seldom survive; nearly nine out of 10 die (15). Guns account for over half of suicide deaths, and suicides account for about 60% of firearm-related fatalities (1). In the United States, men are nearly four times more likely than women to die of suicide, even though men have lower rates of depression (16). Greater access to firearms is one reason for this paradox; 62% of gun owners (17) and 86% of gun suicide decedents are men (1).

Gun safety thus deserves a special focus in suicide prevention, especially in the male population. The policy challenge is to develop and broadly implement more effective strategies—including legal tools—to keep guns out of the hands of people at highest risk of suicide, without unduly infringing the Second Amendment rights of a large number of gun owners who are unlikely to harm anyone (18).

2 Promise and Challenge of Implementing Gun Policy to Prevent Suicide

Private gun ownership in the United States is highly prevalent (19), culturally entrenched (20, 21), corporately sustained (22), constitutionally protected (23), and politically divisive (24, 25). In this social context, and in contrast with other advanced nations, neither federal nor state laws can broadly limit the general public's access to firearms. Rather, gun restrictions must be narrowly tailored and targeted to categories of people with objective indicators of dangerousness—such as those convicted of a felony or a domestic violence crime or involuntarily committed to a psychiatric hospital (26). But the majority of suicide decedents do not fall into those legal categories, and most persons who are prohibited access to guns are not at high risk of dying by their own hand (27). Thus, in terms of suicide prevention, the 1960s-era federal gun-prohibiting criteria premised on lifetime criminal and civil adjudication records (28) are overbroad and too narrow at the same time (29, 30).

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To be more successful in reducing the suicide rate, firearm laws in the United States must accomplish three intermediate goals: first, modify existing gun prohibitions so they apply to more people at a higher risk of suicide (31); second, comprehensively enforce these improved restrictions, both by denying illegal gun acquisitions at the point of sale and requiring newly prohibited persons to surrender the guns they may already possess (32); and third, develop and implement legal tools to remove access to firearms—at least temporarily—from otherwise gun-eligible individuals who manifest a high risk of suicide, including laws giving those with insight into their own potential future risk of self-harm the agency to prohibit themselves from buying guns through a voluntary and reversible waiver of firearm rights (33). These policy goals must be pursued in such a way as to avoid infringing the rights of many gun owners who pose no danger and without unduly compromising the privacy of psychiatric patients or eroding health care professionals' therapeutic role (34).

There should not be a forced choice between suicide prevention policies that increase the public's access to mental health treatment interventions and those that decrease at-risk individuals' access to firearms; both approaches have their place and should be complementary.

Since the federal Brady Handgun Violence Prevention Act was enacted in 1993 (35), the requirement for a background check before an individual buys a firearm from a licensed dealer has been the lynchpin of gun safety policy in the United States. Established to implement the Brady Act, the FBI's National Instant Criminal Background Check System (NICS) has been in operation since 1998. But a background check is only as good as the legal criteria for denying a sale, the quality and completeness of records in the database, the timeliness of reporting from state authorities, the reach of the requirement to all gun transfers, the suppression of illegal gun markets, and the foreclosure of alternative ways in which prohibited or otherwise dangerous persons can access guns. These moderating conditions have diminished the benefit of background checks to date (36, 37), but they highlight opportunities to make the system work better.

Psychiatric patients with a record of involuntary civil commitment have been legally disqualified from purchasing or possessing firearms since Congress enacted the Gun Control Act of 1968 (28). This prohibiting category invites scrutiny through the lens of contemporary suicide prevention goals. During the era when the law was passed, a substantial proportion of adults with serious mental illnesses spent time in state mental hospitals under involuntary commitment orders (38, 39). A half-century later, after thoroughgoing deinstitutionalization and reform of states' civil commitment statutes, only about 1% of the 11.4 million adults with serious mental illnesses in the United States experience involuntary commitment in a given year (40, 41).

