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ARLINGTON, VIRGINIA

ON BEHALF OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

REGARDING SENATE JUDICIARY COMMITTEE HEARING ON

"RED FLAG LAWS: EXAMINING GUIDELINES FOR STATE ACTION"

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Chairman Graham, Ranking Member Feinstein, and distinguished members of the Judiciary Committee, thank you for giving me this opportunity to testify at this important hearing on Extreme Risk Protection Orders. My name is Ron Honberg and I am Senior Policy Advisor for the National Alliance on Mental Illness (NAMI). NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI is comprised of approximately 600 state and local affiliates in all 50 states and the District of Columbia engaging in support, education and advocacy on mental health issues. Our members are primarily people who live with mental illness, families, and advocates.

In the aftermath of mass tragedies in recent years, the focus of public opinion and dialogue has often been on mental illness as the culprit. This is unfortunate, both because mental illness is frequently not the culprit, and because the often-unfounded presumption that acts of mass violence must be attributable to mental illness reinforces longstanding negative stereotypes linking mental illness with violence.

Overall, only 4% of violent acts in the U.S. are attributable to mental illness.[i] Most people with serious mental illness are never violent towards others and are more often victims of violence than perpetrators of violence. As described in greater detail below, although a small subset of people with serious mental illness may pose increased risks for violence towards others, this is generally associated either with other risk factors for violence or the untreated symptoms of psychosis, such as delusions or hallucinations.

Risk Factors for Violence Toward Others

Research on risk factors for violence, including gun violence, have identified the following factors as potential predictors. It is important to consider these factors in context. The fact that a certain behavior or characteristic may constitute a risk factor for violence doesn't mean that most people who fall into this category will engage in violence.

Evidence-based factors that increase risks of violence include:

- A history of violence, which the strongest predictor of future violence;
- A history of physical or sexual abuse, particularly in childhood;
- Abuse of alcohol or drugs;
- Domestic violence has been identified as a risk factor, particularly for violence with a firearm;
- Past convictions for violent misdemeanors;
- Delusions and paranoia, sometimes characteristic of psychosis. People experiencing first episodes of psychosis may particularly be at risk. However, it should be noted that most people experiencing these symptoms will not act violently towards others.[ii]

Suicides – The Most Significant Risk

The magnitude of the suicide crisis in the U.S. cannot be overstated. In 2016, suicides were the 10th leading cause of death for all Americans. Nearly 45,000 people died by suicide. Suicide rates were more than 2 times higher than homicide rates. For young people between the ages of 10 and 24, suicides were the second leading cause of death in 2016.[iii]

The epidemic of suicides has been particularly severe among veterans. In 2016, the U.S. Department of Veterans Affairs reported that about 20 veterans per day take their own lives. In that same year, veterans accounted for 14% of all suicide deaths in the U.S. Rises in suicide rates among young veterans between the ages of 18 and 34 have been particularly prevalent between 2006 and 2016.[iv]

Nearly half of all suicide death in the U.S. are with firearms. And, suicides account for 60% of gun deaths in the U.S. each year. Because guns, when used, are frequently lethal, 90% of suicide attempts with guns result in deaths. Others result in serious disability.

And, a significant percentage of people who die by suicide were diagnosed with major depression or another serious mental illness. While it is difficult to accurately diagnose the existence of a mental illness after a person's death, the Centers for Disease Control (CDC) recently estimated that about half of all suicide deaths involved people diagnosed with mental illness, and they speculated that the actual rates may have been significantly higher because many others may have had mental health conditions but had not seen a mental health professional and thus were undiagnosed.[v] Other experts have suggested that rates of mental illness among those who complete suicides could be as high as 90%.[vi]

Extreme Risk Protection Orders (ERPOs).

ERPOs are civil court orders issued by judges to temporarily remove firearms or ammunition from persons who are identified as posing immediate or imminent risks to the safety of themselves or others. Currently, 14 states plus the District of Columbia have passed laws authorizing ERPOs and similar legislation is pending in several other states.[vii] Although state laws differ in terms of requirements and procedures, ERPOs generally involve a two-stage process, depending upon the urgency of the specific situation.

In urgent cases which involve concern about potential immediate risk of gun violence, an "ex parte" hearing may be held which may or may not involve notice to the individual who is the subject of concern. In such cases, the judge may issue a temporary order prohibiting the person from possessing or purchasing a firearm. Typically, these orders are in effect for three weeks or less. Based on experiences in the states, sometimes temporary orders are all that are required to alleviate the immediate crisis and prevent harms to the individual or to others.

When ex parte orders are issued or in cases where risk may be viewed as less immediate, a subsequent hearing will take place to further assess dangerousness and determine whether a longer-term order should be issued. At that hearing, the petitioner will be required to testify and present evidence why the order should be issued. The person who is the subject of the

petition must be given notice of the hearing and provided with an opportunity to present evidence that he or she is not dangerous and that an ERPO should not be issued.

When the court determines, based on the evidence presented, that the order should be issued, it typically lasts for up to one year. At the end of this period or earlier if the respondent provides evidence satisfying the court that he or she is no longer dangerous, the firearms must be returned. Most state laws also include provisions permitting petitioners to file requests to renew orders if they believe the person remains dangerous and should continue not to have access to firearms.