Over the past decade, many states have reported their entire archives of historical commitment records to the NICS, dramatically expanding the number of gun-disqualifying mental health records in the database from approximately 650,000 in 2009 to 5.7 million in 2018. Less than 1% of these mental health records have resulted in denial of a firearm sale or license application (42). Thus, even while a much smaller proportion of people with serious mental illnesses than in the past are becoming legally disqualified from possessing guns because of a contemporaneous civil commitment episode, an increasingly large number have had their names added to the NICS by dint of a record from their remote past (30, 43). As a result, over time the correlation has decayed between involuntary commitment as a lifetime gun disqualifier and actual risk of suicide among the persons it has disqualified. Three federal appeals courts have recently issued differing opinions in deciding legal challenges to the lifetime gun prohibition conferred by civil commitment as applied to former psychiatric patients with remote commitment records (44).

However, more than half of these gun-eligible individuals who died by gun suicide had a history of a short-term psychiatric emergency hold for examination.

Meanwhile, short-term holds for evaluation in a mental health crisis have become far more common than longer-term involuntary commitments, particularly in some states (41). Florida, with its extensive use of the Baker Act (45), is an instructive example. In a recent longitudinal study of suicide outcomes among 81,704 adults diagnosed as having schizophrenia, bipolar disorder, or depression in the public behavioral health system in Florida, only 12.8% of patients were found to have records of involuntary commitment; 33.5% had experienced an involuntary psychiatric examination before being released within 72 hours or hospitalized voluntarily. Nearly three out of four gun-suicide decedents in the study could have passed a federal background check to purchase a firearm. However, more than half of these gun-eligible individuals who died by gun suicide had a history of a short-term psychiatric emergency hold for examination. In Florida, and in more than half of the other states, this type of short-term hold for examination, absent a commitment order, does not confer even a temporary restriction from firearms (46). This presents an opportunity for a life-saving policy reform.

Interventions with persons who have alcohol use disorders present another important opportunity for suicide prevention. Heavy drinkers are five times more likely than social drinkers to die of suicide, according to meta-analytic cohort studies (47). Suicide decedents were six to 10 times more likely to have been intoxicated before their death, compared with living persons in a matched control group (48). And there is evidence that chronic, excessive drinking is significantly correlated with dangerous misuse of firearms. A recent large study found that people who have been convicted for an alcohol-related crime, such as driving under the influence (DUI), were four to five times more likely than those with no such convictions to be subsequently arrested for a firearm-related crime (49). Many people with records indicating serious alcohol problems are not prohibited from purchasing and possessing firearms.

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Expanding the categories of persons who are restricted from purchasing guns could help to keep more lethal weapons out of the hands of suicidal individuals but would still leave many at risk who can legally possess firearms. Risk-based, time-limited gun removal laws—formally known as extreme risk protection orders (ERPOs)—represent an innovative legal tool to fill this gap in lethal-means restriction policies. ERPOs authorize police officers or concerned family members to seek a civil restraining order from a court to temporarily remove access to guns from a person who is behaving dangerously and thereby poses a significant risk of self-harm or violence against others. As of May 2020, a total of 19 states and the District of Columbia have adopted ERPO laws (33). National opinion polls show broad support for ERPOs among the general public, including majorities of gun owners (50). Research in two states—Connecticut (51) and Indiana (52)—found that risk-based gun removal orders were being applied to a population with a suicide rate 30 to 40 times higher than the rate in the general population. These studies estimated that for every 10 to 20 gun-removal actions, one life was saved by an averted suicide. Although more research is needed in other jurisdictions, the evidence of effectiveness to date suggests that bringing such a policy to scale could have a large beneficial impact.

3 Selected Gun Policy Reforms to Prevent Suicide

The recommendations described below are firearm-focused statutory reforms to be adopted primarily at the state level. These proposals follow from the arguments developed on the role of gun safety in preventing suicides.

Recommendation 1. Expand and Sharpen Gun-Prohibiting Criteria

States should expand and sharpen their gun-prohibiting legal criteria to better align with risk. This would ensure that a greater proportion of individuals at risk of suicide would not have access to a gun during a season of hopelessness or a moment of intoxicated despair (31, 53). Two specific restrictions, outlined below, would be likely to have a meaningful impact in preventing firearm-involved suicide and would thus reduce the population suicide rate overall.

Recommendation 1a: States should prohibit purchase and possession of or access to firearms for a period of time by persons with a record of a brief involuntary hold for a psychiatric examination

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More than 100,000 people are hospitalized in the United States each year for suicidal behavior (54), and many retain their gun rights when they leave the hospital—despite having a postdischarge risk of suicide 100 times higher than the suicide risk in the general population (11). Individuals who experience a suicidal crisis are often taken to a hospital emergency department, where they undergo an involuntary psychiatric examination and are held for a brief period—typically for less than 72 hours—before being released or admitted voluntary for inpatient treatment. Offering a patient in crisis the option of signing into the hospital voluntarily is standard operating procedure in many psychiatric facilities, which results in a large number of persons avoiding a commitment record who would have been committed under similar circumstances in the past. Under the current laws of more than half the states, unless such individuals receive an involuntary civil commitment order in a judicial hearing, they are not subsequently prohibited from owning, purchasing, or having access to firearms. A review published in 2016 reported that 22 states have enacted laws that limit legal access to guns, at least temporarily and with due process, for persons detained in a short-term hold (46). This typically requires a finding by two qualified clinicians that the patient poses an elevated risk of self-injury or interpersonal violence. Other states should follow suit and adopt such a policy in line with expert recommendations (53).

Individuals who acquire a record of two or more convictions for driving while intoxicated are very likely to suffer from alcohol dependence disorder, which is an especially robust risk factor for lifetime suicide risk.

Recommendation 1b: States should prohibit purchase and possession of or access to firearms for persons with a record of repeated alcohol-impaired driving

More than 1 million people are arrested for drunk driving each year in the United States, and approximately one-third of them are repeat offenders (55, 56). Individuals who acquire a record of two or more convictions for driving while intoxicated are very likely to suffer from alcohol dependence disorder (57), which is an especially robust risk factor for lifetime suicide risk. States could institute a time-limited gun prohibition—5 to 10 years—applicable to anyone who acquires a second DUI conviction (53). Although this restriction would not directly remove an alcohol-dependent person's inclination to self-harm, it could substantially reduce the person's access to the most lethal method of suicide if he or she experiences suicidal impulses, thus rendering suicide attempts by alternative means far more survivable.

Recommendation 2. Enact ERPO Laws

States should enact ERPO laws, which have already been enacted in many states and which enable police officers or concerned family members to seek a civil restraining order to temporarily remove firearms from a person who is behaving dangerously (33). Three specific features of ERPOs, described below, that have not been widely adopted would make these laws more useful and effective.

Recommendation 2a: ERPOs should confer a purchase prohibition in the FBI's background-check database

States' ERPO statutes should explicitly be made applicable to persons behaving dangerously—those who meet the statutory risk criteria—even if these persons do not currently possess a gun or express an intent to obtain one, in order to prevent them from acquiring firearms for the duration of the ERPO. Research has found that many gun suicide decedents obtained a gun for the sole purpose of ending their own life but had not otherwise possessed firearms. There are examples of ERPO respondents who acquired additional guns following the removal order and succumbed to gun suicide soon thereafter (52). ERPO statutes, therefore, should include provisions to prevent any gun purchase by an ERPO respondent during the period covered by the gun-removal order—typically 12 months.

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To accomplish this, states with ERPO laws should include mandated reporting of ERPO cases to the federal NICS database, with a corresponding provision to expunge these cases from the NICS upon expiry of the ERPO order in the issuing state. This feature is designed to prevent at-risk individuals from acquiring or reacquiring firearms while they continue to pose a high risk of suicide or other harmful behavior with a gun. The recommendation could also be pursued through federal regulation, requiring all states to enforce the prohibition conferred by an ERPO issued by any other state, as is required by the federal Violence Against Women Act for other types of protection orders.