NAMI's position on ERPOs

NAMI supports state laws authorizing ERPOs when they are carefully crafted to focus on evidence-based risk factors for violence. ERPOs provide legal mechanisms for family members or law enforcement officers to petition courts for the removal of firearms from people whose actions or statements raise concerns about potential for violence towards themselves or others. The criteria for issuing ERPOs in state laws are based on specific, real time behaviors rather than categorical assumptions based on past events, such as civil commitments, that may or may not reflect the person's current state of mind. When properly utilized, they can be potentially lifesaving, particularly in preventing suicides, which are frequently impulsive acts.

To maximize the positive impact of ERPOs and to prevent unintended consequences or abuses of these laws, we offer the following six recommendations.

First, state ERPO laws should emphasize that determinations of risk should be based on individualized assessments rather than stereotypical assumptions about specific groups of people that are not grounded in evidence. For example, as clarified earlier in this testimony, an individual's history of mental illness or specific diagnosis is not a good predictor for violence. It is therefore neither necessary or appropriate to specifically identify mental illness as a risk factor in state or federal laws. Doing so reinforces historical stigma and prejudice towards

people with mental illness, without providing useful guidance on how to accurately assess potential risk factors.

Second, as with any deprivation of individual liberty, it is very important to ensure that subjects of ERPO petitions are afforded due process protections, including whenever possible notice that a petition has been filed and a hearing scheduled, the right to present evidence in one's own behalf, and the right to periodic reviews to assess whether it is necessary to continue the order.

Third, law enforcement officers assigned responsibility for removing firearms from individuals subject to ERPOs should receive training on crisis de-escalation and crisis intervention. The removal of firearms from individuals who are reluctant to give up their guns or who are in crisis can be difficult and even potentially volatile. In such situations, protecting the safety of officers and the individuals they are responding to is of paramount important. The nationally recognized Crisis Intervention Team (CIT) model is a proven best practice for training first responders on crisis intervention and for linking those people who require mental health care with needed services and supports.[viii]

Fourth, the use of stigmatizing language and terminology should be avoided in writing or describing these laws. Terms like "Red Flag Laws" risk increasing stigma towards people who have been historically marginalized and subjected to prejudice and discrimination, such as people with mental illnesses. Perhaps the most blatant example is the term used to refer to mental illness in the federal law authorizing the NICS system, "adjudicated as mentally defective." Terms such as these are offensive and upsetting to people with mental illness and may even indirectly reinforce perceptions that mental health care should be avoided because of potentially adverse consequences. The term "Extreme Risk Protection Order" is both less stigmatizing and more accurately describes the purpose of these laws, which is to reduce risks and save lives.

Fifth, authority to initiate petitions for ERPOs in state laws should be expanded to include health care professionals. Most existing laws currently limit standing to petition for ERPOs to law enforcement officers and (in some states) family members. While NAMI respects the importance of protecting the therapeutic alliance between health care professionals and their patients, we also recognize that these professionals are often best positioned to recognize crises situations and when their patients are at risk of harming themselves or others. Although laws such as HIPAA and state confidentiality statutes set forth privacy protections, they also contain exceptions that permit communicating information when necessary to protect the safety of individuals or the public. Adding health care professionals to the list of those with authority to initiate petitions should not establish a mandate, but rather create an option for practitioners to act when circumstances so dictate.

Finally, if ERPOs are to be successfully implemented, it is necessary for states to expend resources on educating key stakeholders, including law enforcement, families, and others, about these laws and how to utilize them. Funding for training and the development of written resources for law enforcement, lawyers, judges, health and social service providers, and family members is necessary. Public education about the availability of these laws and how to use them will also be important, as will be technical assistance on the ground. The implementation of laws authorizing ERPOs will only be effective if assertive efforts are undertaken to educate stakeholders about these laws and provide training and technical assistance on how to use them.

Thank you for this opportunity to testify about ERPOs and their implementation in states. I look forward to your questions.

[i] J.Swanson, E. McGinty, S. Fazel and V. Mays, "Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy," Annals of Epidemiology, 25 (2015), 366-376.

[ii] For more information about risk factors for gun violence and suicide, see J. Swanson, E. McGinty, et. al., "Mental Illness and Reduction of gun violence and Suicide: Bringing epidemiologic research to policy," Annals of Epidemiology, 25 (2015) 366-376; also The Educational Fund To Stop Gun Violence, "Guns, Public Health and Mental Illness: Summary of the Best Available Research Evidence," Feb. 2018.

[iii] National Institute of Mental Health, Factsheet on Suicide, downloaded 3/23/2019, https://www.nimh.nih.gov/health/statistics/suicide.shtml

[iv] L. Shane III, "VA suicide rates for younger veterans increased by more than 10 percent," Military Times, Sept. 26, 2018, https://www.militarytimes.com/news/pentagon-congress/2018/09/26/suicide-rate-spikes-among-younger-veterans/

[v] CDC Vital Signs, "Suicides Rising Across the U.S.," June 2018, https://www.cdc.gov/vitalsigns/pdf/vs-0618-suicide-H.pdf

[vi] J. Cavanaugh, A. Carson, et. al., "Psychological Autopsy Studies of Suicide: A Systematic Review," 33 Psychological Medicine, 395, 395-405 (2003).

[vii] States with ERPO laws as of the date of this hearing include California, Connecticut, Delaware, Florida, Illinois, Indiana, Maryland, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington.

[viii] For more information about the CIT program, see http://www.citinternational.org/What-is-CIT