Recommendation 2b: ERPOs should be applicable to persons under age 18 who meet the risk criteria specified in the statute

The application of ERPOs to minors would prohibit minors who pose a significant risk of harm to self or others from having custody, control, or possession of or access to firearms; require notification of their parents or guardians about the prohibition and their legal obligation to secure any firearms; and authorize time-limited removal of firearms from the parents or guardians if they fail to secure their firearms or prevent access to them by the minor.

Recommendation 2c: Clinicians should be authorized to petition for an ERPO for their patients who pose a significant risk of harming themselves or others

States should authorize ERPO petitioners to include physicians and other primary care and mental health care providers. To date, only Maryland, Hawaii, and the District of Columbia include this provision in their ERPO statute. Clinicians are in a unique position to obtain and evaluate time-sensitive information about a patient's risk of suicidal behavior and access to guns. Clinician involvement in ERPOs should be framed as one option on a continuum of interventions for patients with firearms who may pose a suicide risk. On one end of the spectrum are public health–driven preventive practices, such as routinely asking patients about firearms in the home; counseling patients concerning the risks associated with firearms; and educating them about actions to mitigate risk, such as safe storage and handling of guns and ammunition (58, 59). On the other end of the spectrum are proactive interventions, such as encouraging at-risk patients to voluntarily separate from their guns and initiating an ERPO or an involuntary commitment. ERPO statutes should provide limited legal immunity from tort liability for clinicians who exercise discretion in good faith about whether to petition for an ERPO, similar to existing immunity provisions for some civil commitment decisions. Clinicians would need to use caution and utilize an ERPO petition only in cases in which a patient's threatening behavior would otherwise qualify for an unauthorized disclosure of private health information under the HIPAA Privacy Rule (60).

Recommendation 3. States Should Adopt PAS or Self-Enrollment in the NICS

States should adopt an innovative policy known as precommitment against suicide (PAS), or voluntary self-enrollment in the NICS (61). Many individuals who experience recurring episodes of suicidal thoughts and behavior—often associated with a chronic mood disorder—also experience periods when they become insightfully aware of their own risk of suicide during a future relapse of illness. They are thus able to plan ahead to limit their own access to lethal means should such a crisis occur. The PAS policy would make widely available a form that an individual could use to request that his or her own name be entered into the FBI's NICS database of gun-prohibited purchasers. The person could use an analogous process to remove his or her name from the NICS, with a 7-day waiting period. Essentially, the PAS amounts to a self-initiated, opt-in waiting period for buying a gun, and it could save many lives (62).

States should authorize ERPO petitioners to include physicians and other primary care and mental health care providers.

4 Conclusion

There should not be a forced choice between suicide prevention policies that increase the public's access to mental health treatment interventions and those that decrease at-risk individuals' access to firearms. Both approaches have their place and should be complementary. Gun restrictions that apply to people with mental illnesses, in particular, must be very narrowly focused on behavioral indicators of suicide risk to avoid stigmatizing people in recovery and unduly restricting the rights of millions of people who pose no elevated risk of harming themselves or others (63). In their current state, behavioral health care interventions and delivery systems are unlikely to substantially curtail the occurrence of suicidal thoughts and behavior in the population. In the interest of keeping more people alive who will inevitably experience the impulse to end their own life, policy makers in the United States should put more emphasis on expanding the use of tailored legal tools to reduce such individuals' access to firearms. The statutory reforms summarized here are targeted, achievable modifications to existing constitutionally tested policy templates that could save lives.

In the interest of keeping more people alive who will inevitably experience the impulse to end their own life, policymakers in the United States should put more emphasis on expanding the use of tailored legal tools to reduce such individuals' access to firearms.

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